

3A	QUALITY STANDARDS – OPERATIONAL PROCEDURES - ADMINISTRATION
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All Administration Sopps should be read in conjunction with the following:

Core Reference Section (2R)

Information previously duplicated in different SOPPs has now been collated into a new core reference section. This includes management of the abnormal cervical sample (2R.31) and all algorithms (2R.40).

Regional Programme Coordinator

Where there is reference to RPCs in the Sopps; this could include delegated authority to the 'Clinical Lead' in CSAD, where such a post exists.

Free Text Fields on Exeter

Information entered in free text fields should only be used where necessary and kept to a minimum. Information entered in structured fields should not be duplicated in free text, unless it has a direct influence on patient management eg where the histology of a hysterectomy has been reported normal, but due to recent CIN the RPC has requested 2 vault smears.

Manual Amendment of Recall Dates

All instances where the recall is amended whether (forward or back) must be recorded in the W6-RDATE field.

Ceasing Recall

All instances of recalls being ceased manually must be recorded in the W6-CEASE field. There is no requirement to do this where the recall is automatically ceased as an audit trail for this action is automatically recorded on Exeter.

Audit Trails (not Where documents are kept for any length of time eg HMRs, CANISC Lists, Safety Net Letters, Returned Undelivered Mail it is recommended that the persons entering\checking initials and dates (not necessary for person entering HMRs to insert date)

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3A.10 MANAGING THE PRE-INVITATION PROCESSING

3A.10.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.10.2 Quality Standard

From December 2009 practices have not been receiving Prior Notification Lists (PNLs); however, the routine (AJ-RG) that produced PNLs still needs to be processed as part of the call/recall cycle along with W6-PIP (pre-invitation processing).

3A.10.3 Method

i. Processing the AJ-RG

Every month the CSAD processes this routine 4 weeks before women are due an invitation. This routine moves the women's status onto 'GP not informed'.

Before AJ-RG is processed the CSAD run:

- AJ-CYIC integrity checker – this autocorrects errors
- W6-PIP – Pre-invitation processing

W6-PIP identifies:

- All CALL women and sets next test due dates for these women 4 months from the date of processing
- Identifies women with a recall date in the past who have re-registered with a GP. These are resolved prior to running AJ-RG
- Women with an invalid sex code, invalid dates of birth and females who have their title missing. These are passed to the BSC for resolution
- All women 65 and over at their next test due date. CSAD check list to identify which women can be ceased see 3A.11
- All women whose correspondence marker is set to 'No' and automatically changes status to 'YES'
- All women due for recall who have an open SafetyNet episode 12 months after their referral test; do not have an invitation letter produced and their status is moved to 2nd letter

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- All women due for recall who have an open SafetyNet episode and are due to enter special cycle. The default is that an invitation letter will be produced for these women
- Women with an open ColpSafe episode are postponed for 6 months from production of the PIP List

3A.10.4 Quality Measures

- All Women aged 65 and over are discharged from the programme, unless on early recall

3A.10.5 Quality Control/Audit

Monthly run of W6-PIP, AJ-CYIC and AJ-RG

3A.10.6 Further Guidance

- 3A.130 Processing active refusers
- 3A.140 Ceasing women who are eligible to be screened
- 3A.141 Postponing women from the screening programme
- 3A.142 Managing Consent and Capacity
- 3A.510 Retention and disposal of paper records

3A.11 WOMEN AGED 65 AND OVER WHEN NEXT TEST DUE

3A.11.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.11.2 Quality Standard

The population age group for cervical screening is women aged 20 to 64.

Women who are on routine recall (ie women who are not undergoing cytological surveillance after an abnormal or inadequate test or treatment) and will be 65 and over at the time of their next test due date will be discharged from the programme.

Women on early recall aged 70 or over who have not had a test within the last 5 years can also be considered for ceasing from recall.

Women who have no screening history and will be 65 and over at the time of their next test due date will be discharged from the call and recall system, but may be screened opportunistically within the programme.

3A.11.3 Method

Each month, prior to the processing of AJ-RG, W6-PIP (list invitation exceptions) is run to identify any women 65 and over at date of next test due.

The year then month is identified for the date of recall and this job is then printed via the PQ screen.

The cytology history for all women listed should be checked prior to ceasing.

If the woman is on routine recall, or the woman has never been tested, she can be ceased.

If a woman has had one inadequate test and was not on early repeat prior to her inadequate test and has reached non-responder status by the time she appears on the list she will be ceased. If she has not reached 'non-responder' status she will remain in the invitation cycle until she does so.

Women aged 70 or over on early recall who have not had a test within the last 5 years can be ceased from recall. The Regional Programme Coordinator must review all such cases individually before authorising removal from the programme. Letter **WCS9** is sent to the woman advising of the action, with the letter copied to her GP.

3A.11.4 Quality Measures

- 100% of women on routine recall who will be 65 or over at the time of their next test due date will be discharged from the programme
- 100% of women who have no screening history and will be 65 or over at the time of their next test due date will be discharged from the call and recall system
- A list is prepared and printed every month prior to AJ-RG being run and all appropriate women are ceased
- Women aged 70 or over on early recall with no test in the last 5 years, are ceased from the programme, if authorised by the Regional Programme Coordinator

3A.11.5 Quality Control/Audit

W6-PIP- list of invitation exceptions

3A.11.6 Further Guidance

- 3A.10 Managing the pre-invitation processing
- 3A.20 Managing the invitation run
- 3A.140 Ceasing women who are eligible to be screened
- 3A.510 Retention and disposal of paper records

3A.20 MANAGING THE INVITATION RUN

3A.20.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.20.2 Quality Standard

All eligible women are sent a standard written bilingual invitation letter and appropriate leaflet version of "Cervical Screening – The facts".

Invitation letters are produced for five recall types:

- Inadequate
- Call
- Routine
- Repeat Advised
- Suspend

All standard invitations are sent in the name of the registering general practitioner and printed on CSW headed paper. This does not include women registered under Dummy Doctor who will receive their invitations in the name of the Regional Programme Coordinator.

The letters are processed and sent by an external letter provider company.

Invitations are sent by second class post within 1 week of being printed.

3A.20.3 Method

Over a 12-month period the CSAD produce the following cycle, for all call, routine recall invitations:

- First invitation
- Reminder letter at 6 months
- A 'non-responder' card sent to general practitioner at 12 months (see 3A.150)

For all early repeat advised or suspend (latest test R or S):

- First invitation
- Reminder letter at 4 months
- A 'non-responder' card sent to general practitioner at 6 months (see 3A.150)

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- Women who have been through the suspend category cycle once then enter the special cycle of letters after 12 months. This cycle is repeated yearly until a test result is received
- 'special' letter to woman's GP from the Regional Programme Coordinator a further 4 months later
- 'special' letter to woman 2 months after the GP letter has been sent

This cycle is repeated yearly until a test result is received.

NB: If the next test due date is amended then the 'special letter cycle' is broken and the woman will then go through the 'normal' suspend recall category before re-entering special cycle 12 months later.

Step One

4 weeks after running AJ-RG the CSAD processes AJ-RP. This produces invitation letters and non-responder cards. A summary list is produced and printed before the invitation letters as this list show which letters will be produced and the total number of letters by type.

The list will include:

- Women listed due to FP69 status set – CSAD do not take any action as W6-RP routine will identify these (AJ-RP FP69 letters)
- First notification to woman is due but RG has not yet run – women new to the area and test due date is in the past – CSAD to update from list as appropriate
- Notification not required (special letter cycle information) – CSADs to check code in last column. If any letter code other than **SX** appears, then the DD screen and the woman's record must be checked, where appropriate the CSAD may need to issue individual letters

NB: Exeter may produce inconsistency reports at this stage highlighting women due for recall but for whom an invitation letter cannot be produced automatically. These should be actioned as appropriate.

Step Two

W6-RP is processed and produces the following:

- Vault smear invitation letters (**WHY1** and **WHY2**)
- An enquiry letter to the GP for women in the 'special letter cycle'
- An enquiry letter to the GP for women on early recall whose status is set to FP69, An FP69 letter will only be sent to the GP the first time the woman appears as an FP69 entry

If necessary W6-RP allows for certain letters to be printed at CSAD ie women registered on a dummy doctor and students living in residence halls; where the letters are sent to a central point at that address.

NB: The W6-RP **must be processed and completed** before invitation letters are processed and non-responder cards printed.

Step Three (Printing via external letter provider company)

After the AJ-RP and W6-RP have been processed, an email is produced identifying the number of letters for each recall type in the routine; the data is transferred via **L1-A,AP** on Exeter to IT Screening Services for encrypting prior to the transfer to the external letter provider company:

- An email is received from Health Solutions Wales indicating the number of invite letters in the file
- An email is received to advise CSADs that the processing has been complete at the external letter provider company
- Sign into the DA Web
- Choose **Sign-off Reconciliation**
- Select the appropriate CSAD under **customer** and then **submit**
- This then shows the processed file and includes the following information:
 - Region Name
 - Corp ID
 - Total volume of file
 - Date and time file was processed
- Then click on **PDF icon** to download the **PDF** for approval
- While the **PDF** file is downloading, the user is able to continue the process by clicking on the row for the required period, a separate window will show the breakdown of the number of letter types. This will show a breakdown of letter types and volumes for each. This can be reconciled against the email produced by HSW; if the number of letters matches, the **sign off** option is chosen. If the number of letters do not match, then this should be discussed with the external letter provider company
- The **PDF** file is then opened; this contains sample letters together with demographic details and the sexual health clinic leaflet. When the CSAD have checked that the samples are correct, **Sign-off PDF** is chosen; if there are any concerns then these are again fed back to the external letter provider company. The screen is frozen whilst the data is transmitted and when refreshed it appears with a '**green tick**' to indicate that the PDF sign off has been transferred to the external letter provider company

3A.20.4 Quality Measures

- 100% of eligible women are sent the appropriate invitation letter in an appropriate timescale
- Sample of invitation letters are checked against a master copy
- 100% of letters are balanced against the summary list

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- 100% of invitation letters produced on a print run are posted within 1 week
- AJ-RP is run 4 weeks after AJ-RG

3A.20.5 Quality Control/Audit

Inconsistency report

AJ-RP is filed in date order and retained for 1 screening round and current year

3A.20.6 Further Guidance

3A.10 Managing the pre-invitation processing

3A.140 Ceasing women who are eligible to be screened

3A.150 Non-responder cards for GPs

3A.240 Managing FailSafe

3A.510 Retention and disposal of paper records

3A.30 RECEIVING THE REPORT FORM

3A.30.1 Staff Responsible

Managerial Responsibility

CSAD managers

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.30.2 Quality Standard

All cervical screening reports (eg HMR forms) received at the CSAD are recorded on receipt from the Pathology Laboratory, verified and sorted for processing. All processed report forms are filed appropriately for retrieval.

3A.30.3 Method

Report forms are either printed at the laboratory and posted to CSAD or in some areas the report forms are printed directly at CSAD.

A named individual within each laboratory is responsible for the safe transfer of report forms to the administration department.

i. Receiving and Verifying batches of report forms received (printed at laboratory)

Where paper copies of report forms are printed at laboratories and sent to CSAD, each envelope batch is uniquely identified with the laboratory identification and a consecutive numbering system. Each envelope displays the following information:

- Laboratory Identification
- Dispatching Officer Identification
- Date of dispatch
- Total number of negative reports
- Total number of action required reports

The envelope details described above are recorded by the laboratory in a dispatch logbook.

On receipt of a batch of report forms the CSAD enters the following information in the Batch Receipt logbook:

- Batch number
- Date sent from the Pathology Laboratory
- Laboratory Officer Identification

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- Date received at CSAD
- The initials of the person receiving the batch
- Confirmation that the laboratory has been informed of receipt (see below)

The batch number is checked by the CSAD with the previous batch number. Any discrepancies must be reported to the laboratory immediately.

Laboratories are strongly advised to keep a note of the accession numbers of tests included in the 'action' bundle until safe receipt is confirmed by the CSAD. The record may be included in the dispatch log (this is not a mandatory requirement).

On receipt of the batch the CSAD telephones the designated dispatching officer or named deputy (or a laboratory manager/senior BMS if the appointed officer is not available) to confirm receipt of the batch. The identity of the dispatching officer or deputy is clearly indicated to the receiving officer. The date of the call and the initials of the CSAD staff member making the call is recorded in the Receipt Logbook.

Acknowledgement of receipt is expected by the laboratory within 1 working day; non-response will be notified to the CSAD, by telephone, for immediate investigation. This action will be recorded in the laboratory's dispatch log.

Results which have been sent to other areas may be noted on the exceptions list produced by W6-PATH. Once the list has been resolved it is archived.

Urgent referrals requiring an appointment within 2 weeks (see 6C.20) will be notified to CSAD by laboratory via telephone and/or fax. CSAD will in turn telephone the colposcopy service and notify them that an urgent referral is being processed. The colposcopy service do NOT take any definite action until the direct referral paperwork is received from CSAD, other than using the information to ensure an appointment slot is available within the appropriate timescales.

Report forms printed at CSAD

On a daily basis CSAD print report forms which have been authorised by the laboratory the previous working day:

- To produce normal recalls, repeat advised and negative repeats the code **FACT** is inputted at the CSAD and this then generates the next run of report forms
- To produce Direct Referrals the code **FR** is inputted

The system identifies the total number of reports to be printed and issued in the batch. This total is noted by CSAD so that a check is made once all report forms are printed. The batch number will run consecutively.

All report forms are printed in slide number order for the CSAD copy and the GP copy. In cases where there is a different sender eg Community Clinic a sender copy is printed. Each copy is printed on CSW report paper and each one is labelled to state which copy belongs to who. Once the reports have printed the laboratory is telephoned to enable them to begin their internal FailSafe checks.

CSAD produce a summary report which lists each smear produced in that particular run and the total number of reports printed. This figure is matched against the quantity given at the first stage when the run is quoted. The laboratories also receive this summary report and use it for their FailSafe checks.

All reports at CSAD are counted to ensure they match the figure previously quoted.

Once a telephone call has been received from the laboratory stating they have completed all their checks and is satisfied with the inputted data on report form the reports are date stamped ready for input at the CSAD. The GP and sender copies are also distributed at this stage.

i) Date Stamp

Each report form in the batch is date stamped. The stamp contains the following:

- Date received
- Space for the initials of the person who entered the test on the system
- Space for the initials of the person who checked the details and the date checked

ii) Sorting report forms for processing (3A.40)

- Forms are sorted by result code
- Every report form from that batch is coded and entered on Exeter or is entered as a 'logged test result'
- At least on a weekly basis the CSAD will request a logged test result report using utilities menu 16 (smears awaiting action) or the AJ-CSLP routine. This ensures that all test results entered on the Exeter as 'logged' will continue to be queried by the CSAD until resolved (see 3A.60)

iii) Filing report forms

All report forms are filed by the month in which the test is taken and further sorted alphabetically by the first letter of the woman's surname.

3A.30.4 Quality Measures

- 100% of Batches are recorded in the Receipt Batch Log and the total number of negative and non-negative test results are checked against the laboratory totals
- 100% of Batches are confirmed as received by the CSAD to the laboratory within 1 working day
- 100% of discrepancies are referred to the laboratory and if not resolved then referred to the Regional Programme Coordinator

3A.30.5 Quality Control/Audit

Audit of dispatch/receipt logs
Weekly check of logged tests

3A.30.6 Further Guidance

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.70 Processing electronic check lists from pathology laboratories
- 3A.510 Retention and disposal of records
- 4P. Pathology quality manual

3A.40 PROCESSING THE REPORT FORM

3A.40.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.40.2 Quality Standard

All report forms received by the CSAD are coded in line with CSW suggested management and entered accurately onto the Exeter system within 1 week of receipt at CSAD.

3A.40.3 Method

CSADs may decide to process all referral test results before other results to ensure that they are entered onto the SafetyNet and referred to the Colposcopy service within 1 week (under direct referral).

NB: CSAD staff should query any result which they feel may be out of the ordinary eg if two test results have been received on the same woman in a short space of time, the result should be queried with the laboratory to ensure details on the forms are correct.

i) Coding and inputting the report form

The laboratory should always append a management recommendation to the final report form (unless an alternative CSW agreed procedure has been temporarily put in place).

As a minimum standard all report forms are coded and inputted by one member of staff and verified by a different member of staff. All report forms are coded against the screen. It is the CSAD manager's responsibility to ensure that staff who code and input are trained to undertake these tasks.

It is the responsibility of the local CSAD manager to ensure that inputting and verifying results are done using the same method by all staff in the local CSAD.

NB: either the inputting or verifying method must use the NHS number (if available) as the main identifier.

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On receipt of the report form the CSAD officer:

- Identifies the woman on the CY screen using the agreed local method
- Checks the woman's registration details against the report form:
 - Date of birth
 - NHS number (if available)
 - Full name
 - Address
 - Name and address of GP (if available)
- Marks the report form if the registration details differ
- Checks the coding on the screen and codes in accordance with CSW coding procedure (see 3A.50). The suggested management is recorded on the report form at the laboratory before the report is issued to the sender and the CSAD
- Checks the suggested management of the woman given by the laboratory. Any discrepancies from the CSW procedure are queried with the laboratory. If the CSAD and laboratory are unable to agree on the suggested management the report form must be passed to the Regional Programme Coordinator for discussion with the Pathologist or Cervical Cytology Manager

ii) Data entry

- Identifies the woman on CY screen. All registration detail discrepancies are altered where appropriate in accordance with the associated procedure
- Completes the relevant fields on the screen:
 - Lab code
 - Slide number
 - Test date
 - Sender national code (not used)
 - Result Notification (if applicable)
 - Source
 - Sender (if applicable)
 - Result code
 - Infection code (not used)
 - Action code
 - Repeat in months (if applicable)
 - Correspondence (no longer in use)
 - Comment (if applicable)
 - Complete

If the result is a direct referral 'NONE' is entered in the result notification box which sets a direct referral entry on W7 and allows clinic details to be printed on the result letter.:

- Inputs the following on the W7 screen (if applicable):
 - **Historic:** (if applicable)

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- **Date Received:** Date report form received at CSAD
 - **Smear Taker:** The CSW sample taker code (this field will define the actual taker of the test, as opposed to the sender of the test)
 - **Sender Letter:** (if applicable)
 - 1 Clinically Indicated (No Longer Used)
 - 3 Ceased
 - 5 Under Age
 - 11 Unprocessed Sample
- Sample Error**
If the smear is reported inadequate due to an 'administration error' then a **U** is entered
- Letter Code**
If a **U** has been entered in sample error then one of the following letter codes must be used to produce the appropriate result letter
- **WUCS** (unprocessed sample)
 - **WIDA** (inadequate post natal)
 - **WIDB** (repeated too soon)
- **Gland\Endo\?HG**
 - **GC** Endocervical
 - **GM** Endometrial
 - **GX** Other Glandular
 - **H** Borderline\?HG
 - **HC** Borderline\?HG/Endocervical
 - **U** Unprocessed
- **Direct Referral:** (automatically picked up from result entry)
- **Colp Clinic:** (automatically picked up from result entry)
- **TZ sampled:** this defaults to Y; tests with no TZ sampling need to be manually changed to N
- **T/I Refer:** transfer in with smear indicating referral
- **Smear Clinic:** (if applicable)

Correspondence address (direct referrals only)

If a correspondence address has been included on a report form CSAD enter the details onto W6-SN/MISC. This will ensure that the result letter and information sent to the Colp clinic will be sent to her correspondence address rather than her registered address.

The report form is initialled once the result has been inputted.

iii) Verifying the report forms

All results are verified against the original report form. All verification must be carried out by a CSAD officer who did not complete the coding or data input for the batch. The CSAD verifier:

Selects the CY screen by using the locally agreed method for verification:

- Checks the woman's registration details

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- Checks that all fields on the CY screen have been correctly completed
- Ensures that all entry queries are returned to the CSAD officer to be re-checked
- Ensures that all coding queries are referred to the Regional Programme Coordinator for correction/amendment
- Initials and dates the back of report form on completion of verification

NB: The verifier checking the report form against the inputted data does not take ultimate responsibility for the accuracy of the data for that form.

Verification of the W7 screen is not carried out routinely by CSAD.

iv) Woman aged under 20

The CSAD staff:

- Enters the woman's test onto the computer and a result letter is generated. For negative results the date is automatically set to either the woman's 20th birthday or routine recall date - whichever is the furthest away. For women with abnormal results the recall date is set in line with CSW policy
- For women with inadequate results the recall is also set in line with CSW policy. If woman is younger than 19 years and 6 months at time of test then her recall is set to her 20th birthday (letter **WIDR** is issued). If woman is older than 19 years and 6 months then result is processed in line with CSAD policy
- CSAD run a quarterly list via option 4 of the CSW utilities menu to identify cervical tests taken on women aged under 20. This list is produced for the Regional Programme Coordinator or Regional Nurse Coordinator

Women under 20 should not be routinely screened. All report forms received for women under 20 must be shown to the Regional Programme Coordinator/Regional Nurse Coordinator for monitoring purposes or a list of under 20's is produced on a regular basis from the CSW utilities menu (depending on local procedure).

v) Females aged under 16

The CSAD contact the sender of the test to determine whether the result and/or invitation letter may be sent to the home address if aged under 16 years of age. If no response is received after three attempts the result is logged onto the computer with **NONE** entered in 'result notification'. The result letter is then produced via W6-NB\LETTER\PAT.

The result letter together with a covering letter is sent to the sender of the test stamped with 'no home contact'.

vi) Coding Queries

All coding queries are referred back to the pathology laboratory by the CSAD, and if not satisfactorily resolved will be referred to the Regional Programme Coordinator for discussion with the laboratory.

All change of managements must be processed by the CSAD Manager, Deputy or other designated member of staff and agreed with designated members of staff at the laboratory.

If an amendment to the woman's recommended management is required following discussions with the laboratory a CSW 'change of management form' will be issued to the GP/sender (if applicable) by the CSAD.

A copy of the CSW 'change of management form' will be issued to the laboratory by the CSAD for record purposes and data amendment, confirming the agreed reason for the change.

The laboratory will issue an amended report to the GP and, if appropriate, the test taker. The text of the amended report must be clearly marked to indicate that the suggested management has been altered eg - '*Amended Report*'.

The CSAD will record the amendment on the administration copy of the laboratory report (computer generated report).
The laboratory will alter its database to record the amended recall interval.

The woman should not normally have received a result letter and will therefore be unaware of any change of management. In a situation where a result letter has already been sent to the woman she is informed of the amendment by letter, from the CSAD Regional Programme Coordinator.

vii) Changing results on Exeter following review

In some cases it may be necessary to amend a woman's test result. Any such change must be authorised in writing to the Regional Programme Coordinator.

In the following instances CSAD record changes electronically on Exeter:

- Where management has changed since the woman was issued with her test result
- Where CSAD have received subsequent information which may alter a result which has already been issued

CSAD log changes on **W6-NB\NHS number\Test**. The following are reasons for recording changes:

- CER - CSAD admin error

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- LAE – Lab admin error
- LSR – Lab slide review
- SUB – Subsequent information received

The following can authorise the changes:

- CSM – CSAD manager
- LM – Lab manager
- PC – Regional Programme Coordinator

When altering an Exeter record in this way, a full record of the change must be maintained, both on paper and on the Exeter system. CSADs should also note where to find any paper information which may be held relating to the review alteration.

3A.40.4 Quality Measures

Coding report Forms

- 90% of report forms received by CSAD to be coded, inputted and verified within 3 working days
- 100% of report forms received by CSAD to be coded, inputted and verified within 1 week

Checking of registration details against report form

- <10% allocated as coding queries
- 100% of report forms are coded against the screen

3A.40.5 Quality Control/Audit

Audit of Batch Receipt Log

Audit of results from 'women under 20'

3A.40.6 Further Guidance

- 3A.41 Processing results other than those received from pathology laboratories working as part of CSW
- 3A.42 Unprocessed samples
- 3A.50 Suggested management
- 3A.60 Managing the result run (AJ-CP)
- 3A.62 No result letter to home
- 3A.110 Women not registered in CSAD area
- 3A.171 Management of smears with changes in Glandular Cells
- 3A.510 Retention and disposal of paper records
- 4P.80 Pathology quality manual
- 4P.120 Pathology quality manual

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CHANGE OF MANAGEMENT FORM

a) Form sent to woman's GP

Dear

Re: Name.....DoB:.....NHS numbers:.....Path Lab:..... Slide:.....
Test Date:.....

It has been agreed that recommended management according to CSW policy for this woman should be:

.....
The reason for this is:

.....

.....
A copy of this notification will be sent to the Pathology Laboratory.

If necessary, the laboratory will issue an amended result to you.

If you have any concerns regarding this recommendation, please do not hesitate to get in touch.

Yours sincerely

Regional Programme Coordinator
CSW

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b) Form sent to sender of the test (if different from woman's GP)

Re: Name: DoB: NHS number: Path Lab: Slide: Test:
Date:

It has been agreed that the recommended management according to CSW policy for this woman should be:

.....
The reason for this is

.....

.....

A copy of this notification will be sent to the Pathology Laboratory.

If necessary, the laboratory will issue an amended result to you.

If you have any concerns regarding this recommendation, please do not hesitate to get in touch.

Yours sincerely,

Regional Programme Coordinator
CSW

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c) Form sent to laboratory

Dear Cytology Manager

Re: Name: DoB: NHS number: Path Lab: Slide: Test:
Date:

It has been agreed that recommended management according to CSW policy for this woman should be:

.....

The reason for this is:

.....

.....

A copy of this notification will be sent to the woman's general practitioner.

If necessary, you should issue an amended result to the woman's general practitioner and if appropriate to the sender of the test.

If you have any concerns regarding this recommendation, please do not hesitate to get in touch.

Yours sincerely

Regional Programme Coordinator
CSW

3A.41 PROCESSING RESULTS OTHER THAN THOSE RECEIVED FROM PATHOLOGY LABORATORIES WORKING AS PART OF CSW

3A.41.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.41.2 Quality Standard

All results received from sources other than pathology laboratories working as part of CSW should be processed in accordance to CSW policy within 1 week of receipt at CSAD.

These results could come from any one of the following sources:

- Over the network from CSADs and/or BSC's/PCT's
- Paper results received from Scotland and/or Northern Ireland
- Results received from women tested in other areas but registered with a Welsh general practitioner with a list on a Welsh BSC database
- Copies of results received from general practices
- Private tests (see 3A.280)
- Tests taken abroad (see 3A.280)

3A.41.3 Method

The CSAD process all results received other than from pathology laboratories as follows:

- All results which are received on paper are date stamped and entered manually (see 3A.40)
- Results received electronically are automatically updated from other BSC's/PCT's (see 3A.60) W6-CP (alphabetic list of letters) and Management of incoming cytology (see 3A.180)
- Results for women tested in Scotland and Northern Ireland are entered as per CSW policy, with the appropriate National Lab Code (if known) and screening BSC/PCT entered (see 3A.40)
- All women with test results which are not received electronically and are less than 4 months old are sent result letters issued in the name of the Regional Programme Coordinator

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- All results received electronically where it appears the woman has not already received a result are sent a result letter in the Regional Programme Coordinator's name

3A.41.4 Quality Measures

All test results which are not received electronically and are less than 4 months old will be sent a result letter.

3A.41.5 Quality Control/Audit

Audit of Batch Receipt Log

3A.41.6 Further Guidance

- 3A.40 Processing the report form
- 3A.50 Suggested management
- 3A.51 Coding table for CSAD staff
- 3A.60 Managing the result run (AJ-CP)
- 3A.280 Private women and tests reported abroad
- 3A.510 Retention and disposal of paper records

3A.42 UNPROCESSED SAMPLES

3A.42.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.42.2 Quality Standard

The laboratory informs the CSAD immediately of all samples which are unable to be processed and the woman is asked to attend for a repeat test. These may include damaged, lost, mislabelled, out of date or incomplete samples.

3A.42.3 Method

On receipt of the request form the laboratory immediately record the appropriate reason for a repeat test and send to the CSAD. The laboratory also advise the Regional Nurse Coordinator about the incident.

On receipt of the report form the CSAD enters the result onto Exeter by:

- Coding the form 1R (inadequate repeat) on the CY screen
- Entering **NONE** in the notification box to stop the standard inadequate result letter being produced
- Entering **U** (unprocessed) for the repeat test on the W7 screen (see 3A.40) and identifying the appropriate result letter
- Laboratories that do not use slide numbers as a matter of course for such occasions will use a dummy index starting at 90,000 for the year concerned, eg 90,000/11 as results cannot be entered onto Exeter without a slide number

Once the result has been processed a letter for the repeat test will be automatically generated for the woman. After the appropriate letter is entered on the W7 screen it is printed via the W3 screen.

Notifications of private tests which are damaged, lost, mislabelled or an out of date vial has been used are not sent to the CSAD from the laboratory and the laboratory contact the sample taker directly.

Because the result has been coded as a 1R staff check that the result is not included in her past management for any referral to colposcopy (ie three

inadequate results). The W7 screen will warn staff if it appears that an unprocessed sample has been included in a referral.

If a woman fails to attend for a repeat test she will receive a standard reminder letter in 6 months from the date the result was entered and will then move onto the non-responder stage 6 months later.

3A.42.4 Quality Measures

100% of women whose samples have been damaged, lost, mislabelled, taken too soon or received in an out of date vial will be recalled for a repeat test.

3A.42.5 Quality Control/Audit

W6-CP Alphabetical List

W3 screen

W7 screen

3A.42.6 Further Guidance

3A.20 Managing the invitation run

3A.40 Processing the report form

3A.60 Managing the result run (AJ-CP)

3A.43 SAMPLES TAKEN FROM WOMEN WITH A CEASED RECALL

3A.43.1 Staff Responsible

Managerial Responsibility

Regional Programme Coordinators
CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.43.2 Quality Standard

CSW discourage the taking of tests from women previously ceased from recall with a valid ceasing reason. This excludes women who have previously signed a CSW opt out as they may opt back into screening at any time if they are within the screening age group.

CSW inform women in their result letter that they will no longer be called for screening if:

- Their test result was negative/inadequate, and
- They had previously been ceased due to age or no cervix

CSW also send GPs and sample takers a 'ceased woman' letter under the above circumstances.

3A.43.3 Method

Receiving the test at CSAD

When a test is received at CSAD the CSAD Officer checks if that woman was ceased for a valid reason, or as a result of signing a CSW opt out form.

If the reason for ceasing was not valid, the woman is reinstated on recall and her test processed as for any other woman.

If she was ceased as the result of signing an opt out, the woman is reinstated on recall and her test processed as for any other woman.

For all other women, the management is decided by the test result (see below).

Processing tests by result type

Negative and inadequate tests

- Appropriate result letter (**WCS1** for negative/**WCS2** for inadequate) is sent informing the woman that she does not need further tests (no letter is sent if the test was taken in colposcopy service)
- Recall is immediately re-ceased
- A 'ceased woman' letter (**WCS6**) is sent to the GP/sample taker (no letter is sent if the test was the woman's first ever test)

NB: CSADs should be aware of circumstances where a test result is received at the same time as a woman being notified of cessation following production of a non-responder card, when she would have been 65 or over at the time of her next test.

Borderline or worse

- Direct referral letter is sent (no letter is sent if the test was taken in colposcopy or oncology clinic)
- Woman is immediately re-ceased
- Woman is directly referred to colposcopy for clinical assessment (unless the test was taken in colposcopy or oncology clinic)
- Woman is added to SafetyNet
- Women with borderline or worse tests whose test were taken in oncology clinic or privately must not receive a result letter. No referral is generated, but they are added to SafetyNet and their tests FailSafed. In each case the Regional Programme Coordinator contacts the test taker concerned asking them to inform CSW what action they have taken regarding the test result

NB: For borderline or worse for women aged 65 or over CSW policy is to directly refer women to Colposcopy and include on SafetyNet until they are discharged. Further management of the women on Exeter will depend on the outcome of the colposcopy. If negative or no abnormality is found recall is ceased. If CIN is diagnosed follow up will be as CSW protocol.

If a test is taken in Gynae or Colp for a woman who has previously withdrawn from the screening programme then advice is sought from the Regional Programme Coordinator on future management.

3A.43.4 Quality Measures

100% of tests received from ceased women are re-ceased unless their ceasing reason is invalid or they have previously signed a CSW opt out form.

3A.43.5 Quality Control/Audit

W6-CP Alphabetical List
CSW Utilities menu

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3A.43.6 Further Guidance

- 3A.40 Processing the Report Form
- 3A.50 Suggested Management
- 3A.60 Managing the Result Run (AJ-CP)
- 3A.120 Managing women with no cervix
- 3A.130 Processing active refusers
- 3A.141 Postponing women from the screening programme
- 3A.510 Retention and disposal of paper records

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3A.50 SUGGESTED MANAGEMENT

Please refer to 2R. Core Reference Section

3A.51 CODING TABLE FOR CSAD STAFF

LIST OF CODES

Code	Result
1R	Inadequate
1R (U)	Inadequate (unprocessed)
2A	Negative - routine recall
2R	Negative early repeat
3R	Mild Dyskaryosis
8R	Borderline
8R (GC)	Borderline changes in endocervical cells (not used after 31.03.11)
1S	Inadequate
8S	Borderline
8S (GC)	Borderline changes in Endocervical cells
8S (GM)	Borderline changes in Endometrial cells
8S (GX)	Borderline changes - Other Glandular
8S (H)	Borderline changes ? high grade
8S (HC)	Borderline changes? high grade and borderline changes in endocervical cells
3S	Mild Dyskaryosis
7S	Moderate Dyskaryosis
4S	Severe Dyskaryosis
5S	Severe Dyskaryosis/? Invasive Carcinoma
6S	?Glandular Neoplasia
6S (GC)	? Glandular Neoplasia - Endocervical origin
6S (GM)	? Glandular Neoplasia - Endometrial
6S (GX)	? Glandular Neoplasia - Other Glandular
2S	Negative smear taken in Colp

NB: all **S** coded results are either direct referrals (except 2S) or they are samples which have been taken in the Colposcopy service

NEGATIVE RESULT

	CURRENT TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
1	NEGATIVE	NOTHING	2A	
2	NEGATIVE	2A	2A	
3	NEGATIVE	1R AND 2A'S	2A	No previous history except negatives and inadequate
4	NEGATIVE	1S 1R 1R 2A	2A and no letter sent if taken in Colposcopy	Three previous inadequate preceded by a routine recall test therefore current test coded as routine recall
5	NEGATIVE	1R WITH PREVIOUS HISTORY (IF ON CYTOLOGICAL SURVEILLANCE OR FOLLOW UP)	2R12 or 2R6	See notes on cytological surveillance and follow up
6	NEGATIVE (Colp)	1S 4S, 5S, 6S, 7S	2S	
7	NEGATIVE	8R or 3R (ignore intervening inadequate)	2R6	Under cytological surveillance following borderline or mild
8	NEGATIVE	2R6 8R or 3R (ignore intervening inadequate)	2R12	Under cytological surveillance following one previous negative
9	NEGATIVE	2R12 2R6 8R or 3R (ignore intervening inadequate)	2A	Under cytological surveillance following 2 previous consecutive negatives.
10	NEGATIVE (Colp)	(CIN1 or HPV at Colp) 8S or 3S	2S	Cytological Surveillance – woman has been to Colp and CIN1 or HPV confirmed
10a	NEGATIVE (Colp)	(No abnormality at Colposcopy) 8S or 3S	2S (adjust recall to normal)	Modified surveillance if requested by consultant
10b	NEGATIVE	2S (No abnormality at Colposcopy) 8S or 3S	2A	Modified surveillance if requested by consultant
11	NEGATIVE	2S 8S or 3 S (CIN1 or HPV confirmed)	2R12	Cytological Surveillance – woman has been to Colp and has had one negative and CIN1 or HPV confirmed
12	NEGATIVE	2R12 2S 8S or 3S (CIN1 or HPV confirmed)	2A	Cytological Surveillance – complete return to routine recall
13	NEGATIVE (COLP)	8S or 3S (biopsy CIN 2/3)	2S	Cytological Follow up

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14	NEGATIVE (COLP)	7S or 6S or 5S or 4S (biopsy CIN 1/2/3)	2S	Cytological Follow up
15	NEGATIVE (2 years after treatment)	2R12 2S 8S or 7S or 6S or 4S or 3S or 5S (biopsy CIN 2/3)	2R12	Cytological Follow up (one or more previous negative)
16	NEGATIVE (3 years after treatment)	2R12 2R12 2S 8S or 7S or 6S or 4S or 3S or 5S (biopsy CIN 2/3)	2R12	Cytological Follow up
17	NEGATIVE (4 years after treatment)	2R12 2R12 2R12 2S 8S or 7S or 6S or 4S or 3S or 5S (biopsy CIN 2/3)	2R12	Cytological Follow up – 5 or more previous consecutive negatives at least 12 months apart but current test must be at least 10 years post treatment to return to routine recall therefore it is another repeat
18	NEGATIVE (10 years after treatment)	2R12 2R12 2R12 2R12 2S 8S or 7S or 6S or 4S or 3S or 5S (biopsy CIN 2/3)	2A	Cytological Follow up as above but woman can go back to Routine Recall
<p>Or if a woman fails to attend for one or more of the above follow-up tests, she may still be returned to routine recall if she has had at least 5 consecutive negative tests, each at least 12 months apart, and the final negative test is at least 10 years post treatment.</p> <p>NB: The above follow up does not apply to women who have been returned to routine recall within the 10 year period under previous CSW policy.</p>				
19	NEGATIVE WITH SUSPICIOUS CERVIX/CLINICAL SYMPTOMS	See main negative table	See main negative table	No action – GP refers if appropriate

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BORDERLINE CHANGES

	CURRENT TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
20	BORDERLINE	2A	8R6	Repeat in 6 months
21	BORDERLINE	2R6 8R6	8R	One previous borderline
22	BORDERLINE	2R6 3R	8S	One previous mild and current borderline – refer to Colp
23	BORDERLINE	2R12 2R12 2S 7S or worse	8S	Woman under follow up and has borderline therefore refer to Colp
24	BORDERLINE	2S 3S (CIN 1 at Colp)	8R6	One previous mild but woman has been to colposcopy and had negative smear so de-novo borderline.
25	BORDERLINE	2R12 2S 8S (CIN 1) (woman previously been to Colp)	8R6	Woman has been to Colposcopy and had negative smears so de-novo borderline.
26	BORDERLINE	8R6 2S 8S/3S (CIN 1 in Colp)	8R6	Second de-novo borderline so repeat.
27	BORDERLINE	2A 2R12 2S 8S (CIN 1 or HPV) 8R6 8R6	8R6	New occurrence as woman has completed previous cytological surveillance – repeat test.
28	BORDERLINE	2A 2R12 2R6 8R6 8R6 (within 10 years)	8S	A combination of three borderlines in 10 years – refer to Colp
29	BORDERLINE	2A 2R12 2S 8S 3R6	8R6	Previous surveillance completed – new occurrence so repeat test
30	BORDERLINE	3R	8S	Woman under surveillance following one mild therefore into Colp.
31	BORDERLINE (Colp)	(CIN1 biopsy) 3S 8R 2A	8S	Woman not discharged from Colp until negative test has been taken in Colp as under cytological surveillance.

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32	BORDERLINE (Colp)	(Negative Colp) 3S 8R 2A	8S No letter sent to woman	Modified surveillance if requested by consultant – repeat smear in 12 months in community
33	BORDERLINE	8S (Negative Colp) 3S 8R 2A	8R6	Modified surveillance if requested by consultant - second borderline following colposcopy
34	BORDERLINE	8R 8S (Negative Colp) 3S 8R 2A	8S	Third borderline following colposcopy.
35	BORDERLINE ?HIGH GRADE	Any result	8S (H)	Urgent referral (4weeks)
36	BORDERLINE CHANGES IN ENDOCERVICAL CELLS	Any result	8S (GC)	Routine referral (8 weeks)
37	BORDERLINE ? HIGH GRADE AND BORDERLINE CHANGES IN ENDOCERVICAL CELLS	Any result	8S (HC)	Urgent referral (4 weeks)
38	BORDERLINE CHANGES IN ENDOMETRIAL CELLS	Any result	8S (GM)	Urgent referral (4 weeks)
39	BORDERLINE CHANGES - OTHER GLANDULAR	Any result	8S (GX)	Urgent referral (4 weeks)

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INADEQUATE

	CURRENT TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
41	INADEQUATE	1R 1R 2A	1S	Third consecutive inadequate
42	INADEQUATE	1R 2A 2A 2A	1R2	Previous smear inadequate – repeat no sooner than 6 weeks
43	INADEQUATE	2A 1R 2A 1R 2A 1R	1R2	Inadequates are not consecutive – repeat no sooner than 6 weeks
44	INADEQUATE (Colp)	8S 8R 8R	1S (no letter)	Test taken in Colp therefore no referral is needed as woman is already in Colp

MILD DYSKARYOSIS OR WORSE

	CURRENT TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
45	MILD DYSKARYOSIS	Woman on early recall at time of test (ignoring inadequates)	3S	Refer in all cases (8 weeks)
46	MILD DYSKARYOSIS	Woman on routine recall	3R6	Surveillance
47	MILD DYSKARYOSIS (Colp test)	No abnormalities in Colp 3S 8R	3S (no letter)	Woman not discharged from Colp
48	MILD DYSKARYOSIS (Colp test)	CIN1 or above or 7S (mod dysk) or worse	3S (no letter)	Woman not discharged from Colp and followed up as per Colp protocols.

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MODERATE DYSKARYOSIS OR WORSE

	CURRENT TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
49	MODERATE DYSKARYOSIS	ANY RESULT	7S	Refer in all cases 4 weeks
50	MODERATE DYSKARYOSIS (Colp)	ANY RESULT	7S (no letter)	Remains in Colp
51	SEVERE DYSKARYOSIS	ANY RESULT	4S	Refer in all cases 4 weeks
52	SEVERE DYSKARYOSIS (Colp)	ANY RESULT	4S (no letter)	Remains in Colp
53	SEVERE DYSKARYOSIS/ ?INVASIVE CARCINOMA	ANY RESULT	5S	Refer in all cases 2 weeks
54	SEVERE DYSKARYOSIS/ ?INVASIVE CARCINOMA (Colp)	ANY RESULT	5S (no letter)	Remains in Colp
55	? GLANDULAR	ANY RESULT	6S (If possible should be accompanied by GC/GM or GX)	Refer in all cases 2 weeks
56	? GLANDULAR (Colp)	ANY RESULT	6S (no letter)	Remains in Colp

PRIVATE TESTS

	PRIVATE TEST RESULT	PREVIOUS HISTORY	MANAGEMENT	COMMENT
57	NEGATIVE	Normal recall on Exeter	2H	No result letter sent to woman and recall date is not changed
58	NEGATIVE	Early repeat on Exeter	2H	No result letter sent to woman and recall date is not changed
59	INADEQUATE	Normal or early recall on Exeter	1H	No result sent to woman and recall date is not changed
60	BORDERLINE/ MILD/	Refer to main table	8R or 3R	No result letter sent and woman will be re-invited in 6 months time
61	ANY REFERRAL SMEAR	Refer to main table	1 - 8 S coded smear	No result letter sent Not directly referred to CSW Entered onto SafetyNet

Letter Codes Used on CY

The following letter codes are entered in the **result notification** box of the CY screen, in the circumstances stated when inputting a test result.

WCS1

This is used when a **negative** result is entered for a woman who is already ceased for a valid clinical reason, or who may become ceased as a result of a clinical reason from information included on the report form.

WCS2

This is used when an **inadequate** result is entered for a woman who is already ceased for a valid clinical reason, or who may become ceased as a result of a clinical reason from information included on the report form.

WECA

This is used when an **abnormal (8Ror3R)** result is entered for a woman where there is also mention of endometrial cells on the report form.

WECE

This is used when a **negative early repeat (2R)** result is entered for a woman where there is also mention of endometrial cells on the report form.

WECI

This is used when an **inadequate repeat (1R)** result is entered for a woman where there is also mention of endometrial cells on the report form.

WECN

This is used when a **negative normal recall (2A)** result is entered for a woman where there is also mention of endometrial cells on the report form.

WHYC

This is used when a woman is ceased as a result as a result of a hysterectomy (see also **WNRC**).

WHYN

This is used when a woman requires a further vault smear after hysterectomy.

WIDR

This is used when a woman has an inadequate test which does not need to be repeated at present eg inadequate test for an 18 year old.

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WNRC

This is used when a woman has her **2nd negative vault** following a hysterectomy which showed any CIN.

NONE

This is entered for all **Direct Referral** smears and also for non-negative colposcopy smears; or for an unprocessed sample.

3A.60 MANAGING THE RESULT RUN (AJ-CP)

3A.60.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.60.2 Quality Standard

All women receive their results in a timely manner.

More than 80% of women receive results within 4 weeks of their test being taken.

100% of women receive results within 6 weeks of test being taken.

At least two AJ-CP runs are carried out every week on separate days. All actions within this quality standard are carried out within 1 week of the CP being initiated.

3A.60.3 Method

i) Pre-CP Routine

Option 5 of the utilities menu is produced to identify women who may have had a smear taken inappropriately

ii) Preparing the CP Run

The AJ-CP run is requested and processed. This request is made at least twice weekly (but on different days) by CSADs due to the possibly urgent nature of direct referral. Three prints are produced:

- Result letters
- Result print summary
- Laboratory list

The final two prints are no longer used by CSAD and are deleted as they have been replaced by W6-CP, which produces alphabetical lists of letter by recall type. The W6-CP which is requested immediately after AJ-CP is processed produces the following lists:

- W6-CP Alpha List
- W6-CP FailSafe List
- Dir. Ref Ltrs
- Tests in SafetyNet (if applicable)
- GP Endometrial letter (if applicable)

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- Deducted cards (if applicable)

When AJ-CP is running, it is not possible to use the CY Screen to input new results or run any other jobs on the system.

iii) Printing CP Letters and Reports

All report forms for which a letter should be produced are counted and balanced against W6-CP Alpha List.

The result letters are printed within a day of the CP run being processed. However, if there is a delay between the CP being processed and the letters being printed the PQ screen is checked to see if changes have been made to the CY screen since the run was requested. If so, it is possible that the Next Test Due date held on the AJ-CP file may be different from that which is now held on the main CY file. This appears on PQ as an NTD Date Exception Report for CSAD managers to check.

Each letter type is checked against the master copy to confirm that the text is correct. Alterations to the Exeter system sometimes result in the change of wording on letter types.

The number of letters printed are counted and checked against the summary from the result print run.

Women registered with a CSAD but who have given a different address on the report form

The result letter is taken out of the CP run and sent to the address on the test report form or the CSAD may choose to produce a manual result letter for her. The report is marked to indicate that the result has been sent to the address on the form. The summary sheet is also marked to indicate that a letter has been removed from that section. The address the letter was sent to is written in the "**comment field**" for that particular test, on the CY screen.

If the new address indicates that the woman's registration details should be an inter-area transfer to a neighbouring authority, the registration department of the BSC is notified. The report form is marked to indicate that notification has occurred. The address to which the letter is sent is recorded on the 'comment field' for that test.

iv) Verifying Results

Direct referral result letters

These appear as a separate entry on the PQ screen. The letters and list are verified against the original report form.

All non-negative early repeats

For all inadequate and abnormal repeat (3R and 8R) results the original report forms are totalled against the CP summary sheet (produced with result letters) total. Then each report form details are cross checked with the corresponding result letter.

Routine recalls and negative early repeats

Routine recalls and negative early repeats are checked by total number of report forms with the total numbers on the summary print.

Result notifications not required.

All notifications in this category which originate from another CSAD/PCT (Primary Care Trust) are investigated and resolved appropriately. Occasionally, if a woman has recently moved into the area and the result is re-directed electronically from her previous area the CSAD would amend the CY screen as appropriate to produce a result letter.

W6-CP Alphabetical List - for all result types

Each report form is cross checked with details on the W6-CP summary.

W6-CP FailSafe List

This produces a list of women who have returned to routine recall after being on early test recall. This list is checked by CSAD to ensure that it is appropriate for the women to be returned to routine recall.

NB: It is recommended that these women's details are checked against the CY screen to identify examples that the FailSafe list would not routinely identify. For example, in the case of a low grade referral where histology has confirmed CIN2 or worse.

v) Automailer

All letters are printed by recall type C, I, N, R or S (Direct Referral).

Cancelled

Automailed and total checked against CP summary sheet total.

Inadequate letters

These are fed through automailer with the local clinic leaflet and the total noted against the CP summary sheet.

Normal

Automailed and total checked against CP summary sheet total.

Abnormal repeats

Processed through automailer with the leaflet '**the cervical test that needs to be repeated**'. The total is noted against the early repeat total on the CP summary sheet.

Negative early repeats

Letters automailed and the total number of letters checked against CP summary sheets and total for abnormal repeats added to them.

Direct referral letters (suspend)

These are fed through automailer and the total noted against the total on the W6-CP (direct referral summary sheet). The '**Your colposcopy appointment**' leaflet is enclosed.

If a request has been made for the result to be sent to a different address from the report form a note will have been placed on the CP summary to identify the letters which have been removed from the result print for this reason.

It is recommended that W6-CP Alphabetical List is checked to ensure that an infection code has not been recorded on Exeter (this appears next to result type) on W6-CP summary.

All results fed through the automailer are counted and checked to ensure two letters are not included in one envelope.

As soon as balancing checks have been made all direct referral report forms are actioned as per SOPP 3A.300 Direct Referral to Colposcopy.

W3 Screen

The W3 screen is checked to see whether any ad hoc letters have been produced, if so they are processed appropriately.

vi) Mailing the letters

All negative letters are sent within 1 or 2 working days of the CP print. All non negative results are sent 1st class.

CSAD must ensure there are adequate local postal arrangements in place.

vii) Inconsistency report

If a database inconsistency report is produced CSAD staff contact the Support Team for a resolution. This print is produced automatically by the system, and provides details of an inconsistency or error detected in the data.

viii) Filing W6-CP

The summary from W6-CP is filed in date order and retained for 12 months.

ix) Manual result letters

A note is placed on the woman's electronic and paper record that a manual result letter was issued.

3A.60.4 Quality Measures

The CSAD ensures that:

- At least two AJ-CP runs are made in any 1 week (but not on the same day)
- 100% of inadequate, abnormal repeat and direct referral letters are checked against the original report form and totals on the W6-CP print
- 100% of all result notifications not required are checked against the original report form
- 100% of report forms are checked against details on the W6-CP summary
- 100% of negative letters are posted within 2 working days
- 100% of non negative results are posted within 1 or 2 working days
- Inconsistency reports are resolved within 1 week

3A.60.5 Quality Control/Audit

Checking of PQ screen

Checking of W3 screen

Inconsistency reporting

3A.60.6 Further Guidance

3A.40 Processing the report form

3A.41 Processing results other than those received from pathology laboratories working as part of CSW

3A.42 Unprocessed samples

3A.50 Suggested management

3A.51 Coding table for CSAD Staff

3A.120 Managing women with no cervix

3A.170 Smear with Endometrial Cells as an Incidental Finding

3A.171 Management of Smears with Changes in Glandular Cells

3A.300 Direct referral to colposcopy

3A.510 Retention and disposal of paper records

3A.61 DATA AND UNRESOLVED REPORTING DISCREPANCIES

3A.61.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.61.2 Quality Standard

A log of all data and unresolved reporting discrepancies are kept by the CSAD to monitor data accuracy and that every effort has been made to resolve reporting differences.

3A.61.3 Method

Unresolved reporting discrepancies

An 'unresolved discrepancy' is where final pathology reporting and/or management do not correspond to CSW policy and the Regional Programme Coordinator has over-ruled the laboratory.

All unresolved reporting discrepancies must be forwarded to the CSW Information department every 3 months.

Data discrepancies

A CSW incident report form and copy of the original report form is completed for any data discrepancies made on the report form or on the Exeter system, which has affected the management of a woman.

Other data discrepancies

An incident report form is also completed for all discrepancies which could have affected a woman's management, and SOPPs would not have identified the error.

3A.61.4 Quality Measures

- Details of all unresolved reporting differences are forwarded to the CSW Information department on a quarterly basis
- An incident report form is completed for all data discrepancies which have affected a woman's management
- An incident report form is completed for all discrepancies, which could have affected a woman's management, and SOPPs would not have identified the error

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3A.61.5 Quality Control/Audit

Review of quarterly statistical information
Local CSAD monitoring of data discrepancies
CSAD Quality group review of data discrepancies
Incident report review by risk management group

3A.61.6 Further Guidance

CSW Information Project, CSAD – Workbook, data items
A026/A026a/A026b
CSW Information Project, Closing report

CSW Incident Form for Discrepancies

- Unresolved reporting on the HMR 101 form
- Data entry error which has affected the woman's management
- Other

Identity of test which discrepancy relates to:

NHS Number _____
Date of Test _____

Suggested management by laboratory _____

Reason given for laboratory management _____

CSW recommended management _____

Steps taken by CSAD and Regional Programme Coordinator to resolve discrepancy

Description of data entry error and action taken

Date referred to Regional Programme Coordinator _____
Date Regional Programme Coordinator over ruled laboratory _____

3A.62 NO RESULT LETTER TO HOME

3A.62.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.62.2 Quality Standard

All women who are tested as a result of the CSW call/recall programme and who do not wish for the result letter to go to their home address are informed by the sample taker that a letter will not be sent to her home address for that particular result.

Sample takers must inform women that if the result requires referral the colposcopy service will send the appointment letter to the woman's registered home address.

3A.62.3 Method

If a woman requests that her result is not sent to her home address the test taker marks 'no home contact' on the report form. On receipt of the report by the CSAD it is highlighted and kept separately from the other result forms. For such results '**NONE**' is entered in the '**Result Notification**' field. The result letter is then produced via W6-NB\LETTER\PAT.

The result letter together with a covering letter is sent to the sender of the test stamped with 'no home contact'.

After the AJ-CP/W6-CP are processed and the result letters printed the 'no home contact' letter is intercepted and stamped 'NO HOME CONTACT REQUESTED' or a covering letter is set. This is then sent to the sample taker and avoids possible confusion that might arise when the sample taker receives the result letter.

If the result is:

- **Negative normal recall**, the invitation in 3 years time will then be sent to the woman's address on the database at that time
- **6 or 12 month repeat or inadequate**, the next test due date is forwarded by a minimum of 3 months, from the date of recall to give the woman time to arrange another test

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- **Referral to colposcopy**, as a referral sets the next test due date 12 months ahead there is no need to change the recall date

3A.62.4 Quality Measures

- 100% of 'no home contacts' are completed in line with this procedure within 1 week of receipt at the CSAD

3A.62.5 Quality Control/Audit Feedback from women

3A.62.6 Further Guidance

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.510 Retention and disposal of records

3A.70 PROCESSING ELECTRONIC CHECK LISTS FROM PATHOLOGY LABORATORIES

3A.70.1 Staff Responsible

Managerial Responsibility

CSAD managers

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.70.2 Quality Standard

To ensure that all results sent by a laboratory to a CSAD have been received and processed.

3A.70.3 Method

On a weekly basis a file of slide numbers are downloaded from laboratory systems to the Exeter system of the local CSAD relating to reports authorised during the previous week.

On a daily basis the list automatically matches slide numbers after they are entered from the report forms by CSAD.

If a laboratory sends report forms to more than one CSAD, then the CSAD that process the greater number of slides will generally receive the list (there are some occasions when two CSADs will receive lists from the same laboratory). However, that CSAD database will automatically, on a daily basis, check and match with the other CSAD databases if the slide numbers have been entered.

If all the slides received on the download are matched then the list is automatically archived and no further action taken.

i) Setup

The Exeter system matches the lists daily, however an unmatched list will not be highlighted for CSAD attention until 21 days after receipt. The CSAD manager will be alerted by an email to the fact that a list received 3 weeks ago has still not been completely matched.

ii) Processing electronic lab list

CSAD is only informed of lists that do not automatically match. Notification is received via PSM email. The email will give the lab and sequence number for easier identification.

Using W6 screen with a qualifier of PATH\Lab Code, all reports received for the lab specified will be listed. Reports which are marked ** are already archived and do not require further attention, however, they can be easily retrieved at any time if required.

iii) Updating Unmatched Records

Select the appropriate un-archived list.

Once the appropriate report is selected a summary of that file is given along with details of matched/unmatched information. To view details of the unmatched slide numbers use option [U] with a record number of [?] – this will allow scrolling through unmatched slides. Alternatively, an email of those not matched can be requested by using option [EM].

Identify/resolve query and update as appropriate using the comment field, if outstanding slides have been sent to other areas these will need to be updated manually.

If after 6 weeks of receipt of list it has not been fully resolved, the Regional Programme Coordinator is notified via email on a weekly basis until resolution.

Once all outstanding queries have been resolved the path list is ready to be archived. This may be done manually, or if left will be carried out automatically via the overnight processing.

If manual archiving has been selected on the set-up screen, a PSM email will be received notifying the CSAD that a manual archive is required.

NB: It is recommended that CSAD check the transfers on a regular basis after receipt before receiving the 21 day email alert.

iv) Paper Notification

From some English Laboratories, the retrospective list is received in paper form. CSAD managers should ensure that these are received at least monthly. All lists should be verified by a 2nd team member after the initial check.

The lists should be resolved within 2 weeks of receipt.

3A.70.4 Quality Measures

- 90% of batches resolved within 1 week of notification of outstanding list
- 100% of batches resolved in 2 weeks of notification of outstanding list

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3A.70.5 Quality Control/Audit

Lists are reported as outstanding 21 days after the initial match and then every 7 days.

Lists outstanding for 6 weeks are reported to the Regional Programme Coordinator on a weekly basis until resolution.

3A.70.6 Further Guidance

3A.30 Receiving the report form

3A.40 Processing the report form

3A.80 AMENDMENT OF A WOMAN'S DATE OF BIRTH

3A.80.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.80.2 Quality Standard

All valid notifications of changes to a woman's date of birth are actioned and the Exeter database updated with the correct information.

3A.80.3 Method

i) Receipt of notification

- The CSAD will only amend the date of birth on the database when in receipt of a signed notification from the woman
- On receipt of the signed notification the CSAD ensures that the notification is clear and precise. If notification is not complete in any way a standard CSW pro-forma is sent to the woman to complete and sign (see 'Change of Details' pro-forma in 3A.100)
- From Bowel and Breast Screening Programmes where the participant has signed the screening services proforma confirming the correction
N.B. the can include notifications from men participating in the Bowel Programme. These are updated via the Screening Services spreadsheet on quality which is accessible to all programmes. It is the responsibility of CSAD staff to check the scanned proforma for each amendment rather than relying on the information recorded on the spreadsheet. Once updated, the relevant PDF file is electronically archived into the appropriate folder
- If notification is received from a GP the CSAD sends a pro-forma to the woman concerned for signed confirmation
- If notification is received from a colposcopy service the CSAD sends a pro-forma to the woman concerned for signed confirmation
- All pro-formas sent to women from the CSAD are recorded in the 'pending date of birth pro-forma' file which is checked by the CSAD on a monthly basis
- All returned pro-formas are filed in the 'date of birth pro-forma' file

ii) Checking historic details

On receipt of notification the CSAD:

- Identifies the woman on the database via the ID screen
- Ensures the correct woman's file is retrieved by checking the registration details
- Checks for any previous amendment using the CH, DP and /or DH screens in case they have a bearing on the amendment

iii) General Enquiries

- If any doubt exists regarding the notification, telephone enquiries should be made to the source/GP for verification
- If doubt continues or the pro-forma is not returned by the woman the CSAD liaises with the BSC

Data Entry

All verified amendments to the woman's date of birth are made on the ID screen as appropriate.

All amendments made on the database to the date of birth are checked, signed and dated by another member of CSAD staff.

An entry is made on the AD screen that a signed notification has been received from the woman.

All alterations made on the ID screen are also noted on the test report form if appropriate and initialled by the member of staff making the alteration.

Filing

All notifications are filed in the 'date of birth pro-forma' file, if requested a copy is sent to the local BSC for their records.

3A.80.4 Quality Measures

- 95% of the amendments must be completed within 1 week of receipt of signed pro-forma of a change of date of birth
- 100% of the amendments must be completed within 2 weeks of receipt of notification of a change of date of birth
- All amendments are made on the ID screen within 2 weeks
- All amendments are checked by a CSAD member of staff within 1 week
- All amendments are filed for easy retrieval

3A.80.5 Quality Control/Audit

Audit of 'date of birth pro-forma' file

Screening Services spreadsheet / proformas

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.80.6 Further Guidance

See Proforma after 3A.100

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.90 Amendment of a woman's address
- 3A.100 Amendment of a woman's name
- 3A.150 Non-responder cards for GP's
- 3A.510 Retention and disposal of paper records

3A.90 AMENDMENT OF A WOMAN'S ADDRESS

3A.90.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.90.2 Quality Standard

All valid notifications of changes to a woman's address are actioned and the Exeter database updated with the correct information.

3A.90.3 Method

i) Receipt of notification

The CSAD will only amend the address on the database when in receipt of:

- A signed notification from the woman
- Notification originating via test report forms (if CSAD are in any doubt about altering information from the report form the GP is contacted for confirmation. If the GP can not confirm details a 'change of details' proforma should be sent to the woman at the 'new' address)
- Notification via CSAD documents
- From Bowel and Breast Screening Programmes where the participant has signed the screening services proforma confirming the correction

N.B. the can include notifications from men participating in the Bowel Programme. These are updated via the Screening Services spreadsheet on quality which is accessible to all programmes. It is the responsibility of CSAD staff to check the scanned proforma for each amendment rather than relying on the information recorded on the spreadsheet. Once updated, the relevant PDF file is electronically archived into the appropriate folder

If CSAD is advised of a change of address the Exeter system is updated

Any demographic changes to women in SafetyNet are notified via a daily print to the CSAD officer.

Notification of a change of address can also be received via electronic 'links', which will be updated by the Patient Data Department in the BSC.

On receipt of the signed notification the CSAD ensures that the notification is clear and precise.

On receipt of notification from any other sources the woman concerned is sent a standard CSW pro-forma to complete (see 'Change of Details' pro-forma in 3A.100). All pro-formas sent to women from the CSAD are recorded in the 'pending change of address pro-forma' file which is checked by the CSAD on a monthly basis.

All returned pro-formas are filed in the 'change of address pro-forma' file.

ii) Checking historic details

On receipt of notification and verification of the notification the CSAD:

- Identifies the woman on the database via the ID screen
- Ensures the correct woman's file is retrieved by checking the registration details
- Checks for any previous amendment using the CH, DP and/or DH screens in case they have a bearing on the amendment
- Checks that the new address is within the GPs practice area

iii) General Enquiries

- If any doubt exists regarding the received notification telephone enquiries should be made to the source/GP for verification
- If doubt continues or the pro-forma is not returned by the woman CSAD may seek advice from their local BSC

iv) Data Entry

All verified amendments to the woman's address are made on the ID screen as appropriate, ensuring the address code and postcode is accurate. If not, one of the following procedures is followed:

- If CSAD has access to the VA screen the postcode is used to ensure the address is written down correctly
- If the woman is eligible to have drugs dispensed and her address has changed the CSAD should bring it to the attention of BSC
- If the address on the report form is 'outside practice' the result letter from the CP run is retrieved and placed in an envelope with the new address
- If address is outside GP practice area the woman's details and the new address are passed to the Patient Data Department in the BSC

All alterations made on the ID screen are also noted on the report form and initialled by the member of staff making the alteration.

v) Filing

All notifications are filed in the 'change of address pro-forma' file.

3A.90.4 Quality Measures

- 95% of the amendments must be completed within 1 week of receipt of signed pro-forma of a change of address
- 100% of the amendments must be completed within 4 weeks of receipt of notification of a change of address

3A.90.5 Quality Control/Audit

Audit of 'change of address pro-forma' file
Screening Services spreadsheet / proformas

3A.90.6 Further Guidance

See Proforma after 3A.100

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.80 Amendment of a woman's date of birth
- 3A.100 Amendment of a woman's name
- 3A.150 Non-responder cards for GPs
- 3A.230 Processing notification of women who do not live at the current address due to returned correspondence sent from CSAD/Screening Services
- 3A.290 Undelivered returned mail (W6-RUM)
- 3A.510 Retention and disposal of paper records

3A.100 AMENDMENT OF A WOMAN'S NAME

3A.100.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.100.2 Quality Standard

All valid notification of changes to a woman's name are actioned and the Exeter database is updated with the correct information by the CSAD.

3A.100.3 Method

i) Receipt of notification

The CSAD will only amend the name on the database when in receipt of:

- A signed notification from the woman
- Notification originating via report (if CSAD are in any doubt about altering information from the report form the GP should be contacted for confirmation. If the GP can not confirm details a 'change of details' proforma should be sent to the woman)
- Notification via CSAD documents
- From Bowel and Breast Screening Programmes where the participant has signed the screening services proforma confirming the correction

N.B. the can include notifications from men participating in the Bowel Programme. These are updated via the Screening Services spreadsheet on quality which is accessible to all programmes. It is the responsibility of CSAD staff to check the scanned proforma for each amendment rather than relying on the information recorded on the spreadsheet. Once updated, the relevant PDF file is electronically archived into the appropriate folder

If CSAD is advised of a change of name the SafetyNet system and Exeter system is updated

Any demographic changes to women in SafetyNet are notified via a daily print to the CSAD officer.

On receipt of the signed notification the CSAD ensures that the notification is clear and precise.

On receipt of notification from any other source the woman concerned is sent a standard CSW pro-forma to complete. All pro-formas sent to women from the CSAD are recorded in the 'change of name pending' file which is checked by the CSAD on a monthly basis.

If any doubt exists regarding the notification, telephone enquiries should be made to the source/General Practitioner for verification.

All signed pro-formas are kept in an 'amendment to woman's name' file.

ii) Checking historic details

Following verification of the notification, the CSAD:

- Identifies the woman on the database via the ID screen
- Ensures the woman's file is retrieved by checking the registration details
- Checks for any previous amendment using the CH, DP and/or DH screens to cross reference the woman's details and identify any discrepancies

iii) Data Entry

All verified amendments to the woman's forename and/or surname are made on the ID screen as appropriate.

All alterations made on the ID screen are also noted on the report form and initialled by the member of staff making the alteration.

3A.100.4 Quality Measures

- 95% of enquires that are made regarding amendment to a woman's name are resolved by the CSAD within 1 week
- All amendments are made on the ID screen within 4 weeks

3A.100.5 Quality Control/Audit

Audit of 'amendment to woman's name' file
Screening Services spreadsheet / proformas

3A.100.6 Further Guidance

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.80 Amendment to a woman's date of birth
- 3A.90 Amendment to a woman's address
- 3A.150 Non-responder cards for GPs
- 3A.510 Retention and disposal of paper records

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CHANGE OF DETAILS PRO-FORMA

Amendments to a participants date of birth, address, name:

To safeguard the integrity of your Business Service Centre database, you will find below a signed amendment to the registration details of one of our screening participants. We have amended our records accordingly.

To be completed by Screening Services

Screening number:.....

Date:.....

NHS number:.....

Previous participants name:

New name:

Previous Address.....

.....

New Address

.....

Incorrect Date of Birth:.....

Correct Date of Birth:.....

To be completed by the participant

I confirm that the above details are correct

Signature:.....

Date:.....

Details changed on Screening Services records:

Initials: Date:

CSADs responsible for GP: DYE/ MORG/ NORTH/ GWENT/ BRO TAF (please circle)

Change confirmed by CSAD:

Newid manylion (dyddiad geni, cyfeiriad neu enw):

I gadw'r manylion ar gronfa ddata'r Ganolfan Gwasanaethau Busnes yn ddilys, mae'r ffurflen hon yn cadarnhau newid ym manylion cofrestru unigolyn sy'n cymryd rhan yn un o'r rhaglenni sgrinio. Mae'r unigolyn dan sylw wedi llofnodi'r ffurflen. Rydyn ni wedi newid ein cofnodion ninnau.

Y Gwasanaethau Sgrinio i lenwi'r adran hon

Rhif sgrinio:

Dyddiad:

Rhif GIG:

Enw blaenorol yr unigolyn:

Enw newydd:

Cyfeiriad blaenorol:

.....

Cyfeiriad newydd:

.....

Dyddiad geni anghywir:

Dyddiad geni cywir:

Yr unigolyn i lenwi'r adran hon

Rwy'n cadarnhau bod y manylion uchod yn gywir

Llofnod:

Dyddiad:

Rwy'n cadarnhau bod y newid wedi'i gofnodi yng nghofnodion y Gwasanaethau Sgrinio:

Llythrennau cyntaf eich enw: Dyddiad:

Adrannau Gweinyddu Sgrinio Serfigol sy'n gyfrifol am feddygon teulu:

DYF/MORG/GOGLEDD/GWENT/BRO TAF (rhowch gylch am yr un cywir)

Cadarnhawyd ar ran yr Adran Weinyddu:

3A.110 WOMEN NOT REGISTERED IN CSAD AREA

3A.110.1 Staff Responsible
Managerial Responsibility
CSAD manager

Operational Staff
CSAD officers

QA Advisor
Head of Administration

3A.110.2 Quality Standard
The CSAD ensure that all report forms received for women who are not registered in the CSAD area are dealt with appropriately.

3A.110.3 Method
Woman with resident address in CSAD area but not registered in CSAD area
A check is made whether the woman is registered with another CSAD. This is done using the W6-ENQ method, by telephoning the other CSADs or by checking CSAD databases with relevant staff that have access to those databases

- If the woman is registered with another CSAD, the report form is passed to that area who have the responsibility of informing her of the result and any follow up
NB: If the woman is no longer registered at another CSAD ie she is removed as R/U etc, it is the responsibility of the CSAD within which her address relates to
- If the woman is not registered with another CSAD, her details are entered onto dummy doctor

When the result letter is produced, an enquiry letter (with pre-paid envelope) is sent to the woman asking if she considers the address held for her by CSAD as her resident address. If not she is asked where she considers her resident address to be.

If she considers the CSAD address to be her resident, she is kept on dummy doctor until she either registers with a CSAD or informs CSAD that this is no longer her resident address. If the registered area is known to the CSAD a copy of the report form will be forwarded to them for their records.

If she considers her resident address to be outside CSAD area, the report form is sent to that area with a confirmation slip for the other area to return. On receipt of the confirmation slip she will be taken off dummy

doctor. If no confirmation is received from the other area or the other area inform CSAD that the woman is not registered with them the CSAD will keep the woman on dummy doctor. The exception to this is when a woman has registered elsewhere after the date of the test. In this instance, by entering the result on the CY screen the result will automatically be redirected to the registered area via AJ-CD; due consideration should be given to the result/information on the report form as to whether a paper copy is also sent.

Woman who has had a test in CSAD area but is not registered in CSAD area and her resident address is outside Wales

A check is made whether the woman is registered with another CSAD. This is done using the W6-ENQ method or by telephoning the other CSADs or checking with relevant staff who have access to other CSADs databases

If woman is registered with another CSAD the result will be entered onto their system. The result letter will then be forwarded to the resident address on the report form.

If the woman is not registered with any CSAD or PCT a manual result letter must be sent to the woman (template on Word). If the result is a direct referral the Regional Programme Coordinator needs to give consideration to the content of the result letter in relation to referral to Colposcopy.

Note: When forwarding the report form to another area the, National Laboratory code must always be appended on the form.

Please note: This procedure does not include tests taken from women registered with non-responsible general practitioners who should be dealt with as any other CSW test.

3A.110.4 Quality Measures

- 100% of report forms received for women not registered in CSAD area are actioned within 1 week of receipt at the CSAD
- 100% of women resident with another CSAD have their results forwarded and processed by the registered CSAD
- 100% of women not registered with a CSAD are informed of their smear result by the CSAD of their resident address

3A.110.5 Quality Control/Audit

Returned replies from women

Returned signed notifications from other areas

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.110.6 Further Guidance

- 3A.30 Receiving the report form
- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.160 Dummy doctor procedure
- 3A.200 Women deducted from Exeter

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

To be issued on CSW headed paper for local CSAD

Confirmation of Personal Details

Dear

You recently had a cervical screening test. The personal details you gave when you had your test did not enable us to find your registration details.

Would you please complete the form below to provide us with further information and return to this department in the envelope provided.

Unless you inform us otherwise we will consider this address to be your resident address and will invite you for future cervical screening.

If you do not consider this to be your resident address I would be grateful if you could provide me with the details of your resident address below.

NB: It is recommended that you register with a GP in the area you consider to be your main resident address.

Full Name _____

Date of Birth _____

I consider the address below to be my main resident address:

Name and Address of registered GP

National Health Service Number (if known)

(As indicated on your medical card)

Signature _____ Date _____

Yours sincerely,

CSAD Manager

Cadarnhau Manylion Personol

Annwyl

Fe gawsoch chi brawf sgrinio serfigol yn ddiweddar. Doedden ni ddim yn gallu dod o hyd i'ch manylion cofrestru chi gyda'r manylion personol a roesoch chi adeg eich prawf.

Er mwyn cynnig mwy o wybodaeth i ni, a wnewch chi lenwi'r ffurflen yma a'i hanfon yn ôl yn yr amlen barod i'r adran yma.

Os na fyddwch chi'n rhoi gwybod fel arall, fe fyddwn ni'n ystyried mai dyma'r cyfeiriad lle'r ydych chi'n byw. Fe fyddwn ni'n eich gwahodd chi i gael sgrinio serfigol yn y dyfodol.

Os dydych chi ddim yn byw yn y cyfeiriad yma, a wnewch chi roi eich cyfeiriad cywir chi ar y ffurflen yma.

NB: Y cyngor yw i gofrestru gyda meddyg yn yr ardal rydych yn ystyried yw eich prif cyfeiriad

Enw Llawn _____

Dyddiad Geni _____

Rydw i'n defnyddio'r cyfeiriad yma fel fy mhrif gyfeiriad:

Enw a Chyfeiriad eich Meddyg Teulu

Rhif Gwasanaeth Iechyd Gwladol (os ydych chi'n ei wybod)

(mae'r rhif ar eich cerdyn meddygol chi)

Llofnod _____ Dyddiad _____

Yn gywir,

Rheolwr CSAD

3A.120 MANAGING WOMEN WITH NO CERVIX

3A.120.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.120.2 Quality Standard

All women who have congenital absence of the cervix or who have had a total hysterectomy or Manchester repair should be managed accordingly within CSW Policy

A Manchester repair will follow the same management as total hysterectomy for a benign condition.

All notifications for ceasing are authorised by the Regional Programme Coordinator.

All women ceased from the programme following a total hysterectomy will be sent a confirmation letter by CSW (letter also sent to woman's GP).

Women who require vault smears will be either:

- Invited for vault smears in primary care at the appropriate time
- Referred to a colposcopy service for vault smears

3A.120.3 Method

Vault Smears from Women following Total Hysterectomy or Manchester Repair (MR)

Women who have a sub-total hysterectomy will continue to be included in the cervical screening programme as their cervix is still present.

Upon notification of the sub-total hysterectomy, the woman is sent a standard letter (**WCHS**) advising her that she will still require cervical smears.

The following guidance applies to women who have undergone a total hysterectomy or a Manchester Repair (which involves amputation of the cervix).

Women who have had a total hysterectomy/Manchester repair (MR) more than 5 years ago and not had follow up will be ceased from recall.

Group 1 - Women who do NOT require vault smears post-hysterectomy or MR:

- Vaginal vault smears are not required when:
 - A woman has had a benign total hysterectomy/MR and
 - She has not had a high grade smear or histologically confirmed CIN2+/CGIN in the 10 years prior to her hysterectomy/MR and
 - She has no history of histologically confirmed CIN/CGIN without a subsequent correct return to normal screening recall

In this case, her recall for screening will be ceased and both she and her GP will be informed of this via letter **WCS4**.

Other Groups - Women who DO require vault smears post-hysterectomy or MR.

Group 2 - A woman who has a benign total hysterectomy/MR but had a high-grade smear or histologically confirmed CIN2+/CGIN in the 10 years prior to it, or has a history of histologically confirmed CIN/CGIN without a subsequent correct return to normal screening recall:

- In this case, she will require a single vault smear 6 months after her hysterectomy/MR. If this is negative she will be ceased from the cervical screening programme and advised via result letter (**WHYC**)
- Cervical Screening Wales will send her an invitation for this single vault smear which should be taken in primary care
- If the result is borderline or worse, she will be directly referred to colposcopy clinic by CSAD. She will be ceased from screening at the time the referral is made, and her colposcopist will determine her subsequent management
 - The exception in this group is a woman who has CIN/CGIN or a high-grade smear in the six months prior to the hysterectomy. These women will be managed as in Group 3

Group 3 - A woman who has coincidental CIN/CGIN found at total hysterectomy/MR, which was completely excised (or CIN/CGIN/high-grade smear in the 6 months prior to the hysterectomy)

- In this case, she will require a vault smear 6 months after her total hysterectomy/MR and a second vault smear a further 12 months later
- Both of these should ideally be in colposcopy clinic, but if taken in primary care this will be acceptable
- if the first vault is negative she is sent result letter **WHYN**. If the second vault is negative she is sent result letter **WHYC**.
- If both these smears are negative, she will be discharged from the colposcopy clinic and be ceased from the cervical screening programme

- If either smear is borderline or worse, she will remain in (or be referred to) the colposcopy clinic. She will be ceased from screening at this time and her colposcopist will determine her subsequent management

Group 4 - A woman who has CIN/CGIN found at total hysterectomy/MR, but this was incompletely excised.

- In these circumstances, the woman will require vault smears following her hysterectomy/MR. She will be sent letter **WHYP** to confirm this. Her follow up should be as if the cervix is still in situ:
 - Vault smears at 6 and 12 months post-operation
 - Surveillance or follow-up depending on grade of CIN/CGIN found
 - Return to routine recall until 65 years
- Initial follow-up should take place within the colposcopy service
- The colposcopist may discharge to primary care if appropriate
- If any one of these results is borderline or worse, she will be managed within the colposcopy service. She will be ceased from screening at this time and her colposcopist will determine her subsequent management

NO CERVIX NOTIFICATIONS

The following are sources of notification:

- Non-responder card (Signed and stamped by practice)
- CSW no cervix proforma (signed and stamped by practice – see attached)
- GP letter (signed on headed paper)
- NHS pathology laboratory
- Letter from Consultant Gynaecologist
- CSADs via incoming cytology print

All notifications must be accompanied by histology report where possible.

The source of notification and the date of hysterectomy is recorded in the W6-NB.

VERIFICATION OF INFORMATION

Non-responder card, GP letter, No Cervix Proforma

For notifications from the above sources, all reasonable attempts should be made to obtain histology. If that is not possible, the Regional Programme Coordinator must be satisfied with the available evidence before agreeing to cease from the programme. Where no histology is available CSAD must ensure that the notification is signed and stamped by the Practice.

Where there is doubt as to whether the cervix remains the Regional Programme Coordinator may contact the woman (see below).

The woman's recall is ceased on the CY Screen.

The source of notification is entered in **W6-NB\CEASE**. The histology information is entered onto **W6-NB\MEDICAL**.

A letter is sent to the woman (**WCS4**) advising that she has been cancelled from recall **except when** the hysterectomy was for carcinoma of the cervix. A duplicate letter is automatically produced to the GP confirming the cancellation.

NHS hospital notification

Hysterectomy information is received at least monthly by the CSAD from NHS Pathology Laboratories. These notifications should be passed to the Regional Programme Coordinator, who should indicate the histology and what action should be taken and sign the notification.

If no notifications are received from a Pathology Laboratory in a 4-week period the Programme Manager is informed.

A letter is sent to the woman (**WCS4**) advising that she has been cancelled from recall **except when** the hysterectomy was for carcinoma of the cervix. A duplicate letter is automatically produced to the GP confirming the cancellation.

The source of information is entered in **W6-NB\CEASE**. The histology information is entered onto **W6-NB\MEDICAL**.

Notifications from other CSAD

Notifications of hysterectomies cancelled by another CSAD are acted upon.

The source of information is entered in **W6-NB\CEASE**

Notification of hysterectomies outside UK or where there is no/incomplete documented evidence

In these circumstances a standard letter (**WHQG**) is sent to the woman's GP requesting further information. If no information is available, an enquiry letter (**WHQP**) will be sent to the woman, together with a pre-paid envelope for her reply.

The woman's screening invitation may need to be postponed whilst replies are awaited.

If no response is received the woman will continue to be invited by CSAD.

If the woman is ceased solely on the basis of information she has presented, she is sent letter (**WHQ1**) to confirm that she is no longer in the programme.

NB: Where there is doubt as to whether the cervix remains the Regional Programme Coordinator may contact the woman (see below).

Letters to women who require vault smear(s)

If a woman requires vault smears in primary care following a total hysterectomy/Manchester repair:

- The CSW No Cervix Marker should be set to **Y**
- Her next test due date should be adjusted appropriately
- She should be sent letter (**WHYP**) advising that she will require vault smear(s). This letter should only be used when in receipt of a recent notification-unless the Regional Programme Coordinator believes that the reason for a woman's non-attendance is that she is unaware that she requires a vault smear
- The appropriate invitation letter (**WHY1**) will automatically be sent when a vault smear is due via the monthly RP routine. A reminder letter (**WHY2**) is sent a further 4 months later if no result is received

NB: As the number of vault invitation letters produced on a monthly basis is low, it is recommended that CSAD checks against the CY\W6 screens to ensure that a vault invite is appropriate.

If a woman has a negative vault smear in primary care/sexual health clinic and will not require further screening :

- Her recall must be ceased
- She should be sent either letter **WHYC** or **WNRC** advising her that she no longer requires vault smears

WOMEN WHO HAD A TOTAL HYSTERECTOMY OVER 5 YEARS AGO

CSAD staff should run 'utilities routine 1 - no cervix list' to identify those women still receiving invitations for vault screening who have the 'CSW No Cervix' marker set. This process should be performed at least on an annual basis.

All efforts should be made to determine whether these women have had a total hysterectomy and whether any vault smears were required.

If a woman has had a total hysterectomy, she may be ceased from further screening without histology, provided that:

- The total hysterectomy was over 5 years ago
- She has received at least one round of screening invitations and reached 'final non-responder' status

These women should be sent letter WCH5 to confirm that they will no longer receive invitations for screening. A copy will be produced and sent to their GP.

If the woman has had a total hysterectomy and requires vault smears, but has not yet reached 5 years post-hysterectomy, she should continue to receive invitations for screening.

If the woman does not appear to have had a total hysterectomy, the 'CSW No Cervix' marker should be removed.

N.B. No recall should be cancelled without the prior written authorisation of the Regional Programme Coordinator

Women deducted from CSAD whilst on recall or vault recall

When a woman who requires a vault smear(s), is deducted from a CSAD and registers with a GP outside Wales, a WVMO letter advising of the woman's situation is automatically produced and sent to that area.

Managing records with gender changes

CSADs could be informed of gender changes from the following sources:

- BSC
- GP
- Person

All notification must be received in writing by CSAD prior to any action being taken.

Male to Female

On appearing on the Exeter system as female, the woman is included in the call\recall process, although she is not actually eligible for screening. If the woman's GP writes to the CSAD to inform them of this, the woman's recall for screening will be ceased. If the woman herself contacts CSAD this situation is explained. The CSAD may contact her to GP to ask them to confirm, in writing, that she does not have a cervix. Alternatively, the woman could ask the GP to write to the CSAD herself, or complete the

CSW 'opt out' form. If no notification is received, she will continue to be invited for screening.

If CSAD are contacted verbally by the practice to cease, they are advised to put it in writing and CSAD follow process for no cervix confirmation.

Female to male gender change

On receipt of notification from the BSC the CSAD will be aware that the above gender reassignment has taken place. The BSC will deduct the original record and create a new record and NHS number for that person.

The RPC will contact the man's GP to confirm that CSW will no longer be inviting the man for cervical screening and that it is the GP's responsibility to ensure that the man is aware of this and arranges for any screening that may be necessary. A note of this letter will be recorded on the deducted female record.

NB: Notification from the BSC will be received via the Notice Board (NB) screen on Exeter to named individuals within CSAD.

3A.120.4 Quality Measures

- 100% of valid hysterectomy notifications are actioned within 4 weeks of receipt at the CSAD
- All cancellations of screening recall due to 'no cervix' are authorised by the Regional Programme Coordinator

3A.120.5 Quality Control/Audit

Monthly ceased list for CSAD to check

3A.120.6 Further Guidance

- 3A.20 Managing the invitation run
- 3A.40 Processing the report form
- 3A.50 Suggested management
- 3A.60 Managing the result run (AJ-CP)
- 3A.140 Ceasing women who are eligible to be screened
- 3A.180 Managing incoming cytology
- 3A.200 Women deducted from Exeter
- 3A.300 Direct referral to colposcopy
- 3A.510 Retention and disposal of paper records
- 2R.20 All Wales cervical screening policy
- 2R.40 Algorithms

NO CERVIX PROFORMA

CONFIDENTIAL

Name

NHS No

DOB

Registered GP and practice address

This woman has no cervix because:

- Congenital absence of cervix
- Manchester repair (cervix removed) Date
- Total hysterectomy (cervix removed) Date

Please include a copy of the histology report or other confirmation.

Practice Signature
(signed and stamped)

For CSAD use only:

Input by CSAD

Checked by CSAD

Recall ceased

3A.130 PROCESSING ACTIVE REFUSERS

3A.130.1 Staff Responsible

Managerial Responsibility

CSAD managers

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.130.2 Quality Standard

All women aged between 20 and 64 are invited for screening unless they have been 'ceased' according to the protocols of CSW, on receipt of the signed CSW opt-out letter or where the Regional Programme Coordinator has authorised ceasing.

Every active refuser may present for a test at any time. On receipt of the test she will be automatically returned to the recall programme.

3A.130.3 Method

Woman Requests CSW Opt-out letter

The standard bilingual CSW opt-out letter is created by entering **W6-DIS\NHS number\C**. The letter is printed via **W6-DIS\Print** and is sent to the woman.

The following rules apply:

- No woman is 'ceased' on her own request unless she has signed and returned the opt-out proforma or where the Regional Programme Coordinator has authorised the cessation

If a woman returns the signed declaration, she is 'ceased' on the Exeter system. The following information is logged via **W6-DIS\NHS Number**:

- Date disclaimer received at CSAD
- Date disclaimer logged on Exeter
- **S** - Signed is entered into the 'result' field

The declaration is then filed in an opt-out letter file and retained indefinitely.

A copy of the opt-out letter is sent to the woman's GP.

The woman is sent a confirmatory letter that CSAD have ceased her from the programme.

Should a woman indicate that she wishes to be permanently excluded but refuses to sign the standard opt-out letter, the matter is reported via the local CSAD manager to the Regional Programme Coordinator for consideration by the Director.

Request from woman for CSW opt-out form

An opt-out letter is only sent to a woman following a request, either verbally or in writing, that she receives no further invitations for cervical screening.

Written request from woman to opt out (not on CSW opt-out form).

These are passed to the Regional Programme Coordinator to review and decide whether ceasing should be actioned. If ceased, letter WDIB is sent to the woman (copy to GP) advising that she has been ceased from the programme. If ceasing is not actioned a CSW opt-out letter is sent to the woman with a covering letter from the Regional Programme Coordinator.

Written request from health professional to opt woman out of programme

These are passed to the Regional Programme Coordinator to review and decide whether ceasing should be actioned. If ceased, letter WDIC is sent to the woman (copy to GP and relevant health professional) advising that she has been ceased from the programme. If ceasing is not actioned a CSW opt-out letter together with letter WDID is sent to the woman.

Opt out notifications from other areas

- Women who have **opted out** and have signed a CSW or NHSCSP opt-out letter must be re-ceased by the receiving CSAD
However, for women who have moved in to Wales, letter **WDIE** is sent (copy to GP) confirming she will not be recalled by CSW
- Women transferring between CSADs remain ceased but are not sent a notification

NB: in most instances the cancellation is done automatically by Exeter

Reinstating 'Ceased' Women in the Screening Programme

If a woman who has previously been 'ceased' contacts CSW, either verbally or in writing, to request that she be re-included in the screening programme, then she immediately has her 'ceased' status removed and she is returned to the appropriate recall. A comment is placed in the free text field on the W6-DIS\NHS number recording the date the woman opted back into the programme.

If a test result is received by the CSAD for a woman who has previously withdrawn from the screening programme her 'ceased' status is removed.

If a test is taken in Gynae or Colp for a woman who has previously withdrawn from the screening programme then advice is sought from the Regional Programme Coordinator on future management.

3A.130.4 Quality Measures

- All women requesting to be ceased from the programme are sent a standard CSW opt-out letter unless ceasing authorised by Regional Programme Coordinator
- No woman is ceased before the opt-out letter has been signed and returned to the CSAD unless ceasing authorised by Regional Programme Coordinator
- All women who have signed the CSW opt-out form receive confirmation.
- All women wishing to re-enter the programme are re-instated with an appropriate recall
- Where ceasing is not as a result of the woman signing the CSW opt-out form a confirmatory letter is sent to the woman advising of action
- Where the Regional Programme Coordinator is not satisfied with the ceasing request a CSW opt-out letter is sent

3A.130.5 Quality Control/Audit

Audit of ceased woman

Monthly list of ceased women printed that CSAD check

3A.130.6 Further Guidance

- 3A.43 Samples taken from women with a ceased recall
- 3A.120 Managing women with no cervix
- 3A.140 Ceasing women who are eligible to be screened
- 3A.141 Postponing women from the screening programme
- 3A.142 Managing consent and capacity
- 3A.180 Managing incoming cytology data
- 3A.510 Retention and disposal of paper records

3A.140 CEASING WOMEN WHO ARE ELIGIBLE TO BE SCREENED

3A.140.1 Staff Responsible

Managerial Responsibility

Regional Programme Coordinators
CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.140.2 Quality Standard

Women who are eligible to be screened are only 'ceased' from the cervical screening programme for the following reasons:

- Following a total hysterectomy*
- Following a Manchester repair*
- If there is a congenital absence of the cervix*
- Following radiotherapy to the pelvis
(*see 3A.120)
- At the request of the woman, provided that she has been given appropriate information and has signed and returned an opt-out form**
- At the written request of the woman, with the approval of the Regional Programme Coordinator**
(**see 3A.130)
- Women with significant physical disabilities, eg vaginal strictures***
(***see 3A.143)

3A.140.3 Method

i) Ceasing women by GP on non responder cards

Every month, the CSAD send each practice non responder cards for women who have not responded to two invite letters in the last 12 months. The only reason a woman should be ceased from the non responder cards at the request of the GP is for one of the following:

- Manchester Repair/Total Hysterectomy (copy of the histology should be provided)
- Congenital absence of the cervix
- After radiotherapy for cervical cancer

Treatment for Carcinoma of the Cervix by Radiotherapy Alone

Woman is immediately ceased from the screening programme.

Woman will receive further follow-up determined by her gynaecologist or oncologist, which might include colposcopy. It is the responsibility of the

clinician to ensure that the woman is properly followed up; she will not be subject to further recall by CSW.

The non-responder card must be signed, by a general practitioner, or a designated member of the practice cervical screening team, and returned to the CSAD.

ii) Other reasons for ceasing by CSAD

Other reasons a CSAD could 'cease' a woman is if:

- She has signed and returned an 'opt-out' letter (see 3A.130) or the Regional Programme Coordinator has authorised the request
- The woman has had a gender change (refer to Regional Programme Coordinator before actioning)
- The woman is on routine recall (ie women who are not undergoing cytological surveillance after an abnormal or inadequate test or treatment) and will be 65 or over at the time of their next invitation will be **discharged** from the programme
- The woman has no screening history and will be 65 or over at the time of her next invitation. The woman will be discharged from the call and recall system, but may be screened opportunistically within the programme
- Women who have reached 70 years of age and who are on early recall may be ceased from the programme, at the discretion of the Regional Programme Coordinator, if they have not had a test for 5 years. They are sent letter **WCS9** advising them of this and a copy produced for the GP. These are identified by the monthly W6-PIP routine. These women can also be identified via W6-RNC; it is recommended that this routine is run at least annually

Any information received relating to hysterectomy or Manchester repair, absence of the cervix, radiotherapy for CA cervix other than on the signed non-responder card or letter from the GP should be referred to the Regional Programme Coordinator before the woman is ceased from the programme. Information received via histology lists must be signed by the Regional Programme Coordinator before ceasing occurs.

Regional Programme Coordinator contacts GP if any request to be ceased has been made which does not fall within CSW policy.

iii) Recording of information

A note must be kept on the W6-NB\CEASE screen identifying the source.

iv) Filing

All 'opt-out' forms are filed alphabetically and kept indefinitely.

All amended non-responder cards returned by GP surgery are retained indefinitely.

Any other correspondence relating to the ceasing status of a woman is retained indefinitely.

v) CSW Utilities menu - option 22

This is run on a monthly basis and produces a list of all women ceased by the CSAD during that month. This list is checked to ensure that all women have been ceased in line with CSW policy.

3A.140.4 Quality Measures

- 100% notification of ceasing should be acted upon within 1 week (actioned or referred to the Regional Programme Coordinator)
- 100% of active refusers sign the CSW 'opt-out' letter or be authorised by the Regional Programme Coordinator before they are ceased from the programme

3A.140.5 Quality Control/Audit

Monthly ceased list - option 22 CSW utilities menu
Audit of ceased women

3A.140.6 Further Guidance

- 3A.11 Women aged 65 and over when next test due
- 3A.43 Samples taken from ceased women
- 3A.50 Suggested management
- 3A.120 Managing women with no cervix
- 3A.130 Processing active refusers
- 3A.141 Postponing women from the screening programme
- 3A.143 Women in whom a smear is difficult to take
- 3A.150 Non-responder cards for GPs
- 3A.180 Managing incoming cytology data
- 3A.510 Retention and disposal of records

3A.141 POSTPONING WOMEN FROM THE SCREENING PROGRAMME

3A.141.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.141.2 Quality Standard

Women are postponed from the screening programme for a maximum of 12 months for the following reasons:

- Pregnant
- Woman unwell or undergoing hospital treatment or follow-up
- Woman has requested that the result letter is not sent to home

Where CSAD have been notified of women terminally ill this should be brought to the attention of the Regional Programme Coordinator for appropriate action.

3A.141.3 Method

i) Receipt of notification

The CSAD will only act on the following sources of information:

- Notification originating via non-responder card
- Written notification via woman
- Written notification via responsible clinician
- Telephone call from woman/surgery which is logged on a telephone message sheet (see 3A.500) All telephone callers must be verified before any action taken and the following qualifiers should be checked:
 - Name, address, and DOB
 - General Practitioner name

Postponement may be requested by woman and GP more than once but CSAD will only postpone up to a maximum of 12 months.

CSAD may decide to inform the GP of a woman's request to postpone her recall.

If a woman's recall is postponed because of pregnancy the CSAD should set her recall date as suggested by GP (if does not exceed 12 months) or if

no suggestion given the recall should be set for 3 months after the date of confinement.

On receipt of all notifications the CSAD alter the recall period (up to a maximum of 12 months) and details of postponement is logged on the W6-NB\RDATE screen.

Women may also be postponed upon completion of their ColpSafe episode.

3A.141.4 Quality Measures

- 100% of women postponed are only done so in line with the CSW Quality Standard
- 100% of women who require postponement do not exceed a maximum of 12 months
- 100% of postponements are logged on the W6-NB\RDATE screen

3A.141.5 Quality Control/Audit

W6-DUE

3A.141.6 Further Guidance

- 3A.20 Managing the invitation run
- 3A.130 Processing active refusers
- 3A.140 Ceasing women who are eligible to be screened
- 3A.142 Managing consent and capacity
- 3A.150 Non-responder cards
- 3A.180 Managing incoming cytology data
- 3A.350 Managing ColpSafe
- 3A.500 Telephone messages
- 3A.510 Retention and disposal of paper records

3A.142 MANAGING CONSENT AND CAPACITY

3A.142.1 Staff Responsible

Managerial Responsibility

CSAD Managers

Operational Staff

Regional Coordinator

CSAD staff

QA Advisor

Head of Nursing

3A.142.2 Quality Standard

The Mental Capacity Act 2005 (MCA) came in to effect in 2007 and provides a statutory framework for people who may not be able to make their own decisions. Due to the significance of the impact of this legislation, it is important that we share a common understanding of what the Act means for our organisation, our staff and our service users.

3A.142.3 Method

i) Invitations

All clients within the screening age and meet the eligible criteria will be invited to participate in the screening programme

ii) Unable to consent

- If the administration department is contacted by GP/Lasting Power of Attorney/Court Appointed Deputy inform them that screening services are legally obliged to invite all those eligible for screening
- Suggest using Learning Disability teams if appropriate or disregard invitation if unable to participate at this time. Direct to carers leaflet on website
- If client will never be able to consent and the request is to cease from the programme in their best interest, request a formal letter from GP
- On receipt of letter, Regional Programme Coordinator will authorise ceasing from screening if appropriate

iii) Questions re Capacity and Consent

GP/nurse/carer/LPA rings following woman receiving invitation stating that woman unable to consent.

GP/nurse –

- Inform them that we no longer defer women and all eligible women will receive invitations which can be disregarded
- Some women may benefit from the involvement of the learning disability team and may then be able to consent
- If the woman will never be able to consent and it is in her best interest to cease invitation from screening, request confirmation in writing from GP
- When letter received record on Exeter system
- When the reminder is due it is sent if no formal letter has been received
- Cease from recall following authorisation by the Regional Programme Coordinator

Carer/LPA

- Take details of woman and check when they received their invitation
- Name of woman
- Address
-
- DOB/NHS number
- Inform them that CSW is legally obliged to send an invitation to those who are eligible, but these can be disregarded. However, if the woman will never be able to consent and it is in her best interest to cease invitation from screening, ask them to consult with her GP, requesting a letter be sent to the Regional Programme Coordinator
- Suggest link to carers leaflet on website or offer to send copy of leaflet. This gives advice about learning disability teams

3A.142.4 Quality Measure

All eligible women will be invited to participate in screening.
All requests to cease will be accompanied by a GP letter and authorised by Regional Programme Coordinator/Head of Programme

3A.142.5 Quality Control/Audit

All eligible population invited
Number ceased due to best interest decision

3A.142.6 Further Guidance

3A.140 Ceasing women who are eligible to be screened
3A.141 Postponing women from the screening programme
3A.510 Retention and disposal of paper records
MCA - <http://www.justice.gov.uk/guidance/mental-capacity.htm>
Carers leaflet - www.screeningservices.org.uk
Cervical Screening see help desk questions

3A.143 WOMEN IN WHOM A SMEAR IS DIFFICULT TO TAKE

3A.143.1 Staff Responsible

Managerial Responsibility

Regional Programme Coordinator

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.143.2 Quality Standard

There are women in whom it may be difficult to assess the cervix and obtain a satisfactory smear. For example women with significant physical disabilities/ vaginal strictures etc.

These women may only be ceased from the programme if:

- All options for obtaining a cervical smear have been considered
- Any other options eg hysterectomy have been considered
- The request is with the woman's knowledge and consent
- There is a written request from the woman's GP/consultant gynaecologist

3A.143.3 Method

If a verbal request to cease a woman's recall on the above grounds is received at the CSAD, the requestee must be informed that:

- The request must be written and be from the woman's GP or consultant gynaecologist
- The request must contain the following information:
 - Reasons for the request (ie the specific nature of the problem)
 - Details of any measures taken to obtain cervical smears
 - Confirmation that the request is with the woman's knowledge and consent, and that she has been fully informed of the nature of cervical screening and the risks of withdrawing from the screening programme

If a written request is received from the woman's GP or consultant gynaecologist covering these points, then the Regional Programme Coordinator may cease the woman from the screening programme.

If the Regional Programme Coordinator is not satisfied that all criteria have been met, they should contact the GP/consultant gynaecologist for clarification before ceasing.

All women who are ceased under these circumstances will be sent letter **WHYR** from CSAD confirming this, with a copy to the GP.

3A.143.4 Quality Measures

- 100% of women ceased for inability to view the cervix/take a satisfactory smear are only ceased at the request of their GP/consultant gynaecologist
- 100% of women receive a confirmation letter

3A.143.5 Quality Control/Audit

CSW Utilities menu - Option 22 (monthly ceased list)

3A.143.6 Further Guidance

- 3A.130 Processing active refusers
- 3A.140 Ceasing women who are eligible to be screened
- 3A.141 Postponing women from the screening programme
- 3A.510 Retention and disposal of paper records

3A.150 NON-RESPONDER CARDS FOR GPs

3A.150.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.150.2 Quality Standard

All eligible women who fail to attend following an invitation are included in the CSW 'FailSafe' procedure (see 3A.240 Managing FailSafe) to ensure appropriate action is taken.

i) Non-attendance for a Call or Routine Recall Test

▪ AT 12 MONTHS

A 'non-responder' card must be produced and sent to the general practitioner. The woman is automatically re-entered for recall in 3 years from the initial invitation date

ii) b) Non-attendance for an early Repeat Test following an Abnormal or Inadequate Test and any direct referral test

▪ AT 6 MONTHS

A 'non-responder' card is produced and sent to the general practitioner

▪ AT 12 MONTHS

The woman is automatically recalled (1 year from initial invitation)

3A.150.3 Method

iii) Processing the AJ-RP

On a monthly basis the CSAD run and schedule the AJ-RP. This request is made monthly at least 4 weeks from the previous AJ-RP.

It is not possible to update the CY screen while the AJ-RP is being processed.

After AJ-RP has processed and before the non-responder cards are printed W6-RP is processed. This removes final responder cards from the print run for women who have not been discharged from SafetyNet.

iv) Printing Non-responder cards

All cards for women whose latest test is inadequate or abnormal are highlighted for the GP's attention.

The cards are then split into the GP practices and sent to the relevant practice.

v) Dummy Doctor cards

Cards that relate to ZZZ001 and ZZZ002 GPs should be passed to the BSC for retention in the woman's medical records that are held with the BSC.

Other Dummy Doctor cards should be checked to see if registered elsewhere in Wales (via W6-ENQ) and then destroyed. Any women's records found to be registered elsewhere in Wales should be actioned appropriately.

vi) Management of returned non-responder cards

On receipt of returned non-responder cards the CSAD check for any amendment, the GP signature and practice stamp. If the card is amended but not signed or stamped it is returned to the GP to complete as appropriate:

- For all changes of date of birth see 3A.80
- For all changes of address see 3A.90
- For all amendments to a woman's name see 3A.100
- For all notifications of hysterectomy/Manchester Repair see 3A.120
- For all notifications of pregnancy – postpone for 3 months after date of confinement and record action taken on **W6-NB\RDATE screen**
- For all notifications of previous tests which are not recorded on Exeter the surgery is contacted for a copy of the test
- Cards with no amendments are returned to the practice asking them to place in the women record

All amended non-responder card notifications received from GP's are signed and dated by the member of CSAD staff actioning the amendment and filed for easy retrieval.

The amended non-responder cards are retained in accordance to 3A.510

3A.150.4 Quality Measures

- AJ-RP is run monthly
- W6-RP is processed before the non-responder cards are printed
- 100% of non responder cards are printed, and issued within 1 week of being produced at the CSAD

3A.150.5 Quality Control/Audit

AJ-RP and W6-RP are processed monthly

3A.150.6 Further Guidance

3A.20 Managing the invitation run

3A.80 Amendment of a woman's date of birth

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- 3A.90 Amendment of a woman's address
- 3A.100 Amendment of a woman's name
- 3A.140 Ceasing women who are eligible to be screened
- 3A.141 Postponing women from the screening programme
- 3A.160 Dummy Doctor procedure
- 3A.240 Managing FailSafe
- 3A.510 Retention and disposal of paper records

3A.160 DUMMY DOCTOR PROCEDURE

3A.160.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.160.2 Quality Standard

Women are entered on a dummy doctor code when a report form is received for a woman resident in that CSAD area but not registered with any CSAD.

3A.160.3 Method

Woman's details are entered from the report form onto the ID screen under Code [2] – 1st Acpt. The dummy GP code for cervical screening is entered on the Cytology Dummy Doctor along with the woman's demographic details. The result is then processed by the CSAD in line with 3A.40 Processing the report form. Where possible the proper NHS number should be used, where this is not identified a dummy NHS number may be created.

Women are removed from Dummy Doctor for the following reasons:

- Register with a GP in the local CSAD
- Register with a GP in another CSAD. If the woman does register in another CSAD area then the report form is forwarded with a proforma to confirm receipt of result. Upon receipt of the proforma, the CSAD with which the woman is registered with is entered on the CY-NB box and the woman is then removed from Dummy Doctor
- Woman states that she is resident outside CSAD area and confirmation has been received from that area to confirm. Upon receipt of the proforma, the area the woman is registered with is entered on the CY-NB box and the woman is then removed from Dummy Doctor
- If the woman registers in another area after the date of the test she had in the CSAD area
- When deleting a record from the CY screen an email notification is automatically created as a reminder to re-enter data if applicable

NB: When forwarding the report form to another area the National Laboratory code must always be appended on the form.

ZZZ001 and ZZZ002

There are two Dummy Doctor codes on the system that are mandatory. These are ZZZ001 (Moved woman's request) and ZZZ002 (Moved doctor's request). Women on these codes are not registered with a GP. They cannot be removed. They will receive their invitations via AJ-RP and their result letter via AJ-CP providing the ZZ district has been set up appropriately. CSADs may need to produce invitation letters via W6-LETTER\PAT.

Safe Haven GPs (999999)

The BSC have set up Safe Haven GPs in each geographical area covered by the 5 Exeter databases. Women who come under Safe Haven GPs will continue to be invited in the usual way.

Other Dummy Doctors

There are other Dummy Doctor codes which originate from the BSC. However, CSW is obliged to invite these women in the normal way. These include single handed practices where the patients have been dispersed as a result of the practice not being maintained upon the retirement of the previous GP.

3A.160.4 Quality Measures

- All women that are not registered with a CSAD are entered onto Dummy Doctor

3A.160.5 Quality Control/Audit

Returned proformas from women

3A.160.6 Further Guidance

- 3A.40 Processing the Report Form
- 3A.60 Managing the Result Run (AJ-CP)
- 3A.110 Women not registered in CSAD area
- 3A.150 Non-responder cards for GPs

3A.170 SMEARS WITH ENDOMETRIAL CELLS AS AN INCIDENTAL FINDING

3A.170.1 Staff Responsible

Managerial Responsibility

CSAD Managers

Operational Staff

CSAD Staff

Regional Programme Coordinators

QA Advisor

Head of Administration

3A.170.2 Quality Standard

All report forms received at CSAD with the mention of endometrial cells are processed in line with CSW policy. If normal endometrial cells are considered to be inappropriately present, the laboratory will comment on this taking into account the woman's age and clinical details. The woman is informed that she should seek advice regarding this from her GP, a letter is also sent to the woman's GP highlighting that normal endometrial cells have been identified and may be contacted by the woman.

The presence of normal endometrial cells in a sample does not affect the woman's recall by CSW.

3A.170.3 Method

Where normal endometrial cells are noted in a sample, the laboratory will only include these on the report form if action is required on the part of the smear taker; generally these relate to post-menopausal women.

All smear reports received at CSAD are checked for the mention of endometrial cells. Where endometrial cells are included in the report, the smear is coded and the action code assigned according to the cervical cytology result, and previous cytology history, with the relevant result letter code as stated below, entered in the 'result notification' field on the CY screen.

WECN – negative normal recall

WECE – negative early recall (previous abnormal)

WECA – abnormal early repeat

WECI – inadequate early repeat

Entry of any of the above codes will produce an automatic entry on the PQ screen after W6-CP is processed. This will produce letter (**WECG**) to

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the woman's GP stating that the woman has been informed to seek further advice on her management.

For negative endometrials GM should be entered on the W7 Screen.

NB: It is recommended that all forms indicating endometrials are shown to the Regional Programme Coordinator.

3A.170.4 Quality Measures

- 100% of forms are checked for mention of endometrial cells before a result is issued
- 100% of women where endometrial cells are mentioned in the report are informed to seek medical advice where appropriate
- GP informed in all cases where appropriate
- 100% of forms with endometrials are checked with the Regional Programme Coordinator

3A.170.5 Quality Control/Audit W6-CP Alphabetical List

3A.170.6 Further Guidance

- 3A.40 Processing the report form
- 3A.60 Managing the result run (AJ-CP)
- 3A.171 Management of smears with changes in glandular cells

3A.171 MANAGEMENT OF SMEARS WITH CHANGES IN GLANDULAR CELLS

3A.171.1 Staff Responsible

Managerial Responsibility

CSAD Managers

Operational Staff

CSAD Staff

Regional Programme Coordinators

QA Adviser

Head of Administration

3A.171.2 Quality Standard

All smears reported as showing changes in glandular cells should be referred directly to a colposcopy service. The referral letter should advise when gynaecological assessment may be necessary-although all will be directly referred to a colposcopy service by CSAD. Where necessary CSADs may highlight information on the report form to alert the clinic that this woman may require additional assessment. Women should have the appropriate follow-up or surveillance after these smears.

Smears showing Borderline Changes in Endocervical Cells may be repeated rather than referred depending on previous history.

3A.171.3 Method

i) Coding of smears

Where abnormal glandular cells are seen in a cervical smear sample, the degree of abnormality should be graded and the site of origin stated. The results should be coded as follows:

- 8GC** Borderline changes in endocervical cells (or unspecified site)
- 8HC** Borderline changes in endocervical cells (or unspecified site) with possible high grade changes
- 8GM** Borderline changes in endometrial cells (normal cervical cells)
- 8GX** Borderline changes - other glandular

- 6GC** Dysplastic changes in endocervical cells
- 6GM** Dysplastic changes in endometrial cells
- 6GX** ?Glandular Neoplasia-other Glandular

NB: Where a Borderline Smear does not contain the codes and text in cytology report suggests it is not a straightforward report it should be passed to the Regional Programme Coordinator for coding. Any smears

reported as ?Glandular not coded are also passed to the Regional Programme Coordinator.

ii) Referral to colposcopy service

All results should have recommended management of 'suspend recall – directly refer for colposcopy'.

8GC smears will advise that an appointment should be given within 8 weeks. **8GM, 8GX and 8HC** smears will advise that an appointment should be given within 4 weeks.

6GC, 6GM and 6GX smears will advise that an appointment should be given within 2 weeks.

All direct referral letters sent to the colposcopy service will advise that gynaecological assessment may be needed and that the colposcopist should base their investigations on the smear result.

iii) Follow-up/Surveillance

Surveillance after all smears showing borderline changes where no high grade or glandular abnormality is found.

Surveillance after a smear showing borderline changes in endocervical cells (**8GC**) where no high-grade/glandular abnormality is found.

Surveillance after a smear showing possible dysplastic changes in endometrial or extra-uterine cells where no abnormality is found.

Follow-up after a smear showing possible dysplastic changes in glandular cells (**6GC**) unless the woman has treatment with a total hysterectomy/radiotherapy.

All grade 6 smear results where no abnormality is found should be discussed at an MDT meeting to confirm that no further investigations are necessary.

3A.171.4 Quality Measures

- 100% of all report forms with Result Code 8 (Borderline Changes) and 6 (Glandular Neoplasia) are scrutinised for mention of glandular cells
- 100% of forms with abnormal glandular cells should be received coded with the appropriate 2 digit expansion
- 100% of forms with abnormal glandular cells are checked for mention of site of abnormality before a result is issued

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- 100% of forms with abnormal endometrial cells generate a referral letter advising that colposcopic/gynaecological assessment is necessary

3A.171.5 Quality Control/Audit

- W6-CP Alphabetical List

3A.171.6 Further Guidance

- 3A.40 Processing the report form
- 3A.50 Suggested management
- 3A.51 Coding table for CSAD Staff
- 3A.60 Managing the result run (AJ-CP)
- 3A.170 Smears with endometrial cells as an incidental finding
- 3A.300 Direct referral to colposcopy

3A.180 MANAGING INCOMING CYTOLOGY DATA

3A.180.1 Staff Responsible

Managerial Responsibility

CSAD managers

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.180.2 Quality Standard

All data received from other CSADs or Primary Care Trusts (PCT's) reflect the policies operated by CSW and does not compromise the woman's involvement in the CSW programme.

3A.180.3 Method

i) Printing

Cytology data is received electronically on a daily basis. The CSAD prints the CIN CYTOLOGY RECEIVED DATA from the PQ-AP screen at least twice a week

All women on the list are checked against the CY screen for verification.

ii) Verifying results

The screening history of all women on the list is checked to establish if the most recent test date has been correctly coded. If not, it is re-coded in line with CSW policy (see 2R. Core Reference Section) and the change recorded in the comments field. The next test due date is amended if appropriate and the reason recorded on W6-NB/TEST (See 3A.40)

Recalls which are due in the past are amended to the next appropriate date.

NB: All CIN reports are updated before AJ-RG and AJ-RP is processed.

Test results which are not automatically updated are inputted manually from the print and passed to a verifier to check.

Women with no test details are given an appropriate date and the recall type is automatically set to 'call'; CSADs may wish to allow the W6-PIP routine to automatically set these dates.

Women whose last result is an abnormal 'S' coded test are dealt with as follows:

- If the test was taken within 3 years of registration, enquiries are made with the woman to ascertain her current status/any treatment
- If the test was taken more than 3 years prior to registration, then the woman's name is placed on the next appropriate date for AJ-RG

All irrelevant information in the CY,NB box is deleted.

If the latest electronically received test has been converted from 'rr' to 8R or 'ss' to 4S it must be checked by the CSAD with the GP.

iii) Women who have been ceased in previous area Excluded no cervix marker

Notifications of no cervix

- Any notifications received from a CSAD that a woman has been cancelled **due to no cervix** are actioned appropriately. If in doubt regarding validity of notification CSAD should make enquiries but ensure no invitation letters are issued until information confirmed
- Any notifications received from other sources are checked with the GP by producing the 'No Cervix Proforma' from CSW utilities menu No. 3 and the woman's recall to be forwarded 6 months from the date of the CIN listing print

NB: CSADs will require to 'Uncease' these women and ensure that the 'No Cervix' markers are set to N.

Women moving into Wales between ages 65 and 69

Where a woman moves into Wales who is within the above age guide and appears to have no cervix; the GP is sent letter XXXX advising that they should check whether any follow up is required.

For women aged 70 and over CSAD may enquire with the GP if the cytology history suggests that they may require follow up.

Opt out notifications

- Women who have **opted out** and have signed a CSW or NHSCSP opt-out letter must be re-ceased by the receiving CSAD
- However, for women who have moved in to Wales, letter **WDIE** is sent (copy to GP) confirming she will not be recalled by CSW
- Women transferring between CSADs remain ceased but are not sent a notification

NB: In most instances the cancellation is done automatically by Exeter.

Other Notifications

If a woman's recall was ceased but there is no evidence that she has no cervix or previously opted out of the programme, then she is put back on recall.

Women transferring from outside Wales and ceased for age

If the cessation occurred following a routine recall result when the woman was aged 60 or 61 she is reinstated to recall by CSAD.

iv) Inter area transfers

Any records which cannot be matched to a woman's details will appear on the CIN Cytology Received Data print and require a manual solution.

If the woman is registered with a linked practice, the practice should be contacted and asked to register the woman with the correct Business Services Centre (BSC).

If the woman has not been registered after 2 weeks the information is passed to the BSC's GP Links Officer for resolution.

If the woman is still not registered after a further 2 weeks the BSC is informed that efforts to register this woman have failed. At this time the practice is contacted for her new address and she is entered on the Cytology Dummy Doctor to ensure that she is not lost to the Call/Recall Programme.

If the woman is registered with a non-linked practice the transfer needs to be resolved with the relevant BSC/PCT.

Failed inter area transfers appear on the RE Screen and should be resolved by the BSC in a timely manner.

v) No Trace

There are records received that cannot be matched against the database that are not inter area transfers.

In these instances the sending authority is contacted and asked to check with the woman's previous GP to see if the woman is still being seen by that GP. CSADs may also enquire to Central Register via the NQ Screen or attempt a trace via PX Screen.

If the sending BSC/PCT is satisfied that the woman is no longer registered, details of the transfer are discussed with the local BSC for advice/resolution.

If there is no resolution after 6 weeks the Director of Contractor Services in the BSC is informed that a transfer has been received for whom a registration cannot be found.

3A.180.4 Quality Measures

- CIN Cytology Received Data reports are printed at least twice weekly
- 100% of records are verified within 6 weeks from the date of production at the local CSAD
- 100% of records received with 'Excluded from no cervix marker' are resolved or have enquiries made within 5 weeks from the date of notification
- 100% of inter area transfers with non-matching details are produced on paper and actioned upon within 8 weeks from the date of notification
- 100% of no trace queries are actioned within 8 weeks from the date of notification
- 100% of women who have signed an appropriate opt out will remain ceased from the programme and will receive confirmation
- 100% abnormal 'S' results are either directly referred, investigated or placed on the next appropriate AJ-RG run

3A.180.5 Quality Control/Audit

Checking of incoming cytology received data

Emails are received daily notifying where the woman's recall was ceased in the previous area.

RE Screen.

3A.180.6 Further Guidance

- 3A.40 Processing the report form
- 3A.41 Processing results other than those received from pathology laboratories working as part of CSW
- 3A.50 Suggested management
- 3A.60 Managing the result run (AJ-CP)
- 3A.120 Managing women with no cervix
- 3A.130 Processing active refusers
- 3A.160 Dummy Doctor procedure
- 3A.190 Managing ICM (Independent Communication Manager)
- 3A.390 Women transferring into the area with an abnormal result
- 3A.510 Retention and disposal of paper records

3A.190 MANAGING ICM (INDEPENDENT COMMUNICATION MANAGER)

3A.190.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.190.2 Quality Standard

To ensure the cytology and breast screening data sent between CSADs, PCTs(from England) and Screening Offices in Wales are transferred correctly and data failure is investigated and resolved.

3A.190.3 Method

There are 3 screens used to monitor/ manage network transfers via ICM; IE-Error Control; IM-Interchange Management; and IR-Remote Site Settings.

NB: The ICM is used both by CSADs and the BSC; where there are options that involve both organisations only the one's used by CSAD have been listed.

IE-Error Control

This is the screen that identifies any outstanding errors and displays the following information:

- Other Site
- Date of Error
- Type of Error

There are 4 possible resolutions:

R-Resubmit transfer

E-Error Resolution (this would be used where it has transpired that although an error message has appeared the transfer has gone through successfully)

F-Prepare 'F'ax

M-e 'M'ail

NB-The local BSC may do this work on behalf of some CSADs; however it is the responsibility of the CSAD manager to ensure that this work happens within the appropriate timescales.

IM-Interchange Management

This is the screen where queries are generated.

The following fields are displayed, not all require completion for Screening queries-most of the fields have a Control L facility to identify the codes available for that field.

Link Code-The site code for which an enquiry has been chosen.

Direction-Sent or Received

Senior GP Code-Not Required for Screening.

Application Area-C for Cytology, B for Breast Screening

Status-Type of query eg identifying specific errors

Date from-Start of query date

Date to-End of query date

<Data Type>Type of transfer eg Batch Specification

Proceed with query-A Y is required to proceed with the query.

The query when complete will appear on the top line of the **IM** screen.

IR-Remote Site Settings

This controls the settings of all organisations involved in ICM transfers; CSADs should use this screen for reference purposes; it is possible to look in detail at the settings for any organisation. It is possible to include contact details for individual organisations, eg Breast Screening Offices.

If required, it is recommended that CSADs request the BSC to do this on their behalf.

3A.190.4 Quality Measures

- ICM should be checked on a daily basis with all errors resolved within 5 working days

3A.190.5 Quality Control/Audit

Daily Check of IE screen

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.190.6 Further Guidance

3A.180 Managing incoming cytology data

3A.200 Women deducted from Exeter

3A.200 WOMEN DEDUCTED FROM EXETER

3A.200.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.200.2 Quality Standard

Screening history is transferred appropriately between BSC/PCT areas for all women who change registered areas.

3A.200.3 Method

Requesting

The AJ-CD is automatically set to run on a weekly basis. This transfers cytology data for women who have been deducted since the last AJ-CD to the area in which they are now registered.

The AJ-CD routine automatically transmits the cytology history for these women to a new CSAD or equivalent organisation in England/Northern Ireland/Isle of Man.

All Scottish transfers migrate to paper and dispatched accordingly.

If any woman who is deducted to another CSAD area has details on W6/W7 which are relevant to her future management, these are produced during the AJ-CD processing and appear on the PQ screen as **CYIC Welsh removals: QW 1-5**.

These are printed off and sent to the relevant CSAD. On the print out there is a section for the new area to sign and acknowledge receipt of the information and return the section to the deducting CSAD.

The deducting CSAD then sign off the acknowledgement on W6-MOVE\NHS Number.

Reminders

If the transfer has not been acknowledged a month after deduction then a reminder is sent to the new CSAD reminding them that the deducting CSAD has not received acknowledgement of the transfer. If in a further

month there is no resolution then the deducting CSAD will receive notification via email of the outstanding acknowledgement and will continue to receive monthly emails until resolution.

Printing

The deducted list is printed which shows:

- The summary of information transferred
- The deducted list section
- Delayed transfers

All cervical screening deductions requiring action from the CSAD fall into the categories listed and are printed on cards.

Category	Action
Service Dependant (S/D)	Send to central register
Removal (R)	Process cards
Registration Cancelled (R/C)	Check for subsequent registration and update woman's record.
Mental hospital (M/H)	Retain at CSAD and check periodically for registration with new CSAD/PCT.
Adopted child (A/C)	Refer to Regional Programme Coordinator to consider on an individual basis.

Delayed Transfers

Deducted details are transferred electronically for women deducted as E, R/U or O/R when they register with a new BSC/PCT. Details of these women are printed on the list under this heading, showing original deducted date and new BSC/PCT date.

This also includes women when a test is entered after the date of deduction.

If a new area requires information on a deducted woman's history, a print can be produced via AJ-SAP or AJ-CR.

3A.200.4 Quality Measures

- 100% of deducted cards to be actioned within 1 week of AJ-CD print

3A.200.5 Quality Control/Audit

Email reminders for CSAD transfers

3A.200.6 Further Guidance

- 3A.380 Women deducted from the Exeter database with SafetyNet information
- 3A.510 Retention and disposal of paper records

3A.210 WOMEN WHO HAVE MOVED TO ANOTHER CSAD/ PCT REQUIRING EARLY FOLLOW UP (THE DF SCREEN)

3A.210.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.210.2 Quality Standard

All women who have moved to another PCT (Primary Care Trust)/CSAD requiring early recall will appear on the DF screen after AJ-CD has processed. Processing the DF screen will ensure that the receiving PCT/CSAD are informed that the woman is on early recall.

3A.210.3 Method

i) Deducted follow-up acceptance notification report

When a woman's screening history has been received at another PCT/CSAD, an electronic notification is usually sent to the deducting CSAD which automatically updates the DF screen.

ii) Outstanding acceptance reports

Where an automatic notification has not been received, quarterly, outstanding acceptance reports are generated by CSAD and sent to the relevant areas.

On return of these reports the CSAD check that the report has been signed. The DF screen is then checked and the woman identified. A 'Y' is placed in the box provided to clear the woman's details from the DF screen. This must only be done when the CSAD has received a signed notification from the receiving area.

3A.210.4 Quality Measures

- 100% of women who are deducted from the Exeter system requiring early recall are acknowledged by an electronic notification sent by the receiving PCT/CSAD

3A.210.5 Quality Control/Audit

Audit of deducted follow-up acceptance notices

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.210.6 Further Guidance

3A.200 Women deducted from Exeter

3A.510 Retention and disposal of paper records

3A.230 PROCESSING NOTIFICATION OF WOMEN WHO DO NOT LIVE AT THE CURRENT ADDRESS DUE TO RETURNED CORRESPONDENCE SENT FROM CSAD/SCREENING SERVICES

3A.230.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.230.2 Quality Standard

All patients who are identified by the CSAD or notified to CSAD by another Screening programme as not living at the 'current' address are dealt with appropriately to minimise the number of letters sent to women who appear to have moved address.

CSAD will only act on not living at the 'current address' on receiving returned mail sent initially from CSAD or another programme within Screening Services.

The CSAD notifies GPs of all patients in their practice whose addresses have been identified by the CSAD as not known to the Business Services Centre (BSC).

A GP has 6 months notice to satisfy the BSC that s/he is responsible for providing general medical services for that patient, if not, after 6 months the patient will be removed from the GPs list and their details will appear on the weekly deducted list at the CSAD.

All returned mail should be opened on receipt to check for returned result letters.

3A.230.3 Method

i) Undelivered Cervical Smear Result Letters

On receipt of an undelivered result letter a CSAD officer undertakes the following procedure:

- Logs undelivered returned mail – See 3A.290 Undelivered returned mail – this procedure sets up the W6 'Returned Undelivered Mail' marker which automatically sets the FP69 tag for the woman. This tag may need to be unset if any of the following action points are carried out

- The ID screen is checked to see if there is a new address. If there is, a new result letter is created and sent via W6-LETTER\PAT. If no new address is present the report form is checked with the test sender to clarify address
- If the address had not been updated from report form it is amended and a new result letter is created and sent on the next CP run
- If the address can not be clarified, CSAD check address with GP,
 - If the CSAD address and the GP address are the same then the woman is placed on FP69 status via the **AD** screen and an FP69 notification is sent to the woman's GP. The woman's screen is 'tagged' (via W6 screen) by the CSAD so that any change by the registration department or GP links is brought to the CSADs attention
- The result letter relating to a woman placed on FP69 status is filed separately. A copy of the result letter with a covering letter from the Regional Programme Coordinator is sent to the woman's GP and the sender of the test
- If new address is outside of BSC area then CSAD send manual result letter and a note is placed on the comment field that manual result has been sent

ii) **Undelivered Cervical Smear Invitation Letters**

On receipt of an undelivered invitation letter the CSAD undertakes the following procedure:

- The ID screen is checked to see if a new address has been entered. If no new address has been entered the woman is placed on FP69 status via the **AD** screen and a note may be put on the PN screen to identify where the FP69 originated if requested by the BSC
- If the CSAD is subsequently informed of a new address for that woman a new invitation letter is generated
- Any women on early recall and who are due or overdue a test with FP69 status set will appear on AJ-RP district list. The processing of W6-RP will produce an enquiry letter to the GP indicating that CSAD are unable to invite the woman due to the fact that she is at FP69 status. An enquiry letter is only sent the first time a woman appears on the district list. This appears as a PQ entry **AJ/RP FP69 letters**
- If the woman's record is updated within 6 months with a new address CSAD enter a new recall date as appropriate

iii) **Undelivered notifications from bowel/breast screening programmes**

CSW has an agreement with the BSC that undelivered returned mail notifications from other Screening Services programmes can be included in the FP69 process. CSAD will only receive notification from these programmes after the address has been checked on their local screening

system and against the Welsh Demographic Service (WDS). The information is received via a shared spreadsheet which is accessed via quality share and includes both men and women.

Where the information relates to a woman who is still eligible for cervical screening and is overdue a test, the woman's record is tagged (F).

NB: CSAD staff should take advice from GP practice/BSC where the information on the returned envelope isn't categoric as to whether the addressee is not at the address given, eg letter refused or address inaccessible.

3A.230.4 Quality Measures

- 95% of notifications for result letters are processed within 1 week
- 100% of all notifications are processed within 4 weeks

3A.230.5 Quality Control/Audit

Automatic notification via email alert

3A.230.6 Further Guidance

- 3A.20 Managing the invitation run
- 3A.60 Managing the result run (AJ-CP)
- 3A.90 Amendment of a woman's address
- 3A.240 Managing FailSafe
- 3A.250 Tagged women
- 3A.290 Undelivered returned mail (W6-RUM)
- 3A.510 Retention and disposal of paper records

Screening Services procedure for notifying BSC of change of details and undelivered returned mail

3A.240 MANAGING FAILSAFE

3A.240.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.240.2 Quality Standard

CSW 'FailSafe' procedures ensures that appropriate action is taken when a woman fails to attend an appointment for a routine test, early repeat test, colposcopy appointment or follow-up test. For each category of missed appointment, the arrangements are proportionate to the degree of risk for the woman who does not attend.

The CSAD sends appropriate information to relevant women, GPs, laboratories and colposcopy services and, in specified circumstances, refers women into the CSW ColpSafe programme. The CSAD relies on information provided by GPs, laboratories and colposcopy services.

3A.240.3 Method

i) Non-Attendance for a Call or Routine Recall Test

Women failing to attend an appointment for a call or routine recall test are considered to be at relatively low risk. Therefore, the FailSafe arrangements consist only of a reminder invitation being sent to the woman and the issuing of a 'non-responder' card to the woman's general practice. These steps are all supported by the Exeter system.

Table 1 Summary of FailSafe for a Call or Routine Recall Test

	CSAD
0 months	First invitation sent to woman
6 months	Reminder invitation sent to woman
12 months	'Non responder' card sent to GP
36 months	Invitation cycle restarts First invitation sent to woman

ii) Non-Attendance for an Early Repeat Test following an Abnormal or Inadequate Test

Summary

Women failing to attend an appointment for a repeat test following an abnormal test are considered to be at moderate risk. Therefore, 'twin track' FailSafe arrangements are used, with the CSAD being supported by the laboratory. The same arrangements are used following an inadequate test.

Table 2 Summary of FailSafe for a Repeat Test

	CSAD	Laboratory
0 months	First invitation sent to woman	
4 months	Reminder invitation sent to woman	
6 months	'Non responder' card sent to GP Laboratory notification is sent to CSAD who check that the appropriate action has been taken	CSAD notified that no repeat test received
12 months	Invitation cycle restarts First invitation sent to woman	
16 months	Reminder invitation sent to woman	
18 months	'Non responder' card sent to GP Laboratory notification is sent to CSAD who check that the appropriate action has been taken	CSAD notified that no repeat test received
24 months	Invitation cycle restarts First invitation sent to woman	
28 months	Reminder invitation sent to woman	
30 months	On receipt of laboratory notification, a check is made that the invitation cycle has restarted. Where a woman has become a non-responder for the third time she can be removed from the laboratory FailSafe system	CSAD notified that no repeat test received

CSAD and Regional Programme Coordinator Procedures

Initially, the similar procedures as for non-attendance for a routine test are followed by the CSAD. However, the procedures use different timings. The Exeter system is used to implement these procedures.

The invitation cycle restarts at **12 months**, as opposed to the normal 36 months. If the woman still does not attend, the invitation cycle restarts a further **12 months** later (ie **24 months** after the initial invitation).

Action Following Instigation of FailSafe Procedure by a Laboratory

When the laboratory notifies the CSAD that a follow up test has not been received, the woman's records must first be checked to determine whether the woman is, in fact, due to have a repeat test. If the woman is due to have a repeat test, further checks are made to determine:

- Whether the woman's details are correct. If there is a mismatch between laboratory and CSAD data, the CSAD must contact the GP for clarification and notify the laboratory. The appropriate changes must be made to the laboratory and/or Exeter systems. If the Exeter data had been incorrect, the invitation cycle may need to be restarted using correct data. In such cases, the CSAD notifies the laboratory so that the date used by the laboratory FailSafe system can be amended

OR

- Whether the woman has had a repeat test reported at another laboratory, has had treatment or has moved out of the area

OR

- Whether, the appropriate action has been taken by the CSAD (as specified in Table 2). If not, this must be rectified and the reasons identified and reported to the Regional Programme Coordinator and CSAD Manager. In such cases, an incident form must be forwarded to the Head of Administration via the Risk Manager & Clinical Governance Coordinator

Once the above action has been taken by the CSAD, the Regional Programme Coordinator must notify the laboratory in writing of the result of the checks and, in specified cases, request that the woman be removed from the laboratory FailSafe system (this may be done via W6-FAIL via the Exeter System). One of the following results must be specified for each woman to be removed from the laboratory FailSafe system:

- Woman not due for a repeat test (with explanation)
- Repeat test reported by another laboratory
- Woman has received treatment
- Woman has moved out of Wales
- Woman has become a non responder for a third time
- Woman has completed a CSW 'opt-out form'

NB: Where a woman has been removed from the Exeter system but has not registered elsewhere, she will be kept on the laboratory FailSafe for 1 year from the date of removal from the Exeter system.

Laboratory Procedures

When a laboratory issues a cervical cytology report with an early repeat test as the suggested management, the laboratory must enter the woman's details on their own FailSafe computer system. The laboratory FailSafe system must ensure that:

- The woman is identified on a weekly list 6 months after the due date for the repeat test, if a repeat test is not received by the laboratory
- The CSAD (not the general practitioner) is provided with a copy of the weekly list. The information included on the list must include: name, address, date of birth, NHS number, date of test, grade, and recommended management
- The woman is removed from the laboratory FailSafe system
 - When a follow up test is received
 - Falls into a category previously mentioned
 - At the written request of the Regional Programme Coordinator (see above)
- If no repeat test is received and no request is received from the Regional Programme Coordinator to remove the woman from the laboratory FailSafe system, the woman is identified on the weekly list a further **12** months later. This cycle is repeated at **12** month intervals for as long as necessary (in practice, almost all women will have been removed from the laboratory FailSafe system before a third 12 month period has elapsed)
- The woman is included on only **one** weekly list every 12 month period

iii) Non-Attendance for a Colposcopy Appointment

Summary

Women failing to attend an appointment for a colposcopy appointment are considered to be at relatively high risk. Therefore, 'twin track' FailSafe arrangements are used, involving the CSAD, using SafetyNet and Exeter systems, supported by the laboratory for an initial colposcopy appointment and by the colposcopy service for a subsequent colposcopy appointment.

CSAD and Regional Programme Coordinator Procedures

SafetyNet Procedures

Women with a colposcopy referral as their recommended management are entered onto SafetyNet.

The purpose of SafetyNet system is to ensure that:

- Women are directly referred to colposcopy
- Women are not lost to follow up during treatment and observation within the colposcopy service
- Women are appropriately followed up by cytology following discharge from colposcopy

Every time information relating to a woman's attendance is received from the colposcopy service, this must be used by the CSAD to update SafetyNet.

Where confirmation of a **first** attendance is not received from the colposcopy service, SafetyNet will identify the woman:

- **4 weeks** after entry of a high grade result on SafetyNet and thereafter every **6 weeks**
- **8 weeks** after entry of a low grade result and thereafter every **12 weeks** if no updated information has been received from colposcopy

Where woman has attended her **assessment** appointment, SafetyNet will identify the woman and query with Colposcopy every **8 weeks**.

Where woman has attended for a **see and treat or follow up visit**, SafetyNet will identify the woman and query with Colposcopy after **thirty weeks** and then every **8 weeks**.

Note: At the discretion of the Regional Nurse Coordinator, in cases where there are known to be delays in the offering of colposcopy appointments CSAD may decide not to send particular queries produced from SafetyNet to the Colposcopy service.

ColpSafe (see 3A.350 Managing ColpSafe)

Women who fail to attend two consecutive colposcopy appointments and fail to contact the clinic are discharged by the colposcopy service and included in the CSW ColpSafe scheme.

On entry to the scheme the woman is sent a letter explaining that there is concern that she has not completed her episode of care at the colposcopy service and encourages her to contact the Regional Programme Coordinator. A letter is also sent to the woman's GP.

If no information is received from the woman within a month, a second letter is sent to her GP recommending that the practice attempt to persuade the woman to re-attend colposcopy.

If, a further 5 weeks later, no information is forthcoming a letter is sent to the woman advising her that CSW has taken all reasonable steps to encourage her to attend colposcopy and that the next communication from CSW will be an invitation for a test.

Those returned to recall are advised to attend their GP Practice/Sexual Health Clinic for an immediate test.

Table 3: Summary of Exeter FailSafe for non attendance for a repeat test after colposcopy

	CSAD
0 months	First invitation sent to woman
4 months	Second invitation sent to woman
6 months	'Non responder' card sent to GP
12 months	<i>Woman placed on Exeter 'special invitation cycle'</i> First 'special letter' invitation sent to woman
16 months	'Special letter' sent to GP
18 months	Second 'special' invitation letter to woman
24 months	<i>Exeter 'special invitation cycle' restarts</i> First 'special' letter sent to woman

Table 4: Women in colposcopy who have not been discharged but CSAD have not received another test.

	CSAD
12 months	Woman moved to reminder status on Exeter (no letter sent)
14 months	Woman is moved automatically onto non-responder status but no non-responder card is produced
24 months	<i>Woman placed on Exeter special invitation cycle</i> First 'special letter' invitation sent to woman (CSAD will check if it is appropriate for letter to be sent)
28 months	'Special letter' sent to GP
30 months	Second 'special letter' sent to woman
36 months	<i>Exeter 'special invitation cycle' restarts</i> First 'special' letter sent to woman

Action Following Instigation of FailSafe Action by a Laboratory

When the laboratory notifies the CSAD that confirmation of attendance has not been received from the colposcopy service, the woman's records must first be checked to determine whether the woman is, in fact, due to have a colposcopy appointment. If the woman is due to have a colposcopy appointment, further checks are made to determine:

- Whether the woman's details are correct. If there is a mismatch between laboratory and CSAD data, the CSAD must contact the GP for clarification and notify the laboratory. The appropriate changes must be made to the laboratory and/or CSAD systems. If the CSAD data had been incorrect, the referral may need to be reissued using correct data

OR

- Whether the woman has attended a colposcopy service sending histology or cytology requests to another laboratory

OR

- Whether, the appropriate action has been taken by the CSAD. If not, this must be rectified and the reasons identified and reported to the Regional Programme Coordinator and CSAD Manager. In such cases, an incident form must be forwarded to the Head of Administration via the Risk Manager & Clinical Governance Coordinator

Once the above action has been taken by the CSAD, the Regional Programme Coordinator must notify the laboratory in writing of the result of the checks and, in specified cases, request that the woman be removed from the laboratory FailSafe system.

One of the following results must be specified for each woman to be removed from the laboratory FailSafe system:

- Woman not due for a colposcopy appointment (with explanation)
- Woman has attended a colposcopy service sending histology or cytology requests to another laboratory
- Woman has moved out of Wales
- Woman has been included in ColpSafe and sent a disclaimer letter by CSAD
- Woman has been placed on the Exeter system 'special invitation cycle'
- Woman has completed a CSW 'opt-out form'

Action Following Instigation of FailSafe Action by a Colposcopy Service

When the CSAD is notified by the colposcopy service that a woman has not attended, the woman's records must be checked to determine:

- Whether the woman's details are incorrect. If there is any mismatch, the CSAD must contact the GP for clarification and notify the colposcopy service. The appropriate changes must be made to the colposcopy and/or CSAD systems. The invitation may need to be reissued using correct data

OR

- Whether the woman has attended a different colposcopy service

Once the above action has been taken, the CSAD must notify the colposcopy service if the woman's details have been changed or the woman has attended a different colposcopy service.

Laboratory Procedures

When a laboratory issues a cervical cytology report with a colposcopy referral as the suggested management, the laboratory must enter the woman's details on their own FailSafe computer system. The laboratory FailSafe system must ensure that:

- The woman is identified on a weekly list **6** months later if no confirmation of attendance is received from the colposcopy service (eg a histology or cytology request)
- The CSAD (not the general practitioner) is provided with a copy of the weekly list. The information included on the list must include: name, address, date of birth, NHS number, date of test, grade, and recommended management
- The woman is removed from the laboratory FailSafe system when confirmation of attendance is received from the colposcopy service or at the written request of the Regional Programme Coordinator (see above)
- If no confirmation of attendance is received from the colposcopy service and no request is received from the Regional Programme Coordinator to remove the woman from the laboratory FailSafe system, the CSAD is notified, as above, a further **12** months later. This cycle is repeated for as long as necessary (in practice, all women should have been removed from the laboratory FailSafe system before a third 12 month period has elapsed)
- The woman is included on only **one** weekly list every 12 month period

Colposcopy Service Procedures

Each time a woman attends for a colposcopy appointment, the colposcopy service notifies the CSAD, including the following information (this can be achieved by routinely copying to the CSAD all letters sent by the colposcopy service to a woman's GP):

- Woman's full name, date of birth, NHS number and address
- Date of attendance
- Date and type of any subsequent appointment (including for follow-up tests within the colposcopy service)
- Test/biopsy results (if applicable)
- Whether the woman has been discharged from the colposcopy service

When a woman does not attend a colposcopy appointment, she must be sent a further invitation. If she still does not attend, she is discharged from the clinic and the colposcopy service must notify the CSAD and GP. The CSAD then include the woman in the ColpSafe (see 3A.350).

i) Non-Attendance for Annual Follow-Up Tests

Women requiring annual follow-up tests after colposcopy are dealt with, for FailSafe purposes, by the CSAD, backed up by the laboratory, in the same way as repeat tests following an abnormal or inadequate test.

CSAD responsibility by laboratory

Where a laboratory serves more than one CSAD, the CSAD who has the majority of tests read at the laboratory, will be responsible for that laboratory's FailSafe. This will apply even if the woman is not registered on their database.

The CSADs are responsible for the laboratories listed against them.

Dyfed Powys

West Wales, Carmarthen
Withybush, Haverfordwest
Princess Royal, Telford
County Hospital, Hereford

Morgannwg

Princess of Wales, Bridgend
Singleton, Swansea

North Wales

Glan Clwyd, Bodelwyddan
Wrexham Maelor, Wrexham
Ysbyty Gwynedd, Bangor
Countess of Chester, Chester

SE Wales

Prince Charles, Merthyr
Llandough, Cardiff
Royal Glamorgan, Pontypridd
Royal Gwent, Newport

Women who move out of Wales

Women who are part of the CSW FailSafe system and move out of Wales appear on deduction lists. The CSAD inform the laboratory that the woman has moved outside Wales and to remove her from the laboratory FailSafe list.

Women who move to another CSAD

Women who move to another CSAD will be entered onto the receiving CSAD FailSafe system. However, the woman will remain on the original laboratory FailSafe list and the original CSAD will track these women on behalf of the new CSAD with the laboratory until she can be removed.

Women who move into the CSAD area

All women who move into the CSAD area with a cytology screening history containing an 'S' coded test are managed appropriately.

Abnormal test within 3 years of registration

If the test was within 3 years of registration, an enquiry is sent to the woman to determine her current status. On receipt of her reply the Regional Programme Coordinator will either recommend a colposcopy referral or a repeat smear test with her GP/Sexual Health Clinic.

Abnormal test more than 3 years from registration

The woman's name is given an appropriate recall for a repeat smear test with her GP/ Sexual Health Clinic.

3A.240.4 Quality Measures

- 100% of women who do not respond to a screening invitation are FailSafed according to CSW policy.

3A.240.5 Quality Control/Audit

Incident reporting
Comments and complaints

3A.240.6 Further Guidance

- 3A.20 Managing the invitation run
- 3A.150 Non-responder cards for GPs
- 3A.180 Managing incoming cytology data
- 3A.300 Direct referral to colposcopy
- 3A.340 Discharging women from SafetyNet
- 3A.380 Women deducted from the Exeter database with SafetyNet information.
- 3A.390 Women transferring into the area with an abnormal result
- 3A.510 Retention and disposal of paper records
- 4P.100 Laboratory FailSafe procedures

3A.250 TAGGED WOMEN

3A.250.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.250.2 Quality Standard

Women who come under certain categories are tagged to ensure that relevant information relating to woman identity or screening details is flagged to the person(s) concerned via email.

There are 2 automatic tags:

F - FP69 (Returned Undelivered Mail)

W - ColpSafe

There are other tags which may be specific to individual CSADs. These should NOT be set up without the prior agreement of the Lead CSAD Manager.

3A.250.3 Method

Women entered on Exeter for ColpSafe, FP69 are automatically tagged.

The following are tag codes for each category:

D = Dummy Doctor

F = FP69

G = General (use of this must be approved by local CSAD Manager)

W = ColpSafe

This is done by accessing the **W6** screen with a qualifier of TAG\NHS NUMBER\TAG CODE.

Whenever there is a change to the RA audit on Exeter an email is produced the following day.

The system is then set up to report every 14 days after any changes on the RA screen.

When a tag is no longer required for a woman it is removed.

It is possible to specify by tag code, which staff members receive which tag reports.

Dummy Doctor (D)

CSADs may wish to tag women on Dummy Doctor so that they are advised of changes to individual records.

FP69 (returned undelivered mail) (F)

When a new address is received for women for whom a letter was returned undelivered, the recall date is amended to the next invitation run. A check is made that the FP69 flag has been removed.

Tags are set to report changes captured on the Exeter RA screen the following day.

For women deducted as R/U a check is made whether the deduction may have occurred despite the address being amended after the FP69 had been set. In this instance an incident form is completed and the instance brought to the attention of the registration manager of the BSC.

If a new address is identified for result letters that are returned undelivered, a check is made with the Regional Programme Coordinator whether to re-issue a new result letter.

NB: On the first day of each month an email is produced with details of women due for deduction from Exeter the following month, highlighting that an amendment has been made to the ID screen and the FP69 marker has not been removed. These are checked by CSAD staff to ensure that no woman is deducted inappropriately. Any discrepancies should be brought to the attention of the Patient Data Manager at the BSC.

General (G)

These can not be used by CSAD staff without prior agreement with the local CSAD Manager. The local CSAD Manager informs the Lead CSAD Manager of all uses for the 'general' tag.

ColpSafe (W)

These are tagged to identify women who may have DNA'd colposcopy, either because of a change of address, have left the area or had a test outside colposcopy.

3A.250.4 Quality Measures

- Automatic notification via email alert

3A.250.5 Quality Control

Emails are only sent to the relevant members of staff.

No tag is set up without prior agreement of the Lead CSAD Manager

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.250.6 Further Guidance

- 3A.160 Dummy Doctor procedure
- 3A.230 Processing notification of women who do not live at the current address due to returned correspondence sent from CSAD/Screening Services
- 3A.350 Managing ColpSafe
- 3A.510 Retention and disposal of paper records

3A.280 PRIVATE WOMEN AND TESTS REPORTED ABROAD

3A.280.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.280.2 Quality Standard

All women who have a test taken privately or reported abroad are also called and recalled for NHS screening programme tests. All notifications of private cervical tests or tests reported abroad, received by CSW, will be logged on the call/recall computer system.

Normal or inadequate test results will not result in a change to the date on which the woman will be called or recalled for an NHS screening programme test.

Women with abnormal test results notified to CSW will be included within the CSW FailSafe system.

No result letter is generated by CSW for a private test.

3A.280.3 Method

Private smear negative and Exeter status normal recall or call

Code as 2H and no change to Exeter recall status

No result letter produced or sent

Private smear negative and Exeter status is early repeat

Code as 2H and no change to Exeter recall status

No result letter produced or sent

Private smear inadequate and Exeter status normal or early repeat

Code as 1H and no change to Exeter recall status

No result letter produced or sent

Private smear abnormal (8R and 3R)

Code as 8R or 3R

No result letter sent

Woman will be re-invited in 6 months time

Private smear referral (1 – 8S)

Code as suspend smear but do not directly refer
No result letter sent but CSW query letter sent

Private smear referral and woman requests NHS colposcopy

Code as suspend smear and directly refer
No result letter sent

Private smear referral and woman requests private colposcopy

Code as suspend smear and do not directly refer
Create episode on SafetyNet as a private referral
No result letter sent

NHS smear referral and woman requests private colposcopy

Code as suspend smear and send result letter
Change referral clinic to private and keep woman on SafetyNet

NHS smear referral and woman initially requests private colposcopy but then requests NHS colposcopy.

Code as suspend smear and send result letter
Change referral clinic as appropriate and keep woman on SafetyNet.

Private test results received at CSAD following treatment

These are referred to the Regional Nurse Coordinator for a decision about the woman's recall status. Any issues of quality assurance relating to private tests can be referred by the Regional Programme Coordinator to the Local Management Group.

If a woman requests no further invitation from CSW she should be sent a CSW opt-out letter. The woman should not be ceased from the programme until the signed opt-out letter has been returned.

Women not registered

If the woman is not registered with a GP, then the result can be entered under a ZZZ code.

Smears taken abroad

For tests which are taken abroad and can not be translated or understood by CSW a letter is sent to the GP informing him that CSW are unable to acknowledge the test as the information is not clear and her recall date will be set by the Regional Programme Coordinator in accordance with current CSW policy. Such results should not be entered on the CY screen but a note should be entered on the CY, NB box (this also relates to information given on non-responder cards where no copy of the test is available). For all other tests taken abroad CSAD will code as per private smears. If a referral smear is received the Regional Programme Coordinator will consider appropriate action.

If CSAD have information that could affect a woman's management the sample taker is informed.

3A.280.4 Quality Measures

- 100% of private cervical test results received by CSAD are logged on the call/recall computer system within 1 week
- 100% of normal or inadequate private test results will be coded as 'H' and will not alter the recall date for the NHS screening programme test
- 100% of women with abnormal private test results notified to the CSAD will be coded according to CSW suggested management and entered onto CSW FailSafe system

3A.280.5 Quality Control/Audit

Audit of private woman tests

3A.280.6 Further Guidance

- 3A.40 Processing the report form
- 3A.41 Processing results other than those received from pathology laboratories working as part of CSW
- 3A.50 Suggested management
- 3A.60 Managing the result run (AJ-CP)
- 3A.240 Managing FailSafe

3A.281 SERVICE PERSONNEL

3A.281.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.281.2 Quality Standard

To ensure that all women in the Services who have their test taken within CSAD area have their result managed appropriately.

3A.281.3 Method

It is not always obvious from the HMR form whether the woman is a Service Personnel or Service Dependant. If not, then the following steps are taken:

- Check the deducted screen to see if the woman was previously registered and for what reason she was deducted
- Follow SOPP 3A.110 for women not registered in the CSAD area

Women who have their test taken whilst in the Services have their result sent to Coventry Primary Care Trust who administer the call/recall programme on behalf of the Services.

3A.281.4 Quality Measures

- All results forwarded to Coventry PCT are sent with a pro forma asking for confirmation of receipt of test result. If no confirmation is received within a month, then enquiries are made with Coventry

3A.281.5 Quality Control/Audit

Check of returned proformas

3A.281.6 Further Guidance

- 3A.40 Processing the report form
- 3A.110 Women not registered in CSAD area
- 3A.282 Service Dependants

3A.282 SERVICE DEPENDANTS

3A.282.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.282.2 Quality Standard

Women who are dependants of a partner in the services are informed of their test result in an appropriate manner.

3A.282.3 Method

It is not always obvious from the HMR form whether the woman is service personnel or service dependant. If not the following steps are taken:

- Check the deducted screen to see if the woman was previously registered and for what reason she was deducted
- Follow SOPP 3A.110 for women not registered in CSAD area
- When tests are received for Service Dependants they are entered onto a Dummy Doctor

A result letter is generated and sent to the woman.

A copy of the test is sent to NHSCR (Central Register) who (should) pass the result onto the woman's appropriate Medical Officer.

3A.282.4 Quality Measures

- 100% of women who have tests taken within CSAD are sent a result letter
- 100% of results are forwarded to NHSCR

3A.282.5 Quality Control/Audit

Check of returned proformas

3A.282.6 Further Guidance

- 3A.40 Processing the report form
- 3A.110 Women not registered in CSAD area
- 3A.160 Dummy Doctor Procedure
- 3A.281 Service Personnel

3A.290 UNDELIVERED RETURNED MAIL (W6-RUM)

3A.290.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.290.2 Quality Standard

A record is kept of all invitations and results sent from CSAD returned undelivered to establish computer data base accuracy for addresses.

3A.290.3 Method

All returned mail must be logged via the W6-RUM screen. The W6-RUM screen will prompt CSAD to complete the following:

- NHS number
- GP practice woman was registered with at time letter was sent
- Date mail was sent from CSAD department (date on letter)
- Date mail was returned to the CSAD department
- Was letter generated as a result of a routine invitation or result
- Type of mail – first invitation **F**, second invitation **S**, result **R**, ColpSafe **C** and other **O**

The FP69 tag is automatically set to 'Y'.

On a monthly basis the above information is forwarded to the CSW Information department for the previous month via automatic download.

The CSAD also retain the original copy of the returned correspondence in a separate file.

3A.290.4 Quality Measures

- All invitations and results received as 'returned undelivered mail' are logged by the CSAD via the W6 screen and the returned correspondence filed
- Information is downloaded monthly for the CSW Information department

3A.290.5 Quality Control/Audit

Audit of W6 screen

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.290.6 Further Guidance

CSW Information Project, CSAD – Workbook, data items

A022/ A022a/ A024

3A.230 Processing notification of women who do not live at the current address due to returned correspondence sent from CSAD/Screening Services

3A.250 Tagged women

3A.510 Retention and disposal of paper records

3A.300 DIRECT REFERRAL TO COLPOSCOPY

3A.300.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.300.2 Quality Standard

All women with a new 'S' coded abnormal or inadequate smear are referred to the appropriate colposcopy service within 1 week of the result arriving at the CSAD via the CSW SafetyNet system which is located on the 'Exeter' system.

3A.300.3 Method

When a Direct Referral result is entered onto the 'Exeter' system a Referral Type of DR is automatically created on the W6-SN screen for that woman.

After completion of the CP result run, the report forms for women who require direct referral to colposcopy, the result letters for these women and the W6-CP print are all cross checked by a CSAD Officer to ensure that all direct referral reports have been received.

All report forms are photocopied to be sent with the direct referral requests to the relevant colposcopy service. Any report forms which require a change of management are passed back to the appropriate person before being filed with the rest of the smear reports.

The **Letter\Form** Batch is printed via **W6-SN\LIST** and contains the following letters and forms:

- i) Request to the appropriate colposcopy service (**WSNR**) for an appointment to be sent within:
 - 2 weeks for severe dyskaryosis/? invasive and glandular neoplasia
 - 4 weeks for moderate and severe dyskaryosis, borderline/? high grade (**8H**); borderline endocervical with ? high grade (**8HC**); borderline changes in endometrial cells (**8GM**); borderline changes - other glandular (**8GX**)
 - 8 weeks for mild dyskaryosis, borderline/endocervical (**8GC**), borderline changes and inadequate

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- ii) Letter to the GP informing that a request has been made to a clinic for his/her woman (**WSNG**)
- iii) Letter to the sender of the smear if taken other than the GP practice (**WSNS**)
- iv) Top Sheet to inform the colposcopy service of any previous Safety Net episodes (**WSNT**)
- v) The woman's screening test history, which is also sent to colposcopy service (**WSNH**)

List (**WSNL**) is printed via the W6-SN\LIST for all Direct Referrals by Colposcopy service. This is sent to the clinics as a summary of all their referrals. This list is also used by CSAD to check against CANISC (Cancer Network Information System Cymru) to ensure that colposcopy have received all referrals.

Urgent referrals requiring an appointment within 2 weeks (see 6C.20) will be notified to CSAD by laboratory via telephone and/or fax. CSAD will in turn telephone the colposcopy service and notify them that an urgent referral is being processed. The Colposcopy service do NOT take any definite action until the direct referral paperwork is received from CSAD but may use the information to ensure an appointment slot is available within the appropriate timescales.

3A.300.4 Quality Measures

- 95% of women requiring referral to a colposcopy service are directly referred to Colposcopy within 2 days of receipt of the result at CSAD
- 100% of women requiring referral to a colposcopy service are directly referred so within 1 week of receipt at the CSAD

3A.300.5 Quality Control\Audit

Letter\Form Batch must be printed within 1 working day of processing the result run.

All receipts of referrals must be confirmed with the colposcopy services within 2 working days, either by looking on CANISC, or if the information has not been entered on CANISC, then the clinic is contacted by phone (subject to local procedures ie some clinics are only open at certain times).

WSNL List of women referred used to check against CANISC

3A.300.6 Further Guidance

- 3A.60 Managing the result run(AJ-CP)
- 3A.320 Change of Colposcopy service

3A.310 'OTHER' REFERRALS RECEIVED FROM COLPOSCOPY

3A.310.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.310.2 Quality Standard

Where CSADs are informed of women referred to colposcopy other than for abnormal smears, these are added to SafetyNet if they have been diagnosed histologically with CIN or worse (including CGIN).

This information is usually received via the weekly CANISC Wizard List, however notifications could also come via ad hoc colposcopy letters and histology from pathology laboratories.

3A.310.3 Method

A referral of 'Other' is created by accessing the **W6-SN\EPISO** screen. Under the 'Referral Type' field, an entry of '**OR**' is made.

The information of the visit is then entered onto the **W6-SN\APPT** screen. This will then calculate a review date for the woman.

The histology is entered in the **W6-SN\MEDIC** screen. When entering histology the procedure should be entered together with the most severe result in the appropriate fields.

The following day the woman's name will appear on the **WROR** List as confirmation that a SafetyNet episode has been created, the list is cross checked with the CANISC Wizard list to ensure that all referrals have been actioned.

3A.310.4 Quality Measures

- The CANISC Wizard List is run on a weekly basis'
- 100% check is made that all 'other' referrals have been actioned

3A.310.5 Quality Control/Audit

CANISC Wizard List

WROR List

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.310.6 Further Guidance

3A.330 Processing Information from Colposcopy services (including CANISC wizard) /Pathology Laboratories

3A.320 CHANGE OF COLPOSCOPY SERVICE

3A.320.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.320.2 Quality Standard

Every woman who requires colposcopy investigation must be seen within a period of time depending on the severity of her smear result which are as follows:

- 2 weeks for severe dyskaryosis/? invasive and glandular neoplasia
- 4 weeks for moderate and severe dyskaryosis, borderline/? high grade (**8H**); borderline endocervical with ? high grade (**8HC**); borderline changes in endometrial cells (**8GM**); borderline changes – other glandular (**8GX**)
- 8 weeks for mild dyskaryosis, borderline/endocervical (**8GC**), borderline changes and inadequate

Women are directly referred to the preferred clinic of their General Practitioner but may request to be seen at another clinic. These requests are acted upon at CSAD and the new clinic will still have the same amount of time to make the initial appointment for the woman as the original clinic would have initially had.

3A.320.3 Method

When CSADs receive a request for a change of clinic (either via GP or woman), the following action is taken:

- The W6-SN\NHS NO\EPIISO screen is accessed and the code for the clinic is amended to the new clinic's code. The appropriate clinic code can be identified by entering a ? in the clinic field and using the 'return' key to scroll through the available clinics until the appropriate clinic has been identified. This is then selected by using the 'tab' key
- This action automatically discharges the current SafetyNet episode and creates a new referral type of **CC** (Change of Clinic)
- The following letters are then produced:
 - **WSNB**-letter to the new clinic
 - **WSNC**-letter to the old clinic
 - **WSND**-letter to the GP

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- **WSNE**-letter to the Sender (if required)
- **WSNP**-letter to the woman

The woman's name will also appear under the new Colposcopy service under the **WSNL** List.

3A.320.4 Quality Measures

- 100% of women who wish to change clinic are referred to the clinic of their choice
- 100% of letters are sent within 2 working days of the CSAD being informed of the change of clinic

3A.320.5 Quality Control\Audit

Women who have changed clinic will appear on the **WSNL** List

3A.320.6 Further Guidance

3A.300 Direct referral to colposcopy

3A.310 'Other' referrals received from colposcopy

3A.330 PROCESSING INFORMATION FROM COLPOSCOPY SERVICES (INCLUDING CANISC WIZARD/PATH LABORATORIES)

3A.330.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.330.2 Quality Standard

All information from colposcopy services and pathology laboratories are used by CSAD to ensure that SafetyNet is updated appropriately. Relevant visit type and the review date are calculated from information received from colposcopy services.

3A.330.3 Method

Information is received at CSAD via the following sources:

i) COLPOSCOPY LETTERS

These should be received on a regular basis from the appropriate colposcopy service.

ii) CANISC WIZARD LIST

This is divided into 8 lists. The 'a' lists relate to women seen as a result of direct referral from CSW, the 'b' lists relate to women referred for other reasons (not by CSW) and who have had a biopsy showing CIN or worse (including CGIN).

CANISC is accessed as follows:

After logging on, go to:

User then Group Options for CSAD (for named CSAD) then Colposcopy Organisation then CSAD.

Go back into **User then Group Options (for named CSAD) then Data Analysis Wizard.**

Then the **date range** appears, they automatically appear and should be the dates required for data entered at colposcopy services in the last 7 days. Click on **next**.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Category then appears followed by the named CSAD, click on **next**.

Query Type appears and the required option is required; click on **next** followed by **run query**.

It will then process for a few moments; select **print report** when it appears.

1a Direct Referrals

Lists all direct referrals from the CSAD whom the colposcopy service have entered onto CANISC during the period the print was produced for.

2a DNAs

Lists all women who have DNAd for the period the list was produced for. This includes 1st and 2nd DNAs.

3a Discharges

Lists all women who have been discharged for the period the list was produced for.

4a Attended\Investigations\Results

Lists all women who have attended during the period the list was produced for. It includes details of biopsies and treatment, histology and woman management

1b Other Referrals

2b Other DNAs

3b Other Discharges

4b Attended\Investigations\Results (Other Referrals)

Entering Information on SafetyNet

Woman details are accessed on screen and their manual record(if applicable) obtained out of the paper file. Personal details on Exeter and correspondence are checked. If there is an old address on correspondence from the colposcopy department then they are informed of the new address via a change of address proforma (**WSNA**) printed via W6-SN\LIST.

- The W6-SN\APPT screen is accessed and the following information entered:
 1. Date of appointment
 2. Type of appointment i.e Assessment(**A**), See and Treat(**S**), Treatment(**T**) or Follow-up(**F**)
 3. Was the appointment Attended(**A**) or Not Attended(**D**)
 - Upon input of data for an attended appointment, the woman's new review date is automatically re-calculated by the system
 - If the woman Did Not Attend then the review date is not changed

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

The review date is re-calculated as follows from the date of appointment depending on the type of appointment:

1. Assessment-Incremented by 8 weeks
2. Treatment-Incremented by 30 weeks
3. See & Treat-Incremented by 30 weeks
4. Follow-up-Incremented by 30 weeks

Occasionally the date of the next visit may not correspond with the above re-calculations. In this instance the review date is amended. This could be by bringing the date forward or postponing as appropriate. In either instance a note is made on the W6-SN NOTES screen as to the reason for the change.

NB: The maximum amount of time a review date can be postponed for is 30 weeks.

If there is a histology result present, this is entered on W6-SN\MEDIC

3. HISTOLOGY FROM PATHOLOGY LABORATORIES

- When entering histology, the procedure together with the most severe result should be entered in the appropriate fields
- Information from histology reports should be used to update the W6-SN/MEDICAL screen only, it should not be used to update the APPOINTMENT screen, unless it is for an 'OTHER' Referral
- All information entered onto SafetyNet is checked by another staff member within a week of updating

NB: CSAD staff should keep information in W6-SN\NOTES to a minimum and should be aware of using inappropriate terminology, eg woman in prison or termination of pregnancy. As this screen is free text, any note should begin with the date of entry on the next available line with the recorded information on the following line.

3A.330.4 Quality Measures

- All information is entered onto the SafetyNet within 1 week of receipt at CSAD
- All information entered is verified by another staff member

3A.330.5 Quality Control\Audit

CANISC Wizard

Histology from Pathology Laboratories

3A.330.6 Further Guidance

3A.510 Retention and disposal of paper records

3A.340 DISCHARGING WOMEN FROM SAFETYNET

3A.340.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.340.2 Quality Standard

All women discharged from colposcopy, are recalled if appropriate for their next smear as stated by CSW protocols.

3A.340.3 Method

CSAD receive all discharge notifications via CANISC Wizard List or colposcopy letters.

W6-SN\NHS Number is accessed and the date the woman is discharged off SafetyNet is entered in the date field in the discharge box. The date will ALWAYS be the date the discharge is done on SafetyNet.

Women can be discharged for the following reasons:

1. **A**-previously ceased
2. **C**-ColpSafe
3. **D**-died (auto discharge)
4. **DO**-other reason
5. **MO**-moved out of Wales
6. **MW**-moved within Wales
7. **NC**-new clinic
8. **ON**-oncology
9. **R**-return to recall
10. **UP**-uploaded and discharged (this applies only to episodes discharged when uploaded from the 'old' SafetyNet)

NB: Women referred to Oncology from a Colposcopy service are not discharged from SafetyNet until confirmation has been received that the woman has been seen in Oncology.

All discharges must be confirmed by a member of staff who did not do the initial discharge. At this stage, a check is made that the discharge is appropriate.

It is important that the recall date and recall status are checked on the CY screen; as either may prevent the woman from being recalled at the appropriate time. If the recall status is not at 'No Action' at time of discharge from SafetyNet an email is produced for the CSAD Manager.

NB: The verifier confirming the discharge does not take ultimate responsibility for discharging action.

All discharges are actioned within 1 week of receiving the notification.

All confirmations are done within 1 week of discharge.

3A.340.4 Quality Measures

- All discharges are actioned within 1 week of receiving the notification
- All confirmations are actioned within 1 week of discharge

3A.340.5 Quality Control\Audit

If no confirmation actioned within 7 days a reminder will be issued via the SN_INTGO email to the CSAD staff who have been identified to receive the email.

Email: SafetyNet_Discharge_with_Recall_Status_not_No_Action

3A.340.6 Further Guidance

3A.330 Processing Information from Colposcopy Services (including CANISC wizard)/Pathology Laboratories

3A.350 MANAGING COLPSAFE

3A.350.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.350.2 Quality Standard

All women who fail to attend **two** consecutive colposcopy appointments, and also fail to contact the clinic are discharged by the colposcopy service and included in the CSW ColpSafe scheme.

Timescale	Action
0 months	<p>CSAD are informed of a woman's 2nd DNA and a ColpSafe episode is automatically produced on the 'W5' screen when the 2nd DNA is entered.</p> <p>A Letter is sent to the woman (WDN6) together with a form (WDNA) for the woman to return in a FREEPOST envelope. A copy of the letter is also sent to her GP, together with a covering letter (WDN2).</p>
4 weeks after first letter sent	Query letter to woman's GP (WDN3)
9 weeks after first letter sent	<p>At this stage a list is produced of women who are due a disclaimer letter; the PC reviews each woman's record and will decide on one of the following options:</p> <ul style="list-style-type: none"> • Send the Disclaimer Letter (WDN7) with a copy to the GP • Send a personal letter to the woman • Return the woman to Colposcopy <p>If a Disclaimer Letter is sent, then the next test due date is adjusted if necessary to the next appropriate AJ-RG run.</p>

3A.350.3 Method

On a weekly basis, a CSAD Officer will process list **2A** from CANISC Wizard to identify all DNAs entered onto CANISC the previous week.

Letters are received from Colposcopy services outside Wales, as they do not use CANISC.

DNA first appointment

All first DNA 's to colposcopy will be re-invited by the colposcopy service. When demographic details held at the colposcopy service are incorrect, the CSAD officer immediately informs colposcopy so that the appropriate contact can be made with the woman and a new appointment date is given.

To process the information, the **W6-SN\APPT** screen is accessed and the following information entered:

1. Date of appointment
2. Type of appointment ie Assessment(**A**), Treatment(**T**) or Follow-up (**F**)
3. (**D**) for Not Attended
4. Clinic
5. Source

As the woman Did Not Attend then the review date is not automatically changed, however a manual update may be required.

DNA second appointment

When a woman has DNA'd two consecutive appointments at colposcopy, she is discharged from the colposcopy service.

To process the information, the **W6-SN\APPT** screen is accessed and the following information entered:

1. Date of appointment
2. Type of appointment ie Assessment(**A**), Treatment(**T**) or Follow-up(**F**)
3. (**D**) for Not Attended
4. Clinic
5. Source

The woman is automatically discharged from SafetyNet, with a code **C** and a ColpSafe episode is automatically created on the **W5** screen. All women in ColpSafe are automatically tagged so that named staff are alerted to any changes done to the woman's demographics or **CY** screen. This tag is automatically removed once the ColpSafe episode is closed.

0 Weeks (Stage 1)

The woman is sent a letter (**WDN6-printed via W5\PRINT**) enquiring why she had DNAd consecutive colposcopy appointments. She is also sent form (**WDNA**) to return to the CSAD giving her an opportunity to give a reason for her non attendance. A FREEPOST envelope is included for her reply. A copy of the letter is also sent to her GP, together with a

covering letter (**WDN2**) informing of the woman's current situation in relation to her non attendance.

If a response is received from the woman within a month, it is reviewed by the CSAD Officer. If it relates to a simple administrative query the CSAD Officer takes the appropriate action, but all clinical issues must be passed to the Regional Programme Coordinator or Regional Nurse Coordinator for advice.

One of the following reasons has to be given as to why a woman has DNA'd colposcopy:

A Clinical Reason

- very recent smear
- pregnancy
- significant health concern

B Administrative Reason

- inappropriate appointment
- difficulty with communication with colposcopy

C Moved away

- out of CSAD area

E Unhappy with the Service

F Change of Address

- Within BSC area

N Not known

- GP may ask for a further appointment to be made and that the woman has been contacted and no other reason given for non attendance.
- Woman may also ask for a further appointment to be made and no other reason given for non attendance.

X Died

Any woman that is coded (**A**) Clinical reason or (**E**) Unhappy with the service will trigger an email to the Regional Programme Coordinator and Regional Nurse Coordinator for action. All other reasons can be dealt with by the CSAD administrative staff.

4 weeks from the first letter being printed (Stage 2)

If there is no response from the woman within a month, the ColpSafe programme automatically produces a query letter to the general practitioner (**WDN3**).

Timings of the printing of the letters can be arranged by the CSAD. All letters can be produced automatically or manually.

9 weeks from the first letter being printed (Stage 3)

The process ends at 9 weeks when there has been no information from either the woman or her general practitioner. At this stage a list is produced for women who are **due** a disclaimer via **W5 PRINT**. These are all reviewed by the Regional Programme Coordinator.

Send Disclaimer Letter

If the decision is to send the disclaimer letter then **N (Not Known)** is entered in the **Reason** field on the W5 screen.

The disclaimer advises the woman that CSW has taken all reasonable steps to encourage her to attend colposcopy and that her next communication from CSW will be an invitation for a smear test. The Next Test Due Date is then amended if necessary on the CY screen to the next appropriate AJ-RG run.

Refer Back to Colposcopy

If the Regional Programme Coordinator decides that she should be re-referred to colposcopy then **S** is entered in the **Action** field.

Personal Letter to Woman

If the Regional Programme Coordinator decides not to issue a disclaimer or re-refer back to Colposcopy then she may decide to write a 'personal' letter to the woman asking for more information. At this stage neither the Reason nor Action fields on W5 are updated.

Woman requests a further appointment

The woman may request a further appointment at the colposcopy service at any time after the ColpSafe episode is created. If this happens, the CSAD will enter '**S**' in the action code on the ColpSafe screen, this will close the ColpSafe episode and create a new referral to SafetyNet episode with an episode type of '**CR**' -ColpSafe re-referral.

NB: Details should be kept in the comments screen on W5 of any relevant information including all comments from the woman.

Options for ACTION field on W5

The following need to be entered manually:

D=Delete

P=Premature Closure

R=Re-open Episode

S=ColpSafe Re-Referral

X=Stopped Re-Referral

The following are automatically created:

C=Complete

E=Episode Created

Women who DNA a 'CR' (ColpSafe Re-Referral) type SafetyNet episode

Women who fail to attend two consecutive appointments in colposcopy after being referred back there from a ColpSafe episode, will, once again be discharged from SafetyNet and put back into ColpSafe. The woman's details are highlighted via email SN_FAPPT as possibly being at risk through continued non-attendance in colposcopy.

Her status in the ColpSafe system will be set to 'Y' for 'suspended' pending a resolution of her case. If the decision is to let her continue through ColpSafe, then the CSAD must unset the suspended field on the W5 screen by entering a N in the suspended field.

If the woman indicates that she will require a further colposcopy appointment, then 'S' should be entered in the Action field. The woman will be discharged from ColpSafe and will have a new SafetyNet episode created with a referral type 'CR' (ColpSafe re-referral).

If the decision is that the woman should take no further part in colposcopy, then 'X' should be entered in the Action field on the W5 screen. This will discharge her from ColpSafe (Stage 4) this stops the re-referral letter being produced.

Women in ColpSafe due an invite letter (W6-PIP)

In some circumstances women in ColpSafe may appear on W6-PIP advising that they are about to re-enter the call\recall invitation process.

To avoid a conflict between ColpSafe letters and call\recall letters, the recall date is forwarded 6 months from the day of postponement.

Smears Taken in Community whilst ColpSafe is Open

It is advised that all community based smears taken whilst the woman has an Open ColpSafe episode are shown to the Regional Programme Coordinator.

3A.350.4 Quality Measures

- 100% of all correspondence received from colposcopy is dealt with by the CSAD Officer within 1 week of receipt
- 100% of women who have DNA'd two consecutive colposcopy appointments are included in ColpSafe
- 100% print of letters weekly
- 100% of all letters to be posted within a day of production

3A.350.5 Quality Control/Audit

Returned enquiry letters from women/GP

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.350.6 Further Guidance

- 3A.240 Managing FailSafe
- 3A.300 Direct referral to Colposcopy
- 3A.510 Retention and disposal of paper records
- 5C.60 Managing non attenders, DNAs and cancellations
- 6C.80 Women who do not attend (DNA)

3A.360 ENQUIRIES GENERATED FOR SAFETYNET VIA EMAILS OR PRINT

3A.360.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.360.2 Quality Standard

The SafetyNet has a series of reminder controls which prompts CSAD to take action in particular circumstances.

All emails generated for SafetyNet are investigated to ensure that the woman concerned is identified and any necessary action taken.

3A.360.3 Method

Access to emails generated for SafetyNet is controlled by the CSAD Manager.

The following emails are available:

- SN_FAPPT
- SN_INTGO
- SN_INTPR

SN_FAPPT-Persistent non-attenders back to Colposcopy from ColpSafe

This email is used in two ways:

1. When entering a second DNA in SafetyNet AND the episode type is 'CR' (ColpSafe re referral), the members of the group are sent an email to highlight a woman who is continually not attending

SN_INTGO-General emails/print for SafetyNet Background

This is a daily email/print which reports the following to the CSAD who take the appropriate action.

Message Type 100-Woman Deducted-Discharge SafetyNet Required

- Notifications of women deducted from Exeter requiring manual discharge from SafetyNet

Message Type 101-Notification of Auto-Discharge

- Women Removed as Death on the 'Exeter' system are the only group auto-discharged from SafetyNet

Message Type 102-Discharge Requires Confirmation

- Notifications of Discharges from SafetyNet, that have not been confirmed. The confirmation of discharge must be made within 1 week of notification

Message Type 103-Women Inappropriately Discharged

- Discharged from SafetyNet inappropriate to CSW policy

Message Type 104-Review Date Exceeded or via Exeter Print

- Notifications of women whose review date on SafetyNet have been exceeded. These are investigated on CANISC and if appropriate an enquiry letter WRVH for direct referrals or WRVO for other referrals or is sent to the colposcopy service. These are actioned within 1 week of notification

If the Direct Referral smear or a subsequent colposcopy smear was moderate dyskaryosis or worse then CSAD are required to acknowledge a response to the letter via W6/SN/LIST/ACK. If no response is received within 4 weeks, CSADs are notified daily on the email that the letter has not been acknowledged.

NB: When the review date is exceeded it is then incremented by a further 8 weeks.

Message Type 105-Multiple Review Dates

- Notifications of women whose review date on SafetyNet have been exceeded on at least 3 occasions. These are reviewed in conjunction with CSAD staff and resolved within 2 weeks of notification

Message Type 106-Referral Tests Do Not Exist

- Notifications of open SafetyNet episode where the referral test has been deleted from the CY screen, thus disabling the direct referral initiated via W7 screen. Such instances must be investigated and resolved within 1 working day

Message Type 108-Highlight Rules Not Yet Acknowledged/Pending

- Notifications of highlight rules not yet acknowledged/pending will appear after 90 days and then every 14 days until they are resolved

Message Type 109-Deleted Highlight Rules

- One off notification of any rules deleted

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Message Type 110-Women not yet Discharged to Oncology

- Women diagnosed with cancer still active on the SafetyNet

SN_INTPR-SafetyNet Prints Outstanding

This highlights lists, letters and forms on **W6-SN\LIST\ACK** that have not been acknowledged.

If direct referral information has not been printed for 2 working days then a notification is produced as follows:

- **Form/Letter Batch**
- **Lists**

These must be resolved within 1 working day.

- W6-SN\LIST appears daily on email if not acknowledged within 7 days of notification
- WRVH/WRVO appears daily on email if letters are not acknowledged within 4 weeks of notification
- WSNA appears daily on email if not acknowledged within 14 days of notification

3A.360.4 Quality Measures

- 100% emails are actioned within 1 week of notification

3A.360.5 Quality\Control Audit

Daily Notification of emails

3A.360.6 Further Guidance

3A.350 Managing ColpSafe

3A.361 Enquiries Generated by Colposcopy Highlight Rules

3A.361 ENQUIRIES GENERATED BY COLPOSCOPY HIGHLIGHT RULES

3A.361.1 Staff Responsibility

Managerial Responsibility

CSAD manager
Regional Programme Coordinator

Operational Staff

CSAD officers
CSAD manager
Regional Programme Coordinator

QA Advisor

Head of Administration

3A.361.2 Quality Standard

Colposcopy Highlight Rules ensure that a query is generated when a woman's management in, or discharge from colposcopy seems to be at variance with the Colposcopy SOPP's. These rules may highlight at:

- Discharge from the colposcopy service
- Entry of an assessment/treatment/ follow-up episode
- A set interval from referral to colposcopy

When a rule is 'set' for a woman, a query is generated in the form of an email to the CSAD manager and Regional Programme Coordinator. A proforma is printed at this point.

All emails generated are investigated to ensure whether the rule was correctly set and whether any further action is needed.

3A.361.3 Method

The highlighted rule appears on the W6 SN screen. This states which rule has been set.

Rules set will appear on a weekly email to designated personnel. A proforma should be printed for each rule set (W6/SN LIST). Once it has been checked that the correct proformas have been printed, the email can be deleted.

The CSAD manager and Regional Programme Coordinator collate relevant paperwork to determine whether all necessary information has been received and correctly put onto Exeter. This may include:

- Obtaining and checking histology reports
- Contacting pathology services, colposcopy services or GPs

If these actions are likely to produce a delay in acknowledging/deleting the rule, the action should be set as 'pending' (see below).

If there is new/additional information, this should be added to the woman's electronic record and the highlighted rule reviewed by the CSAD manager and Regional Programme Coordinator in consideration of this. If the rule is now considered to have been set inappropriately, it can be deleted by the CSAD Manager (see below).

If the rule has been set appropriately, the CSAD Manager and Regional Programme Coordinator will discuss what further action is needed (see below).

Rules set must be actioned within 28 days of the weekly email.

The proforma is completed when all information has been received and any actions taken. The rule is then acknowledged.

Pending rules

If a rule cannot be deleted or acknowledged immediately because further information is needed, it should be set as 'pending' on the W6 MISC screen whilst this information is awaited.

If no further action (acknowledge or delete) is taken after 90 days, this rule will be highlighted in an email, and will continue to highlight every 14 days until the rule is either acknowledged or deleted.

Inappropriate rules

If a woman appears to have been managed according to colposcopy SOPPs, or reasons for her particular management are acceptable, the rule is considered inappropriate and will need to be deleted.

This action occurs on the 'W6 MISC' screen

- Written information must be documented on the proforma
- Additional information (eg biopsy results on 'NB' screen) must be added to W6 Medical Screen
- CSAD Manager/PC deletes the rule
- Woman may then be discharged from SafetyNet if appropriate
- CHR proforma is filed
- CSAD manager checks against email (deleted rules)

Appropriate rules

If woman appears to have been managed outside SOPPs, the rule is considered appropriate and must be acknowledged on the W6 MISC screen.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

All information requested and checked will need to be reviewed by the CSAD Manager and Regional Programme Coordinator on an individual basis.

Regional Programme Coordinator may need to contact woman's colposcopist (or lead colposcopist if woman's colposcopist is in training/not available) citing:

- Woman's details
- Reason for query
- Information or actions requested (eg explanation of management, referral to MDT etc)

If woman is referred to MDT, the Regional Programme Coordinator must be informed of the outcome in writing.

3A.361.4 Quality Measures

- 100% emails are actioned within 28 days of notification

3A.361.5 Quality\Control Audit

Daily Notification of emails

3A.361.6 Further Guidance

3A.330 Processing information from colposcopy services

3A.360 Enquiries generated for SafetyNet via emails or print

3A.370 FILING FOR SAFETYNET

3A.370.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.370.2 Quality Standard

Information received on paper for women on SafetyNet is filed appropriately.

3A.370.3 Method

Currently, the following paper records are generated by SafetyNet.

- Colposcopy Letters-*keep 12 years if amended otherwise check and destroy*
- Wizard Lists-once updated/checked they are kept for **12 months**
- ColpSafe Letters-*only retain woman's reply (12 years)*
- Histology Results-*12 years*
- Query Letters-*keep indefinitely*
- Emails-do not need to be kept, however any changes to SafetyNet should be noted in W6-SN\NOTES

3A.370.4 Quality Measures

- 100% of information received that needs to be retained is filed within 2 weeks of being actioned

3A.370.5 Quality Control\Audit

Early retrieval of notes when required

3A.370.6 Further Guidance

- 3A.300 Direct Referral to Colposcopy
- 3A.330 Processing information from Colposcopy services (including CANISC Wizard)/Pathology laboratories
- 3A.340 Discharging women from SafetyNet
- 3A.350 Managing ColpSafe
- 3A.361 Enquiries generated by Colposcopy Highlight Rules

3A.380 WOMEN DEDUCTED FROM THE EXETER DATABASE WITH SAFETYNET INFORMATION

3A.380.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.380.2 Quality Standard

Women whose registration is removed to another CSAD are managed appropriately if they have SafetyNet details.

3A.380.3 Method

Women's records which are deducted from the BSCs 'live' files on the 'Exeter' system are removed to the 'deducted' patient file.

The weekly AJ-CD routine automatically transmits the cytology history of these women to the new area, whether to another CSAD or outside Wales. All women transferring to a CSAD who have SafetyNet details on W6-SN also have these details forwarded to the new CSAD. However this print requires the 'deducting' CSAD to forward the information manually.

If women register outside Wales, then their new area only receive the standard cytology history off 'Exeter', they are not sent SafetyNet details.

Any woman deducted to another CSAD area and has details on W5/W6/W7 which are relevant to her future management are produced during the AJ-CD processing and appear on the PQ screen as CYIC Welsh Removals: QW1-5.

These are printed off and sent to the relevant area. On the Print Out there is a page for the new area to sign and acknowledge receipt of the information and return the slip to the deducting CSAD.

The deducting CSAD then sign off the acknowledgement on the **W6-MOVE\NHS Number** screen.

Reminders

If the transfer has not been acknowledged a month after deduction, then a reminder is sent to the new area via email informing them that the

deducting area has not received acknowledgment of the transfer. If in a further month there is no resolution, then the deducting area will receive notification via email of the outstanding acknowledgment, and will continue to receive monthly emails until resolution.

Women deducted from Exeter for 'other reasons' with an open SafetyNet episode.

Women deducted with an open SafetyNet episode who have not registered elsewhere are sent letter **WSDE** to try to establish if they are still resident in the area. A prepaid envelope is provided to encourage a response.

3A.380.4 Quality Measures

- All women who move within Wales, have their SafetyNet details transferred if appropriate

3A.380.5 Quality Control\Audit

Monthly email reminders of transfers not acknowledged

3A.380.6 Further Guidance

3A.200 Women deducted from Exeter

3A.390 WOMEN TRANSFERRING INTO THE AREA WITH AN ABNORMAL RESULT

3A.390.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.390.2 Quality Standard

All women transferring into a CSAD area with a cytology screening history whose latest smear is an abnormal 'S' code are managed in line with CSW policy to ensure they receive the correct follow up.

3A.390.3 Method

On a weekly basis the CSAD process routine W6-CINS/REPORT that identifies women who have moved into the area and whose latest test was an abnormal 'S' coded result.

i) WOMEN WHOSE ABNORMAL 'S' CODED TEST WAS WITHIN 3 YEARS OF REGISTRATION

- An enquiry letter is automatically produced for the woman **WMI2**, together with a pro forma **WMIA**. This form should be returned by the woman to inform CSAD of any relevant information she may have regarding any treatment she may have had elsewhere. A pre-paid envelope is enclosed for convenience of reply
- When the pro forma is returned, it is passed to the Regional Programme Coordinator to make a judgment as to whether the woman is referred for colposcopy
- If the Regional Programme Coordinator decides to refer then a manual referral is made using the code **C3**; the following letters are produced:
 - **WMI3** to woman via W6-NB\LETTER\PAT
 - **WSNI** to GP
 - **WSNR** and **WSNH** to Colposcopy
 - **WSNL** and **WSNT** to CSAD
- If the Regional Programme Coordinator after looking at the pro forma and the woman's history decides not to refer the woman; she is sent letter **WMI4**(produced via W6-NB\LETTER\PAT)

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- If the pro forma is not returned within 28 days of production then an automatic referral is generated by SafetyNet using code C4; the following letters/forms are produced:
 - **WMI5 to woman** via W6-NB\LETTER\PAT
 - **WSNI to GP**
 - **WSNR and WSNH to Colposcopy**
 - **WSNL and WSNT to CSAD**

NB: The T/I flag on W7 should move to **R** if a WMI4 letter is printed prior to the 28 day cut off; if not it can be manually set to **R** if required.

ii) WOMEN WHOSE ABNORMAL 'S' CODED TEST WAS MORE THAN 3 YEARS FROM REGISTRATION

These are put on the next appropriate AJ-RG run; however, where the latest test is a Grade 5 or Grade 6 (irrespective of test date) these should be discussed with the Regional Programme Coordinator.

W6-CINS/REPORT

The following information is produced:

- Transfers within the last 3 years
- No response to letter WMI2 within 28 days of production
- All Grade 5 and Grade 6 results; irrespective of the date of test

3A.390.4 Quality Measures

- 100% of women transferring into the area with previous smear suggesting that the woman's colposcopy investigation is incomplete must be individually assessed and directly referred if necessary
- All women sent the **WMI2** letter are directly referred if no reply is received within 28 days of production

3A.390.5 Quality Control\Audit

The SafetyNet system is checked against the weekly W6-CINS\REPORT print to ensure that all women transferring into the area with a previous abnormal 'S' coded smear result are actioned appropriately.

Returned Pro formas

An email is produced on a daily basis when the W6-CINS\REPORT has not been run for 7 days.

3A.390.6 Further Guidance

- 3A.180 Managing incoming cytology data
- 3A.300 Direct referral to Colposcopy

3A.400 TELEPHONE QUERIES FOR SAFETYNET

3A.400.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.400.2 Quality Standard

The SafetyNet system holds detailed information about women in the area who are actively being treated at colposcopy and monitored following discharge from colposcopy. The management of requests for information must not infringe confidentiality but must also make information available where appropriate.

3A.400.3 Method

In the event of a woman requesting information from the SafetyNet – no clinical details should be discussed. CSAD must be confident that they are speaking to the appropriate woman. The call should be verified by the woman confirming her, name, address and dob and GP. If they are enquiring about their appointment, a guideline date may be offered to them. If they require further information, they should contact the colposcopy service to which they have been referred.

Third party callers must be informed that the woman herself should contact CSAD.

In the event of a query from the colposcopy service – the CSAD officer needs to be sure to whom they are speaking before any confidential information is given. The call can be returned using the phone list held at the CSAD.

If there is any doubt about the identity of the caller, the CSAD officer should ring back the enquirer (General Practitioner or Colposcopy service) on the telephone number used for regular contact for this person and not a number that may be supplied by them.

3A.400.4 Quality Measures

- Woman's confidentiality is not breached

3A.400.5 Quality Control/Audit

Audit of information requests

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.400.6 Further Guidance

3A.500 Telephone messages

Safety Net

3A.410 REQUEST FOR SUPPORT TO THE CANISC SYSTEM

3A.410.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.410.2 Quality Standard

All requests for support for the CANISC system are dealt with in accordance with the Service Level Agreement with the suppliers.

3A.410.3 Method

Requests for support on the CANISC system are logged with the CANISC Public Health Wales Servicedesk. Details of the CANISC contact details should be displayed prominently in the CSAD and contain the following details:

- Public Health Wales Service Number: 029 2031 6939 (WHTN 1875 6939)
- Email Address:
 - for new users and changes to user accounts (including password reset): velindre.servicedesk@wales.nhs.uk
 - any other issue HSW Service desk: service.desk@wales.nhs.uk

It is the responsibility of the person logging the request to ensure that they are given a call number for the support log.

Each call is logged in a table with the following details:

- Date reported
- Description of problem
- Call number
- Action Taken
- Date resolved
- Member of staff who made the call
- Response time

The support log is reviewed by Public Health Wales Servicedesk staff daily to monitor response times.

Any requests for development or amendments to CANISC software must be submitted via the Information Analyst at Screening Services (Helen Beer) for monthly discussion with CANISC developers.

3A.410.4 Quality Measures

- 100% of requests for support are reported to the CANISC Servicedesk
- 100% of requests logged are given a call number
- Details of Servicedesk arrangements are displayed prominently in the CSAD

3A.410.5 Quality Control/Audit

Requests for support are dealt with in accordance with the terms of the SLA with the Public Health Wales NHS Trust

3A.410.6 Further Guidance

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Safety Net

CANISC support call log no:

Date & Time Reported: _____

Reported by: _____

Help Desk Contact: _____

Details of Problem: _____

Action Taken_____

Resolved: _____

CSAD Opinion_____

Safety Net

3A.420 REQUEST FOR SUPPORT TO SAFETYNET SYSTEM

3A.420.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.420.2 Quality Standard

All requests for support for the SafetyNet system are dealt with in accordance with the Service Level Agreement with Health Solutions Wales.

3A.420.3 Method

Requests for support on the SafetyNet system are logged with Health Solutions Wales. Details of the Servicedesk arrangements should be displayed prominently in the CSAD.

It is the responsibility of the person logging the request to ensure that the support log is followed up should there be no resolution within 2 working days.

If the support request results in a change to the software, then Health Solutions Wales notify each CSAD (Manager and Deputy) via email of the change.

3A.420.4 Quality Measures

- 100% of requests for support are reported to Health Solutions Wales
- Details of Servicedesk arrangements are displayed prominently
- CSADs are notified of any changes to SafetyNet via email

3A.420.5 Quality Control/Audit

Requests for support are dealt with in accordance with the terms of the SLA with Health Solutions Wales

3A.420.6 Further Guidance

3A.430 Request for Change to the SafetyNet System

Safety Net

3A.430 REQUEST FOR CHANGE TO THE SAFETYNET SYSTEM

3A.430.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.430.2 Quality Standard

To enable SafetyNet to be modified to reflect changes in CSW policy and procedure.

3A.430.3 Method

Requests for change to the SafetyNet system are logged via email with Health Solutions Wales, who will make a decision on whether the change is a:

Software Correction

In this instance the amendment may be resolved with a patch and each CSAD is informed via email.

Minor Amendment

In this instance a judgement may be made by Health Solutions Wales as to whether the request would benefit the functionality of SafetyNet without impinging on current work practice. If Health Solutions Wales believe that the change could impinge on the working of SafetyNet then the Lead CSAD Manager is contacted for advice on whether to carry out the request.

Major Amendment

The Lead CSAD manager is contacted for advice on whether the request should be adopted. The Lead CSAD manager may request advice from members of the Joint Coordinators Group.

Policy

This would only be adopted following approval of a change of policy by both the Joint Coordinator's Group and All Wales Management Group.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

NB: Each change request should be fully documented by Health Solutions Wales. Health Solutions Wales will inform CSW of any financial implications before any work is carried out.

3A.430.4 Quality Measures

- All requests for changes to the system are actioned within the timescale agreed between Health Solutions Wales and CSW

3A.430.5 Quality Control\Audit

Details of the changes are in the Service Level Agreement

3A.430.6 Further Guidance

3A.420 Request for Support to the SafetyNet System

Safety Net

3A.440 PRIVATE WOMEN ON SAFETYNET

3A.440.1 Staff Responsibility

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.440.2 Quality Standard

All women who have had cervical cytology taken privately or are seen as private women in colposcopy are FailSafed appropriately according to CSW procedures.

3A.440.3 Method

Private smear

Women whose 'index' abnormal smear was taken privately are entered on SafetyNet. A note is made to indicate that the smear was taken privately.

A letter is sent to the smear taker if identified, or alternatively the woman's GP is informed that her subsequent follow up is not the responsibility of CSW. If the woman subsequently has an NHS smear she may be included under standard FailSafe procedures. It is the responsibility of the clinician that all relevant information is passed on to the CSAD to ensure that the correct recall repeat interval is identified.

12 months after the 'index' smear, the woman is recalled on Exeter.

NHS smear - private colposcopy

Women who have their 'index' smear taken within the NHS but attend for private colposcopy will be followed up according to CSW SafetyNet procedures.

NHS colposcopy - private treatment

Women who attend an NHS colposcopy service, but subsequently receive private treatment will be followed up according to CSW SafetyNet procedures.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.440.4 Quality Measures

- Women who have their '**index**' smear taken privately are recalled 12 months later on Exeter if no further information has been received
- Women whose referral smear was taken by the NHS are followed up according to standard CSW SafetyNet procedures

3A.440.5 Quality Control/Audit

W6-PIP will identify women whose index smear was taken 12 months earlier.

3A.440.6 Further Guidance

3A.280 Private women and tests reported abroad

3A.500 TELEPHONE MESSAGES

3A.500.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

Regional Programme Coordinators

QA Advisor

Head of Administration

3A.500.2 Quality Standard

All telephone calls taken by CSAD which result in the amendment of a woman's details on the Exeter database are recorded on a telephone message sheet. Amendments can only be made to the CY screen without confirmation in writing for the following reasons:

- Postponement – due to pregnancy (no more than 12 months)
- Postponement – due to illness (no more than 12 months)

Any other reason which may result in an amendment to the CY screen, are not made until confirmation is received in writing from either the source of the telephone message or GP practice.

No amendment to the ID screen is made without written confirmation from the source of the telephone or the GP practice. Comments, complaints and suggestions received about the service are also recorded on telephone message sheets.

3A.500.3 Method

All CSAD staff are trained on induction about the use of the telephone messages file. Individual telephone message sheets are made available to each member of staff to keep on their desks. The information contained on these sheets is at the end of this quality standard.

If approval is needed by the CSAD manager and/or Regional Programme Coordinator for any action taken following the telephone call, the member of staff must ensure that the 'approved by' box is signed before any action is taken.

A telephone message form can be completed for any other reason if a member of staff feels that it would be useful to record details of a telephone call received.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Filing of telephone messages

All telephone messages should be filed in woman name order.

A note should be made on the W6-NB screen if a telephone message was taken if the message results in a change to the CY screen.

3A.500.4 Quality Measures

3A.500.5 Quality Control/Audit

All telephone messages are referred to on W6-NB: screen if the message results in a change to the CY screen.

3A.500.6 Further Guidance

3A.510 Retention and disposal of paper records

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

TELEPHONE CORRESPONDENCE SHEET

DATE OF CALL _____ TAKEN BY _____

CALL FROM/TO (delete as appropriate)

Name _____

Address _____

Contact Number _____

Smear Taker Code _____

CALL TO/FROM (delete as appropriate)

CSAD
Regional Programme Coordinator
Regional Programme Coordinator

Name of Woman _____

Address _____

Date of Birth _____

NHS Number
Nature of Enquiry
Smear Taker Code
Smear Taker Training
Woman Management
ColpSafe Follow-up
Discrepancies
CSW SOPP / ST Guide
Other

Details of Enquiry / Comment / Complaint (delete as appropriate)

Action Taken:

Written confirmation received (if applicable) YES/NO
Query resolved YES/NO

Actioned by _____ Date _____
Approved by _____ Date _____

3A.510 RETENTION AND DISPOSAL OF PAPER RECORDS

3A.510.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD staff

QA Advisor

Head of Administration

3A.510.2 Quality Standard

All paper records are retained securely for the appropriate length of time to satisfy legal requirements and audit whilst minimising storage, for the time periods set out in the Public Health Wales NHS Trust policy document 'Records Management Strategy'.

This applies to all records relating to:

- Financial matters
- Stores equipment and buildings
- Personal health

3A.510.3 Method

i) Retention of records

All staff are informed of the minimum length of time that paper records should be retained by CSW (see Public Health Wales NHS Trust Procedures for the Retention of Records).

Additionally:

* **NB:** indefinitely equates to a retention period of 30 years

Document	Retention period
Prior Notification List	Retain for 6 months from print date unless amended and affect woman's recall when they are retained indefinitely
Report form (HMR form)	12 years
Registration change notification (DOB/ Address/Name)	All notifications retained for one screening round plus current year

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Document	Retention period
Telephone messages	12 years if affects woman's recall
Colposcopy DNAs	Indefinitely
Women correspondence	Indefinitely
Amended non - responder cards	Indefinitely - anything that affects recall. Destroy others after updating records.
CIN listing	Action and destroy, unless woman's recall is affected.
W6-CP	12 months
Women due for recall over 64 (W6-PIP)	Action and destroy
List of tests from laboratory	Indefinitely
AJ-RP District list	12 months
AJ-RG Summary list	12 months
AJ-CD Summary list	12 months
Disclaimer letters	Indefinitely
Integrity checks (all)	Until next run is done
Undelivered returned letters	9 months from date of FP69
Acceptance notification (DF prints)	12 months
Absence of cervix	Indefinitely
Hysterectomy lists	Indefinitely
Histology reports	Indefinitely
Discharge from Colposcopy	Indefinitely
Batch Result Log	Indefinitely
Logged tests	Until resolved and processed on Exeter
Cytology deducted cards	Update and destroy
Other referrals	Indefinitely if alters recall or logged and destroyed as confidential waste
Complaints	Indefinitely
Test lists (retrospective check of tests received from laboratory)	Now produced electronically
Special letters - returned from GP with information on woman	Retain indefinitely
CANISC Lists	12 months
Option 22 - ceased list	12 months
Notification of FP69 removals	12 months

ii) Disposal of records

All paper records containing information on women and/or confidential CSW data is disposed via local confidential waste systems.

3A.510.4 Quality Measures

- 100% of records are kept in line with CSW policy

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3A.510.5 Quality Control/Audit

All staff trained to dispose of confidential waste

Transfer of confidential waste agreement obtained by each CSAD to dispose of confidential material

3A.510.6 Further Guidance

Public Health Wales NHS Trust Records Management Strategy – Black 13
Screening Services’ Information Strategy

3A.520 DEALING WITH INFORMATION REQUESTS AT THE CSAD

3A.520.1 Staff Responsible

Managerial Responsibility

CSAD manager

Operational Staff

CSAD officers

QA Advisor

Head of Administration

3A.520.2 Quality Standard

CSW holds detailed information about women in Wales eligible for and taking part in the screening programme. The management of requests for data must not infringe confidentiality but must also make information available where appropriate.

The Director of the Public Health Division is the 'Caldicott Guardian' for all CSW data.

3A.520.3 Method

All subject access requests (see below) from women must be referred in the first instance to the Screening Services Information Governance lead who will assist and advise.

Requests for information come from a number of groups:

Service users. The women eligible for screening. Individuals have a right to copies of information held about themselves on computer systems and in manual systems. This is known as a subject access request and is covered by the Data protection Act 1998.

Women requesting results from the CSAD department are asked to contact their GP. No results are given over the phone by the CSAD department.

If a woman requests a copy of her last result letter or wants her last test date, the CSAD will print another letter and post it to the woman's address recorded on the Exeter system. If the woman's address is different from the address recorded on the Exeter, the woman is sent a 'CSW change of details proforma', which must be signed and returned by the woman before the copy result letter is issued.

Clinicians. Doctors are normally granted full access to records of women they are treating or currently managing. GPs are given access to data about women in their own practices. However, the CSAD must ensure that any telephone requests for information are verified in the following way:

- If the GP telephones the CSAD, he/she is telephoned back with the information requested. The telephone number used must be from CSAD records, not from the number given by the GP on the telephone

OR

- A written request for information is faxed through to the CSAD on headed paper. Address or fax details should be verified by the CSAD before information is returned to details on the headed paper

Requests for information from laboratories, community clinics, gynaecological clinics and Colposcopy services

If there is any doubt as to the verification of the person phoning the CSAD will phone the person back using the telephone number from a directory rather than the one supplied by the caller.

Other enquiries

These may be students undertaking a recognised course of study or a professional carrying out research. These type of enquires are informed by the CSAD that they should contact the Director of CSW in writing, detailing their request.

The public

All requests for information from the public will be treated as potential Freedom of Information requests. If they can be answered routinely by CSAD staff from published material, this can be done. Otherwise, the request, which must be in writing (including email), should be referred in the first instance to the Information Governance Lead. Written requests must be answered within 20 working days. Exemptions apply in some cases; the Freedom of Information lead can provide advice.

The press

All press enquiries should be directed to CSW Public Relations contact.

Safe Haven faxing

Any written request for information is faxed through to the CSAD on headed paper. Address or fax details must be verified by the CSAD and any response is sent to the details on the headed paper. The CSAD must check if the receiving fax is a 'safe haven' fax machine. If not, the CSAD must:

- Telephone the recipient of the fax
- Ask if they could wait by the fax machine

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- Ask if they could acknowledge receipt
- Use fax cover sheet that states 'Confidential'
- Double check the fax number
- Request report sheet to confirm that transmission is OK

This is the procedure for any fax containing personal identifiable information. A safe haven is a designated area for receiving confidential data about women/ service users and staff under secure conditions and as such will usually have a telephone number and fax machine associated with it.

3A.520.4 Quality Measures

3A.520.5 Quality Control/Audit

Audit of information requests

3A.520.6 Further Guidance

Public Health Wales Data protection and confidentiality Policy – Black 80

Public Health Wales Freedom of Information Policy – Black 102

Public Health Wales NHS Trust Procedure for Handling requests for Information – Black 103

Black 82 – Public Health Wales NHS Trust Information Security Policy

3A.530 DEALING WITH CERVICAL SAMPLE TAKER CODE REQUESTS

3A.530.1 Staff Responsible

Managerial Responsibility

CSAD Manager

Operational Staff

CSAD Staff

QA Advisor

Head of Administration (via Information team)

3A.530.2 Quality Standard

All cervical sample takers in Wales have a unique code issued via the CSW Information team.

The CSW Information team ensure that codes are issued and updated appropriately to ensure accurate recording of data.

3A.530.3 Method

i) Requests for new cervical sample taker codes

Any request for a code, by phone, fax, email, letter or a completed cervical sample taker code request form (A), should be forwarded to the CSW Information Team.

All CSADs have a copy of the blank code request form (A) which is issued by Regional Coordinators during training sessions and practice visits.

A cervical sample taker can begin taking samples without a code until their card arrives from CSW. During training, CSW try to encourage sample takers to register well in advance of beginning to take cervical samples.

CSW will obtain the following details about the cervical sample taker, where possible:

- Title and full name
- Birth date – not essential
- Whether they are a doctor / nurse / accredited or trainee colposcopist;
- Location(s) where they take cervical samples – identifying the main location for correspondence purposes
- The date they last received cervical sampling training and type of training (conventional / LBC and initial / update training)

CSW will log the details on the cervical sample taker database, after checking that the person is not currently registered with another code, one will be allocated. All details for that cervical sample taker will be entered onto the database and a confirmation form (B) produced with the code attached on a small card.

The confirmation form and card are sent by CSW directly to the sample taker to check their registered details and confirm receipt of their code. Sample takers are required to sign and date the completed form and are asked to return it to CSW, who log that the code has been received.

Usually forms are sent via normal post, but if a code is requested urgently, the form can be faxed and a copy of the confirmation form with card attached are still sent via normal post. All codes should only be given to the nominated person at a recognised address.

NOTE: CSW retain copies of all the forms sent and received from cervical sample takers.

A full copy of the database is extracted at least monthly and loaded onto the Exeter system, containing details of code, name and current status of cervical sample taker (ie active or not). A similar extract is uploaded onto the pathology laboratory systems.

CSW always ask GPs and individual cervical sample takers to inform CSW when cervical sample takers no longer require their code or if they've received a second code in error. This code will never be allocated to another cervical sample taker.

ii) Request for a change to cervical sample taker details (via CSW)
All notified changes to cervical sample taker details by phone, fax, email, letter or a completed smear taker code request form (C), are forwarded to the CSW Information Team.

All CSADs have a copy of the new Change of Details form (C).

It is important to know about a change to:

- Name details
- Whether the cervical sample taker has had more up to date training
- If they move from their main location, which is used for all correspondence
- Or if they retire, die or no longer will be taking cervical samples in Wales

Any completed forms received should be returned to the CSW Information Team with the new details, quoting the code.

iii) Forgotten code

These requests can be passed to the CSW Information Team, alternatively CSAD staff can search the Exeter system for the cervical sample taker code.

Obtain the following details about the cervical sample taker, where possible:

- Title and full name
- Birth date – not essential
- Whether they are a doctor / nurse – If colposcopist need to know if trainee or accredited
- Location(s) where they take cervical samples – identifying the main location

If the code is found, confirm that the named person is registered at the main address that they have given. Note that CSW have more addresses logged and cervical sample takers work at multiple locations. If the code is unknown or not found then the CSW Information Team can be contacted. A code can be given over the phone, it is not confidential information.

iv) Request for identification of a code on a report (via CSW)

These requests should be passed to the CSW Information Team who will confirm details on the report before releasing the name of the cervical sample taker.

CSW will always check the location that the caller is ringing from, if the cervical sample taker code that they are requesting identification of, is registered at another address the name will **NOT be given**. CSW will only give out the information to a recognised individual at a recognised location.

v) Requests for information or statistics

All requests for information or statistics from either a pathology laboratory or for a practice, cervical sample sending location or an individual must be made **in writing** and referred to the Regional Programme Coordinator or the Regional Programme Coordinator.

A request should be logged as it arrives at the CSAD, keeping the date received.

The Regional Programme Coordinator or the Regional Programme Coordinator should only release information in writing to a recognised address, if there is a justified reason for the requestor needing the data.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Should any guidance or additional statistics be required, then the CSW Information Team can be contacted.

Any information sent to an individual should be logged as it is sent out from the CSAD. The Regional Programme Coordinator should be informed of all requests.

Contacting the CSW Information Team

In order to maintain anonymity of the codes, only the local CSAD managers, Regional Programme Coordinators should approach the CSW Information Team for identification of a code.

Members of the CSW Information Team will be able to access the database, add details and generate a new ID code for distribution.

The request for a new ID code or change of details can be made by phone, fax, email, letter or CSW form to any member of the Information Team. A code will usually be allocated by card and form, it can only be given over the phone where the CSW Information Team is confident that they are speaking to the nominated person to receive such a code.

Postal address:

Information Department,
Screening Services,
18 Cathedral Road,
Cardiff,
CF11 9LJ

Email: CSW.Info@wales.nhs.uk

Tel: (029) 2078 7812

Fax: (029) 2078 7900

A code will be allocated, with the card attached to the confirmation form, and will be sent to the Sample Taker within 1 working day of CSW receiving the request.

3A.530.4 Quality Measures

- 100% of sample takers in Wales have a unique smear taker number issued by CSW

3A.530.5 Quality Control/Audit

Statistical reports produced by CSW by smear taker

3A.530.6 Further Guidance

3A.540 MANAGING THE ROLE OF THE CERVICAL SCREENING ADMINISTRATIVE DEPARTMENT (CSAD) SCREENING LINK PERSON SUPPORT OFFICER

3A.540.1 Staff responsible

Managerial responsibility

CSAD Manager
Nurse Coordinator

Operational staff

CSAD secretary / CSAD officer

QA advisor

Head of Administration

3A.540.2 Quality Standard

Screening Link Person (SLP) CSAD Support Officer to develop and maintain an effective SLP communication pathway between screening services and other service providers such as:

- GP practice
- Integrated Sexual Health Services
- Hospital setting
- Learning Disability teams
- Other

3A.540.3 Method

i) Maintain accurate SLP records on the:

- SLP Database
- Practice Profile (PP) tracking record
- Group Contact emails

Minimum information to be held includes:

- Name of SLP
- Start date
- Email address (essential)
- Email address on group contacts
- Date of training
- Type of training undertaken
- Name of clinical support (if SLP is an administrative member of staff)
- Details of any previous SLP's

ii) SLP resignation notification

- Record resignation date on SLP Database and on the Practice Profile tracking sheet
- Contact SLP / Practice Manager to enquire who will be taking on the role

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- Inform and discuss with nurse coordinator
- Inform Screening Promotion Officer Secretary
- Remove email address from 'Group Contacts'

iii) Archive details of previous SLP's in Practice Profile (PP)

It is important that we are able to track changes to SLP posts and are aware of who was in post at any one time. This process is to be undertaken solely by the CSAD Support Officer. The following details therefore need to be archived and include:

- Name of the previous SLP
- Date of appointment
- Date of finish
- Name of previous clinical support (if app)
- Old email address

Complete agreed tracking sheet and file in PP

iv) New SLP Appointment

- SLP registration form is completed with date and email address
- Enter details as listed above on the SLP Database and Practice Profile Tracking sheet
- Ensure that details of the previous SLP are archived on the Practice Profile Tracking Sheet before entering details of the new SLP on the SLP Database
- Enter the name of the new SLP on the database in purple to highlight training is required
- Update group email contact list with new email address
- Email Screening Promotion Officer (SPO) secretary of details of new SLP and back fill all the cells relating to that SLP in yellow on the database
- The yellow back fill will be removed by SPO secretary when records have been updated

v) Training for new SLP

SLP's in GP Practice are required to either attend an organised training event or complete SLP Distance Learning Pack. This should be arranged in a timely manner and be completed within a three month period.

Organised Training event

- Arrange a suitable date with Nurse Coordinator (NC) and SPO
- Book venue
- Ensure all training materials are available
- Book refreshments as appropriate
- On completion enter date of training on the Database and PP
- Remove purple highlight from the name on the database
- Issue a certificate of completion available on 'Map Info'

Distance Learning Pack (DLP)

- Instruct SLP's on how to access Distance Learning Pack via the SLP website including the DVD
- Agree with SLP a date of completion
- On return of the Question and Answer booklet inform NC
- If SLP 'Statement of Completion' has not been received by the due date inform NC and contact SLP to discuss
- On completion of the DLP enter date of training on the Database and PP's
- Remove purple highlight from the name on the database
- Issue a certificate of completion available on 'Map Info'

SLP's in areas, other than GP practice, requiring training

- Inform NC of training requirement
- Highlight the name in purple on the database until trained

vi) Problem solving communication pathway default

For the SLP communication pathway to be effective it is imperative that the SLP fulfil their role in accordance to their agreed roles and responsibilities

SLP without or mal functioning email address

- Contact all SLP's without an email address or a mal functioning email address to attempt to rectify the situation
- To record on the SLP Database in the comments box that the SLP has no email address or that address is mal functioning
- Record method of future contact and log the date and name of the person you spoke to

N.B. When circulating information a paper copy needs to be sent to SLP's without or with a mal functioning email address

If doubt exists as to the functioning of the SLP pathway eg

- SLP has not received training
- SLP email has bounced back
- Smear takers not receiving information
- No response to an SLP enquiry

The problem should be resolved as soon as possible but within a 1-2 month time frame and the following carried out:

First Stage

- Alert Nurse Coordinator for guidance
- Contact SLP to problem solve
- Agree further support requirements
- Document in comments box on SLP Database include date and reason
- Highlight practice in green on Database until problem solved

Second Stage

If the problem has not been resolved within two months

- Practice Manager needs to be informed using SLP pathway default letter
- Followed up by telephone correspondence from SLP Support Officer or NC until situation resolved
- Add a notice in the comments section of the Database eg first default letter sent
- When problem resolved green highlight may be removed

vii) Communication with Screening Promotion Officer secretary

It is essential that information regarding SLP management is shared. Information held on the SLP Database is used by other screening services to develop group email contacts list and circulate information.

To ensure information is shared effectively SLP CSAD Support Officer to:

- Email SPO secretary of any SLP changes in GP practice
- Operate colour coding systems as outlined above
- When an audit is being carried out please inform SPO secretary so there is no duplication or over loading of SLP's workload

viii) Circulating information:

- The SLP CSAD Support Officer receives information to be circulated from the 'SLP Communication Lead', which may include information from other screening services
- Instructions on how it is to be circulated i.e. paper copy, email, SLP website, would be included
- All circular information, such as newsletters, circular/general advisory letters, etc., to be addressed to the SLP (details of which are on the SLP database)
- When circulating information to SLP's without or with a mal functioning email address need to send a paper copy
- SLP Support Officer to provide any necessary instructions or a reminder to the SLP, to ensure all registered smear takers, in their practice/area, have an opportunity to see the document as well as considering the needs of non-smear takers
- A read receipt process to be implemented as an audit trail when sending emails
- Important information containing changes to CSW Policies Protocols or Standards must include the circulation of a paper copy
- Prior to sending a paper copy a 'prior notification email' must be sent to the SLP outlining the importance of the information and to advise of what to do if paper information is not received
- Important All Wales circulations may be addressed to other members of the practice or service as well as the SLP, as directed

- The date that information was circulated to SLP's must be logged on the SLP Database Correspondence section. For All Wales circulation the 'SLP Circulation Lead' would save a copy of the information on 'Map Info File' for reference.
- Information sent locally may be saved in a local file
- **If All Wales information was not circulated, for whatever reason, the 'SLP Circulation Lead' must be advised**

ix) Circulating information to non - SLP practices/services

- It is important that practices or services without an SLP are not compromised in any way
- Practices that have not joined the SLP scheme must be easily identified on the SLP Database and an entry '**NON SLP Practice' entered in RED against the practice/services name.**
- Where a practice or service has no SLP appointed a paper copy of all correspondence must be sent and marked for the attention of Head of Practice
- Information relating to regional training events must be circulated to non participating SLP practices

x) SLP Database

- SLP Support Officers have the sole editing permissions of the SLP Database for their area
- The SLP Support Officer is responsible for the upkeep of the database for their area
- Other screening staff have read only facilities with the exception of 'SLP Circulation Lead'
- Information sent to SLP's must be logged on the SLP Correspondence section
- A highlighting system for SLP status is in operation and includes:
 - Yellow back fill of all cells - for newly appointed SLP's
 - Purple - training required
 - Red - Non SLP practice/service
 - Amber - SLP with no email
 - Green - SLP communication pathway default

xi) Web Site and Noticeboard

Editorial responsibility for the SLP Website lies with the Web Development Team.

- Information posted on the 'noticeboard' of the SLP Web Site either reinforces important paper documents already circulated or provides smear takers with information which is helpful.
- The SLP's are advised to check the bulletin section of the Noticeboard on a monthly basis for all Wales or local news.
- The CSAD SLP Support Officer should also check SLP web bulletins on a monthly basis to see what information is being posted

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- For practices that do not have an SLP please print off the memo from the bulletin board and discuss with NC the appropriate format for sending
- For CSW local messages or letters to be posted onto the site please contact 'SLP Circulation Lead' for Cervical Screening i.e Christine Lloyd or Linda Hughes
- SLP Support Officer to check contact details held on the SLP Website on a six monthly basis

xii) Updating Smear Taker details

The upkeep of the 'Practice Smear Taker Register' and the practice Profile:

- Check the names and codes of the smear takers, listed on the Practice Smear Taker Register, against details held on the W8 screen.
- Problem solve any discrepancies and inform CSW IT (Kate Gregory) of any changes
- Ensure any amended versions of the register received are checked, filed and details passed on to IT dept
- File the Practice Smear Taker Register in the Practice Profile
- To carry out periodic requests to SLP's to update Practice Smear Taker Register
- CSAD Support Officers to establish a follow up system to ensure that IT have made the relevant Smear Taker changes

xiii) To Support Monitor and Audit role of the SLP

Development:

- To participate in projects for the development of the 'SLP Communication Pathway', SLP Database, SLP Website as required.

Support:

- To answer queries regarding the role of the SLP
- To keep updated with the SLP and participate in SLP Support Officers meetings and training
- To liaise with the nurse Coordinator over any concerns or feedback received

Monitor:

- Monitor SLP communication pathways
- SLP training completed within a three month period
- Instigate required procedure if pathways are not functioning such as emails being returned unopened
- Review existing systems regularly
- All SLP details up to date
- Maintain good communication with local SPO secretary
- To monitor accuracy of contact details held on the SLP Website at least six monthly

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Audits:

- To be involved in carrying out agreed annual audits e.g.
 - Initial audit – do practice staff know about the role of an SLP and who the SLP is for their practice
 - Annual audit verifying SLP details and email
 - Smear Taker Register audit details verified
- Periodic audits such as:
 - To identify if health professionals are receiving CSW paper/web based information
 - SLP Web Site

3A.540.4 Quality Measures

3A.540.5 Quality Control/Audit

3A.540.6 Further Guidance

3B.10 BATCH SELECTION AND PNL MANAGEMENT

3B.10.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.10.2 Quality Standard

A screening batch is created on the NBSS for each general practice prior to screening. The batch, when created at the CSAD, produces details of all women eligible for a screening invitation for each GP.

For each woman in the batch, including women who have been “ceased”, the following information is recorded:

- Name
- Address
- Age
- Date of birth
- NHS number
- Sex
- Screening status (normal or ceased)
- Last Screening office
- Date of last screening

3B.10.3 Method

At least 6 weeks prior to screening an area BTW provides the CSAD with a list of the relevant GPs together with the dates the women will be invited to attend for screening.

Notification is sent on a paper print to the CSAD and will include the following details:

- Batch number (eg WSE 23944N)
- Type of run ie S (select)
- Selection date
- Screening start and end dates
- Batch title/Screening location/Screening period
- Call/recall interval
- Invitation dates
- GP Group Code
- All address codes

After receiving the information the CSAD:

- Inputs the screening batch information onto their system via the SB screen
- Prints AJ-BCR report
- Completes Part A for the AJ-BCR pro-forma to confirm that:
 - The correct years of birth have been actioned for the batch
 - The correct GP codes have been requested
 - The correct number of women will be recalled
 - The correct dates of screening have been entered

Returns the AJ-BCR pro-forma with BCR print-outs immediately to the relevant screening office. (In 1st instance some CSADs fax the pro-forma for confirmation from BTW before posting it because of distance)

On receipt of the AJ-BCR the BTW office will:

- Check the details are correct for the returned batch
- Verbally confirm with the CSAD that the details are correct
- Sign the pro-forma (SAAP report and pro-forma to be retained for 3 years)

Following verbal confirmation that the pro-forma has been checked by the screening office and at least 4 weeks prior to screening, the CSAD:

- Run the AJ-BCP
- Produces a screening batch list (SBL)
- Electronically transfers the SBL to BTW

If CSAD are in receipt of paper GP definition changes & batch specifications from BTW, the last page should be signed by the CSAD and returned to BTW. It is then filed with the AJ-BCR pro-forma.

CSADs retain batch requests from the breast screening office for 6 months after the end date of screening, as specified on the batch request. This is to allow for any possible overrun at any particular site.

Following electronic receipt of the SBL, the screening office:

- Uses the SBL to investigate any women listed as “exceptions” and registers them as new clients or merges them with existing clients
- Completes the batch
- Sets up clinics and produces appointments

AJ-BCR'S are retained at BTW only.

3B.10.4 Key Quality Control Checks

- BTW produces a screening batch for each GP at least 6 weeks prior to screening an area

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- When the batch has been inputted onto the SB screen a second person in the CSAD must check that all the details on the screen match the printout
- All batch requests are retained by the CSAD for 6 months from the end of screening

3B.10.5 Audit and Reports

Audit of AJ-BCR

Summary report of all information relating to particular screening period

3B.10.6 Further Guidance

BTW Quality Manual 6.60 Identifying Eligible Women

3B.20 AJ-BIN BREAST SCREENING RESULTS

3B.20.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.20.2 Quality Standard

All breast data between CSAD and screening office is accepted or resolved on a weekly basis.

3B.20.3 Method

The AJ-BIN lists all details electronically received at the CSAD from BTW. All rejects and matches are resolved at the CSAD on a weekly basis.

The CSAD run the AJ-BIN 'housekeeping' programme on a weekly basis regardless of whether BTW are screening an area at that particular time.

Prints generated weekly from AJ-BIN include:

i) Update information control reports

CSAD check for any batches that state "awaiting match" and using the BM screen in Home keys the **qualifier 1, WSE, BATCH NUMBER** is entered. This produces a list of women who are a possible match to the woman on top of the screen.

Options include:

- H for 'hit' ie a match
- X for no match

CSAD enter the relevant number which belongs to the match and enters H and enter to complete or X if there is no match. If X is selected the words 'NO MATCH' must be entered into the text box in order to complete.

ii) Update information details

Delete from PQ screen

iii) WF end code exceptions

Delete from PQ screen

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Once a woman is matched, the information is electronically transferred.

The control report is retained until the next one has been printed and checked for failed or rejected transfers.

3B.20.4 Key Quality Control Checks

AJ-BIN programme runs weekly & checked weekly

3B.20.5 Audit and Reports

3B.20.6 Further Guidance

3B.30 AJ-BCO OPEN BREAST SCREENING EPISODES

3B.30.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.30.2 Quality Standards

Women who have been invited for screening but for whom an end code has not been entered on the Exeter system are classified as “open episodes”. All open episodes are identified by CSAD on a monthly basis and resolved by BTW.

3B.30.3 Method

On the first Monday of each month, the CSAD run the AJ-BCO for the previous 12 months. For example, on 1st April 2009, the review date on the AJ-BCO must be set for 31st March 2008. By selecting the AJ-BCO to run up to the 31st March 2008, this gives a 12-month gap from April 2008 to minimise the number of open episodes listed. The majority of open episodes are likely to be closed after 12 months of screening.

The CSAD then send the list to the BTW screening office to check.

If an electronic transfer has not taken place because of a communications failure, the BTW office are not aware of the failure, so a large number of open episodes will be listed.

(BTW send the page listing the batches to HSW for them to check there has been a transmission problem and for them to close any non current episodes).

All episodes require an end code before they are closed. The end codes are:

- SC – screening complete
- DNA – did not attend
- PC – premature closure

The AJ-BCO is filed by the SO until the next run of the AJ-BCO in the following month.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- 3B.30.4 Key Quality Control Checks**
AJ-BCO runs on first Monday of each month

- 3B.30.5 Audit and Reports**
Open episode checks run at BTW

- 3B.30.6 Further Guidance**
BTW Quality Manual

3B.40 AJ-BSH TRANSFER OF SCREENING HISTORY FOR WOMEN MOVING AREAS OR GP'S

3B.40.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.40.2 Quality Standards

When a woman moves into a new Screening Office area her breast screening history must be transferred to the new screening office.

AJ-BSH produces a list, which the CSADs send to BTW on a weekly basis for them to check that every woman has an appointment every 3 years.

3B.40.3 Method

AJ-BSH gives details of women, aged 53-70 newly registered with a general medical practitioner, contracted to the health authority and who have transferred from outside the health authority area.

The pages are laid out for:

- Early recall women
- Women with screening details
- Women without screening details
- Women previously deducted with reason of death

The details provided include:

- Full name
- NHS number
- Name of their GP
- Their date of birth
- New address and postcode
- Previous BSC/PCT
- Date of last screening if known

The above information is provided using the AJ-BSH report at weekly intervals.

3B.40.4 Key Quality Control Checks

Weekly production of AJ-BSH lists

3B.40.5 Audit and Reports

None

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3B.40.6 Further Guidance BTW Quality Manual

3B.60 WOMEN WITH A CEASED RECALL STATUS

3B.60.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.60.2 Quality Standards

Women have a ceased status on the breast screening NBSS system for one of the following reasons:

- Bilateral Mastectomy
- Opted out – the screening office has a signed opt-out letter from the client

(Sometimes Males appear (not realignments). These are not ceased on the NBSS system but the CSAD need to inform registration to alter the man's flag to M.)

All ceasing or reinstatement information is sent electronically to relevant CSADs.

Any request from a GP to the CSAD to cease or revert to normal status a woman from Breast Screening should be referred to the relevant BTW screening office.

3B.60.3 Method

The CSADs annually produce lists on menu AJ-BCSW for the relevant screening office at the beginning of each calendar year requesting only those women with no reason given for ceasing.

3B.60.4 Key Quality Control Checks

- 100% of women are ceased in line with BTW policy

3B.60.5 Audit and Reports

Audit of AJ-BCSW

3B.60.6 Further Guidance

BTW Quality Manual 6.60 Identifying Eligible Women

3B.70 REGISTRATION CHANGES

3B.70.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

Breast Test Wales Screening Officers

QA Advisor

Head of Administration

3B.70.2 Quality Standards

The CSADs send all registration alterations to the relevant screening office on a regular basis to enable all women's records to be updated for address and name changes.

3B.70.3 Method

AJ-PHRC registration changes.

These are electronically transmitted to the relevant screening office on a weekly basis. The CSAD delete the appropriate entry from the PQ screen. The breast screening office then action any exceptions.

3B.70.4 Key Quality Control Checks

- Checks are made when women attend for screening as to why the SO does not have the woman's correct details. CSADs informed by BTW via 'change of details' notification form (*CSADs can only action change of addresses within the GP practice area, names, dates of birth, and only providing the woman has signed the form*)
- The CSADs have their defaults on the SO default screen set from 49 to 99 years of age
- Post office returns are monitored by the BTW screening office

3B.70.5 Audit and Reports

- Audit of AJ-PHRC
- Post office returns

3B.70.6 Further Guidance

BTW Quality Manual

3B.80 WOMEN WHO MOVE INTO THE AREA OR CHANGE GENERAL PRACTICE BETWEEN SCREENING ROUNDS (FAILSAFE BATCHES)

3B.80.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

BTW Screening Staff

QA Advisor

Head of Administration

3B.80.2 Quality Standards

All women aged 50 and over who move into the area covered by a BTW division, or who change GP practice, between screening rounds are identified so that **it can be ensured that they do not have to wait more than 3 years between screening invitations.**

For each woman in the batch, including women who have been “ceased”, the following information is recorded:

- Name
- Address
- Age
- NHS number
- Sex
- Screening status (normal or ceased)

3B.80.3 Method - FailSafe Batches

At least 6 weeks prior to screening a FailSafe batch, the relevant CSADs are sent a run FailSafe pro-forma from the screening office requesting them to produce AJ-BCNS (a list of unscreened women) for the batches corresponding to that area.

This procedure is carried out **6 months after the end of** screening in each screening area.

The screening office specify the birth years of the women to be listed as specified in the original batch selection when the practice was last screened together with recall of 36 months and safety period of 00. Following the checking of the resulting lists for numbers of uninvited women, if there are any women to be screened BTW produce a FailSafe batch specification, which is sent to the CSAD.

After receiving the information the CSAD:

- Inputs the screening batch information onto their system
- Prints AJ-BCR report
- Completes Part A for the AJ-BCR proforma to confirm that
 - The correct years of birth have been actioned for the batch
 - The correct GP codes have been requested
 - The correct number of women will be called or recalled

Returns the AJ-BCR pro-forma and BCR print-outs immediately to the relevant screening office (in the first instance some CSADS fax the proforma for confirmation from SO before posting):

On receipt of the AJ-BCR the BTW office will:

- Check the details are correct for the returned batch
- Verbally confirm with the CSAD that the details are correct
- Sign the pro-forma (SAAP report and pro-forma to be retained for 3 years)

Following verbal confirmation that the pro-forma has been checked by the screening office and at least 4 weeks prior to screening, the CSAD:

- Produces a screening batch list (SBL)
- Transmits SBL electronically to BTW

Invitations are then issued to eligible women who are due for screening, to attend for screening at the static centre or at a convenient mobile site as appropriate. The above procedure is repeated **12 months after the end screening & 12 months before the start of screening** in each mobile site or centre, using the same early default as the original batch but using the older default as used for the **current** year.

In cases where screening in a mobile site takes longer than 6 months, that site is treated as if it were several different sites, each with duration of less than 6 months, for the purposes of following the above procedure. Similarly, for practices screened at the static centres, appropriately sized groups of practices are specified and are treated in the same way as a mobile site.

3B.80.4 Key Quality Control Checks

- All BTW screening sites have FailSafe batches run 6 months after the end of screening and 12 months after the end of screening and 12 months before the start of screening.

3B.80.5 Audit and Reports

- Audit of AJ-BCR

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3B.80.6 Further Guidance

BTW Quality Manual 6.60 Identifying Eligible Women

3B.90 ACKNOWLEDGEMENTS – QUALIFIER

3B.90.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

Breast Screening Office Staff

QA Advisor

Head of Administration

3B.90.2 Quality Standards

CSADs must acknowledge that they have received information from the screening offices.

The transfer screen consists of all transfers received from Breast Test Wales. These are:

- Results
- NBR's (Non Batch Referrals)
- Batch Specifications
- New GP Group

3B.90.3 Method

On receipt of paper transfers from the screening office the CSAD input the details by using the Acknowledgements screen (AK) with a qualifier of R, then the relevant Screening Office identifier. The details include:

- The transfer number
- Date of transfer
- Data type
- The CSAD officer's initials
- The status (C)

The information is found on the front cover of the paper transfer received from Breast Test Wales

3B.90.4 Key Quality Control Checks

Ensure AJ-BIN is run weekly.

3B.90.5 Audit and Reports

None

3B.90.6 Further Guidance

BTW Quality Manual

3B.100 NETWORK CONTROL REPORTS

3B.100.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

Breast Screening Office Staff

QA Advisor

Head of Administration

3B.100.2 Quality Standards

All network control reports are actioned appropriately by CSADs on a daily basis.

3B.100.3 Method

Certain receipt prints on the CSAD database need to be printed off.

The print **CINB: BSS Receive XFERS** is printed via the PQ screen. This list confirms that a woman's screening history has been electronically received.

If it has not the woman's screening details are printed automatically and the CSAD need to check them and enter manually if needed.

3B.100.4 Key Quality Control Checks

None

3B.100.5 Audit and Reports

None

3B.100.6 Further Guidance

None

3B.110 BSCI UPDATING RECORDS INTEGRITY CHECKER

3B.110.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.110.2 Quality Standards

All breast screening records must be consistent with information held in other areas of the Exeter system, eg Screening Office details, screening batch details, women's registration details and BSS system parameters. The AJ-BCSI checks this on a monthly basis.

3B.110.3 Method

AJ-BCSI produces a print detailing the Screening Office/Screening Batch ID/NHS number/File reference associated with an error and the data that has been rejected. The print indicates whether each error can be corrected by the BSC/PCT or should it be reported to the Support Team.

Errors listed by AJ-BCSI are divided into three groups:

- HA corrections – these are errors which BSC/PCT staff can remedy themselves
- Support team corrections – these errors cannot be remedied by BSC/PCT staff. They must be reported to HSW
- Automatic corrections – these errors have been automatically corrected by the System

The System must be set to the following:

Suppress males	YES
Job last run date	
Type or report	
HA corrections	Y (to correct at CSAD)
Support team corrections	Y (to be sent to HSW)
Automatic corrections	N
Enter	Y to proceed

3B.110.4 Key Quality Control Check

AJ-BCSI to be run monthly

3B.110.5 Audit and Reports

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3B.110.6 Further Guidance

None

3B.120 BSUL (UNINVITED WOMEN/EARLY RECALL LIST)

3B.120.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.120.2 Quality Standards

All women on the system, who have not been invited for screening within the last 3 years, are identified via the BSUL analysis job.

3B.120.3 Method

The AJ-BSUL list is printed alphabetically by (surname) and ordered by end code within screening office. Women who have a 'ceased' status appear at the front of the relevant end code section, which shows their ceasing details. The report also shows a woman's Date of Acceptance.

The recall interval displayed on the AJ-BSUL is set to a default value of 36 months, which can be altered by HSW if needed.

An example of the years of birth used on the AJ-BSUL is below:

CURRENT YEAR	YEARS OF BIRTH (to capture 53-64)
2009	1945 - 1956
2010	1946 - 1957
2011	1947 - 1958
2012	1948 - 1959
2013	1949 - 1960
2014	1950 - 1961

NB: BTW offices are now screening up to 70's. CSAD need to contact each Screening Officer Supervisor to establish whether they are at the point where inviting 70 year old has been established for more than 3 years. If this is the case the years of birth will need to be adjusted accordingly (see table below).

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CURRENT YEAR	YEARS OF BIRTH (to capture 53 - 70)
2009	1939 - 1956
2010	1940 - 1957
2011	1941 - 1958
2012	1942 - 1959
2013	1943 - 1960

Every year the age group increases by 1 year each year.

3B.120.4 Key Quality Control Checks

AJ-BSUL is run monthly

Only pages listing women with no episode are printed and sent to the screening office.

3B.120.5 Audit and Reports

None

3B.120.6 Further Guidance

BTW Quality Manual

3B.130 BCX – TRANSFER/PRINT DETAILS

3B.130.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.130.2 Quality Standards

All women who have been deducted from the screening office area are identified via job BCX, which is run on a daily basis and sent weekly to the screening office.

3B.130.3 Method

AJ-BCX prints details of women who have been deducted on the Business Services Centre system. The lists contain the woman's name, address, DOB, NHS number, GP, date of deduction and reason. Since the change in the Exeter system and where there is no longer live and deducted reconciliation it is only death records that appear on this print.

AJ-BCX is run daily by the CSADs and sent weekly to the relevant Screening office to be actioned.

3B.130.4 Key Quality Control Checks

AJ-BCX is printed and sent to the relevant screening offices even when screening is not being carried out for that office.

3B.130.5 Audit and Reports

None

3B.130.6 Further Guidance

None

3B.150 AJ-BSIR BSS INFORMATION REPORTS (LIST OF HIDDEN FLAGS)

3B.150.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.150.2 Quality Standards

All defaults on the system are checked by the breast screening office, on an annual basis, to ensure information is correct.

3B.150.3 Method

Analysis job BSIR is used to identify all the defaults set on the CSAD system to ensure that what is printed is correct.

This is run annually and the print sent to the relevant screening office. The screening office will check each print to ensure that there has been no change and will then query with CSAD any differences.

The print out consists of the following sections:

- General section
- AJ-BCX parameters
- AJ-BSDB parameters
- AJ-BSUL parameters
- AJ-KC63 parameters
- AJ-PHGC parameters
- BSS Audit flags
- First offered appointment date
- HA - SO Transfers - hidden flags
- IS screen parameters
- SB screen parameters
- SE screen parameters
- PHCN parameters
- HA - HA Deductions (sending HA)
- HA - HA Deductions (receiving HA)
- ID Screen end code checks
- Various bin matching values NHS number matches for Date of Birth, Surname, First Forename etc
- SO network Screen parameters for SBL details, SO acknowledgements, SBL results, NBR results etc

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- SO network Screen parameters for Registration Changes, SBL details, acknowledgements, SBL results, NBR Results:
 - AJ – BCSI parameters
 - SO error checks
 - SB error checks
 - Woman error checks
 - BSS System parameters episode checks.

3B.150.4 Key Quality Control Check
AJ-BSIR is run annually

3B.150.5 Audit and Reports
None

3B.150.6 Further Guidance
BTW Quality Manual

3B.160 AJ-BGEN GP PARTNERSHIP DETAILS

3B.160.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.160.2 Quality Standard

AJ-BGEN is run quarterly by the CSAD and sent to the relevant screening offices which could entail one print from each CSAD.

3B.160.3 Method

AJ-BGEN is a printout of all current GP Partnerships within a CSAD. These include single-handed practices, dummy practices and GP's in abeyance and non responsible GP's. An asterisk along side any partnership denotes a change to any details. BTW use these sheets to check any alterations to GP practices, any new practices or GP's. They also use them to check for accuracy of GP names and practice addresses, when preparing the batch specifications.

1. Enter a key of AJ and use BGEN as a qualifier
2. Specify who you want details produced for ie for a specific Screening office or Health Authority; CSADs are advised to use screening office
3. Specify the type of details to be printed, ie P - Partnership or the G - GP details. The screening office have requested the use of partnership
4. Either enter Y in the last field to set up the job for processing via the AJ-Q or enter S to schedule
5. Follow the standard print procedures

3B.160.4 Key Quality Control Checks

AJ-BGEN is run quarterly. It is scheduled automatically and the CSAD will be reminded by an email.

AJ-BGEN is sent to the screening offices as well as the quarterly booklets if they are available.

3B.160.5 Audit and Reports

Audit of AJ-BGEN

Retained at BTW only until the next one has been received and checked at screening office.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

3B.160.6 Further Guidance

BTW Quality Manual 6.62 Identifying & identifying women from responsible and non- responsible GP's within a BSC/PCT.

3B.170 AJ-BSFF FAILSAFE REPORT OF WOMEN WHO ARE ALMOST 53 YEARS OF AGE

3B.170.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.170.2 Quality Standard

All uninvited women who will become 53 years of age in the next 4 months but are not in current screening batches are identified and checked by each screening office to establish how many women are over the age of 53 years before their first screening.

If appropriate an invitation should be sent to them.

3B.170.3 Method

The analysis job may be scheduled to run automatically once a month and will then appear on the PQ screen. However, the job can also be printed manually if requested entering an 'Analysis Job' with a qualifier of BSFF and then entering Y to run the job.

3B.170.4 Key Quality Control Checks

Run this job monthly and the 4 monthly dates will change automatically. Send to Screening Office.

3B.170.5 Audit and Reports

Audit of AJ-BSFF

Checks made by screening office to the numbers included in this printout.

3B.170.6 Further Guidance

BTW Quality Manual 6.60 Identifying Eligible Women

3B.180 ZZZ BATCH SPECIFICATION FOR WOMEN REMOVED FROM GP

3B.180.1 Key Staff

Managerial Responsibility

CSAD Manager

Operational Staff

Breast Screening Officer

QA Advisor

Head of Administration

3B.180.2 Quality Standard

All women who are registered on Exeter but not registered with a GP are identified in a batch using a ZZZ code.

3B.180.3 Method

At the end of each calendar year BTW provides the CSAD with a list of ZZZ codes together with the dates the women will be invited to attend for screening.

Cardiff sends for Bro Taf & Gwent.

Swansea sends for Dyfed Powys & Iechyd Morgannwg.

Llandudno send for North Wales.

Notification is sent on a paper print to the CSAD and will include the following details:

- Clinic number (eg WSE 23944N)
- Type of run ie S (select)
- Selection date
- Screening start and end dates
- Batch title/Screening location/Screening period
- Call/recall interval
- Invitation dates
- GP Group Code
- All address codes

After receiving the information the CSAD:

- Inputs the screening batch information onto their system via the SB screen
- Prints AJ-BCR report
- Completes Part A for the AJ-BCR pro-forma to confirm that:
 - The correct years of birth have been actioned for the batch
 - The correct ZZZ codes have been requested
 - The correct number of women will be sent for

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

- Returns the AJ-BCR pro-forma with the BCR print out immediately to the relevant screening office

On receipt of the AJ-BCR the BTW office:

- Checks the details are correct for the returned batch
- Verbally confirm with the CSAD that the details are correct
- Sign the pro-forma (retained indefinitely)

Following verbal confirmation that the pro-forma has been checked by the screening office the CSAD:

- Produces a screening batch list (SBL)
- Electronically transfers the SBL to BTW

CSAD retain batch requests from the breast screening office for 6 months after the end date of screening, as specified on the specified batch request. This is to allow for any possible overrun at any particular site.

Following electronic receipt of the SBL, the screening office:

- Uses the SBL to investigate any women listed as “exceptions” and registers them as new clients or merges them with existing clients;
- Completes the batch
- Sets up clinics and produces appointments

3B.180.4 Key Quality Control Checks

- BTW produces a screening batch for each CSAD yearly
- All batch requests are retained by the CSAD for 6 months from the end of screening

3B.180.5 Audit and Reports

Audit of AJ-BCR.

Summary report of all information relating to a particular screening period. Retained at BTW only.

BTW should check the WH56 screen on NBSS to ensure all ZZZ codes are picked up.

3B.180.6 Further Guidance

BTW Quality Manual 6.67 Inviting women on Exeter lists but not registered with a GP (ZZZ women).