

5C. COLPOSCOPY

CONTENTS

| | | |
|---------------|---|-----------|
| 5C. | COLPOSCOPY | 1 |
| 5C.10 | STAFFING | 3 |
| 5C.20 | EDUCATION AND TRAINING | 11 |
| 5C.40 | ACCOMMODATION AND FACILITIES | 15 |
| 5C.50 | CLINIC ORGANISATION AND FUNCTION | 18 |
| 5C.60 | MANAGING NON-ATTENDERS, DNAs AND CANCELLATIONS | 23 |
| 5C.70 | HISTORY AND EXAMINATION | 26 |
| 5C.71 | COLPOSCOPY IMAGING | 28 |
| 5C.75 | BIOPSY AND HISTOLOGY | 31 |
| 5C.80 | EXPLAINING THE FINDINGS AND SUBSEQUENT MANAGEMENT | 33 |
| 5C.85 | MANAGING DISCREPANT RESULTS | 35 |
| 5C.90 | INDICATIONS FOR TREATMENT | 36 |
| 5C.100 | USE OF LASER | 43 |
| 5C.110 | USE OF COLD COAGULATION | 46 |
| 5C.115 | USE OF CRYOTHERAPY | 47 |
| 5C.120 | USE OF LLETZ | 48 |
| 5C.130 | CONE BIOPSY | 54 |
| 5C.140 | HYSTERECTOMY, MANCHESTER REPAIR AND CANCER OF THE CERVIX | 55 |
| 5C.145 | MANAGEMENT OF WOMEN FOLLOWING FERTILITY PRESERVING TREATMENT FOR EARLY STAGE CERVICAL CANCER | 56 |
| 5C.150 | GUIDELINES FOR FOLLOW UP AND SURVEILLANCE | 58 |
| 5C.160 | COMMON INFECTIONS | 62 |
| 5C.164 | MANAGEMENT OF THE WOMAN REFERRED WITH POSSIBLE GLANDULAR ABNORMALITIES | 64 |
| 5C.165 | MANAGEMENT OF THE WOMAN REFERRED FOR INADEQUATE CYTOLOGY | 65 |
| 5C.170 | MANAGING THE POST-MENOPAUSAL WOMAN | 66 |
| 5C.180 | MANAGING THE PREGNANT WOMAN | 67 |
| 5C.181 | MANAGING THE IMMUNOSUPPRESSED WOMAN | 69 |
| 5C.190 | INFORMATION AND COMMUNICATION | 71 |
| 5C.195 | MULTIDISCIPLINARY TEAM MEETINGS | 74 |
| 5C.200 | QUALITY MANAGEMENT | 78 |

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

| | | |
|----------------|--|------------|
| 5C.230 | EMERGENCY RESUSCITATION | 81 |
| 5CA.10 | RECEIVING REFERRALS FROM THE CERVICAL SCREENING ADMINISTRATION DEPARTMENT (CSAD) | 82 |
| 5CA.20 | DEALING WITH REFERRAL ALTERATIONS | 84 |
| 5CA.30 | ACTIONING REFERRALS RECEIVED FROM CSAD | 86 |
| 5CA.40 | APPOINTMENTS AND VISIT TYPES | 89 |
| 5CA.50 | PREPARING PAPERWORK FOR A CLINIC | 93 |
| 5CA.60 | DEALING WITH WOMEN ATTENDING THEIR FIRST OR FOLLOW UP APPOINTMENT (NOT TREATMENT) | 95 |
| 5CA.70 | DEALING WITH BIOPSY RESULTS | 98 |
| 5CA.80 | TREATMENT APPOINTMENTS | 99 |
| 5CA.90 | WOMEN WHO DO NOT ATTEND AND CANCELLATIONS | 101 |
| 5CA.100 | DISCHARGING WOMEN FROM COLPOSCOPY | 105 |
| 5CA.110 | CORRESPONDENCE SENT FROM, AND RECEIVED AT, COLPOSCOPY | 107 |
| 5CA.120 | TELEPHONE MESSAGES | 109 |
| 5CA.130 | FILING | 111 |
| 5CA.140 | DATA ENTRY CORRECTIONS AND MERGING OF RECORDS | 112 |
| 5CA.150 | REQUESTS FOR ACCESS TO CANISC | 114 |
| 5CA.160 | UNDELIVERED RETURNED MAIL | 117 |
| 5CA.170 | LOST AND BROKEN SPECIMENS | 118 |
| 5CA.180 | WOMEN MOVING BETWEEN COLPOSCOPY SERVICES | 119 |

5C.10 STAFFING

An appropriate staffing structure is essential to the provision of a high quality service; a team approach to the provision of colposcopy services is, therefore, encouraged. This approach requires that a lead colposcopist and adequately qualified staff of appropriate grade must be appointed for each individual colposcopy service and clinic.

5C.10.1 Professional Groups

Colposcopists:

- Lead colposcopist
- Medical staff
- Nurse colposcopists

Nursing staff:

- Lead nurse
- Qualified staff
- Support grades

Administrative and clerical staff

Other support staff

5C.10.2 Quality Standards

National Service Framework for the Cervical Screening Programme in Wales
British Society for Colposcopy and Cervical Pathology (BSCCP)
The Royal College of Obstetricians and Gynaecologists (RCOG)
NHSCSP Publications
NMC of Practice
GMC Guidelines
Appropriate local standards and guidelines

5C.10.3 Area of Application

Standards apply to All Colposcopy Services and Departments.

5C.10.4 The Lead Colposcopist

Each Colposcopy service has a **designated lead colposcopist** to facilitate the local delivery of colposcopy services and act as a main point of liaison with other elements of CSW.

The precise details of the job description are identified in the service LTA.

The lead colposcopist will not be expected to take direct responsibility for the quality of the work of his/her colposcopist

colleagues, **unless such an accountability arrangement has been agreed with the employing Trust.**

The lead colposcopist need not be the most senior consultant member of staff or the Director of gynaecological services but a BSCCP certificated colposcopist, currently routinely practising colposcopy

A generic job description for the lead colposcopist is described in the BSCCP guidelines

The lead colposcopist:

- Must be a practising colposcopist
 - Must fulfil the practice criteria laid down for all clinical staff
 - Provides a professional lead for all members of staff in the local service
 - Provides the first point of contact for local service management issues
 - Is a member of the CSW Local Management Group (LMG) for the appropriate screening division of CSW
 - May provide local advice and guidance on the implementation and development of the local service

The lead colposcopist must ensure that:

- The requirements of the CSW Colposcopy Quality Manual (including all SOPPs) are adhered to
- Regular audit of the service takes place to compare practice with SOPPs and national standards. The All-Wales Colposcopy Information System (CANISC) will facilitate this requirement (other local audits are not essential but are recommended where service deficiencies are recognised)
- Procedures are in place to facilitate clear and rapid communication with women, other hospital departments
- Primary care agencies, cytopathology and histopathology services
- Regular multidisciplinary meetings are arranged with cytology and histology services for individual case audit and discussion of the introduction of new working methods and technologies
- Effective, accurate and timely data collection is in place to facilitate audit, communication and FailSafe
 - Regular dialogue is established with users and providers of care to ensure that service developments are both appropriate to and meet the needs of the local population
- Relevant data are reported to the LMG

- Adverse occurrences are reported to the Director of CSW
- Liaison is maintained with senior management representatives of CSW
- Every colposcopist (trainee or certificated) has a four digit smear taker code as allocated by the CSW information team
- The information team is informed of any new colposcopist (trainee or certificated) who works in their clinic and of any change in status, or if they leave. The information team will inform the Programme Manager of any changes in personnel
- Is expected to attend Local Management Group Meetings
- Must ensure appropriate attendance of staff at CSW user groups

5C.10.5 Colposcopists

Practising colposcopists are qualified professionals contracted to deliver the clinical aspects of the service.

Colposcopists may be either:

- Medically qualified staff certificated by the BSCCP to practice colposcopy or
- Nurse colposcopists who are trained to perform both diagnostic and therapeutic procedures (or diagnostic procedures only) and are certificated by the BSCCP to practice colposcopy

Clinical staff must register as smear takers with CSW (via the lead colposcopist) and be given a four digit code for use on the HMR 101 form. Similarly with locum staff, colposcopist trainees and trainee nurse colposcopists.

All colposcopists providing a service on behalf of CSW must:

- Be professionally qualified
- Be currently registered with their appropriate professional body as a practitioner
- Be certificated by the BSCCP as a colposcopist
- see at least 50 new abnormal cytology referrals per year
- attend at least one BSCCP recognised colposcopy meeting every 3 years
- Maintain and update their current knowledge
- Participate in an appropriate CPD scheme
- Take part in regular audit procedures
- Participate in regular multidisciplinary team meetings with the cytology and histopathology staff
- Maintain and renew their certification status. (see recertification below)

Recertification

In order to recertify colposcopists must:

- see the requisite number of new abnormal smear presentations during the audit period. The audit period is any 6 month period in the 36 months prior to the recertification date. The requisite number of new presentations is 25 (the overall majority should be women seen with **abnormal cytology**). The recertification date is the date set by the Certification and Training Committee and is the same date for all certificated colposcopists irrespective of how long they might have been certificated
- attend at least one BSCCP-recognised postgraduate meeting in the preceding 3 years. It is essential to keep and be able to present attendance certificates as evidence
- collect and be able to provide the necessary data required to complete a **BSCCP Audit proforma** Data for re-certification for all colposcopists in a clinic is supplied to each colposcopist from CSW annually (and on request or via the data analysis wizard on CANISC)

Locum staff

Where locum staff are employed they **must** be able to demonstrate that they meet the criteria for permanently contracted practising colposcopists. *The lead colposcopist for each unit must take responsibility for the appointment of all locum staff.*

Trainee colposcopists (doctor and nurse) (see 5C.20)

All trainees must first register with the BSCCP as trainee colposcopists. Trainees can undertake colposcopy only under direct supervision, until they have managed 50 cases of which 20 cases must be appropriately referred new cases. When a trainee has completed 50 cases s/he may practice under indirect supervision provided that the trainer is within the clinic but not necessarily in the same room as the trainee. A trainee may apply for certification to the BSCCP when s/he has completed the defined training procedure.

Trainee nurse colposcopists

Certification criteria for nurse colposcopist trainees are defined by the BSCCP. Essentially these are the same as for medically qualified staff, except that 3 days training within the cytology and histopathology laboratories is required rather than the 1 day recommended for medical trainees.

5C.10.6 Nursing Staff

Clinic staffing

The colposcopy unit requires the following staffing

- All clinics must have a named colposcopist with appropriate skills who leads the service, supported by a specialist team specific to the colposcopy unit. The named lead colposcopist must have a job description
- There must be at least two nurses for each clinic in addition to the colposcopist or colposcopists. The primary nurse should be a registered nurse trained in counselling. This should be the named nurse dedicated to the unit, without other concurrent outpatient duties. The second nurse should be for the support of the patient, and need not be a registered nurse. These roles are NHSCSP May 2010 Colposcopy and Programme Management | 23 interchangeable: the second nurse could be the clinic assistant, while the primary nurse could work outside the colposcopy room but remain available where needed for supporting activities
- Nurse colposcopists working in a clinic role must be supported by another registered nurse and a second nurse or clinic attendant (as described above)
- All colposcopists need support staff in the colposcopy room throughout the session
- Clinic staff must be familiar with the treatment method(s) used (100%)
- There must be adequate dedicated clerical support for the clinic.
- Evidence: Having a specialist team specific to the colposcopy unit provides continuity of care and allows women to gain confidence in individual members of staff. This in turn helps reduce their anxiety and improves both attendance and their satisfaction with the service. The extended role of the nurse colposcopist may be of particular benefit here.

Designated nursing staff are essential to support and organise the smooth running of clinical aspects of the service. There must be at least two nurses available to service each clinic one of which must be level one registered nurse.

One nurse, working within the Colposcopy Service will be permanently appointed as the lead colposcopy nurse for the clinic.

The lead colposcopy nurse must be a level one registered nurse, appropriately trained and experienced.

An appropriately trained level one registered nurse must be available to deputise for the lead nurse in case of absence.

When a clinic is serving two separate colposcopists, the ratio of trained nursing staff must be increased accordingly.

Where a Trust runs a colposcopy service on more than one site, as part of an integrated service, it may designate only one level one lead colposcopy nurse for the service, provided that adequate permanent nursing staffing, appropriately trained and experienced, is available at all of the sites served, to maintain staffing ratios and that the lead nurse is available to organise and run the clinic at the alternate site.

If the lead nurse is not available to organise the clinic at the alternate site, there should be a designated senior nurse, level one registered, available to take responsibility for running the clinic.

Lead colposcopy nurse

Each clinic will have a lead nurse to supervise the running of the clinic. This person will be an identified individual 'dedicated' to the colposcopy service and will:

- Be a qualified level one registered nurse
- Be registered with the NMC
- Manage the running of the clinic
- Be responsible for the smooth running of the clinic
- Cascade information to appropriate staff
- Be responsible for ensuring equipment is in good order
- Assist the lead colposcopist in providing an effective service, including dealing with practice updates and organising staff training and development
- Be required to assist in the clinic duties, when necessary
- Provide a contact number for woman enquiries within and outside normal clinic times
- Be competent to provide counselling and appropriate support to women during their colposcopy visit, addressing their concerns and worries
- Undertake and organise nurse lead clinics
- May be required to provide information derived from CANISC

Colposcopy nurse

- Each woman should be assigned a named nurse following registration at the clinic, to provide continuity of care and promote woman confidence
- The colposcopy nurse will accompany and support the woman throughout the colposcopy and treatment procedures
- Counsel women both pre and post colposcopy

5C.10.7 Administration Staff

Clerk/Receptionists

Each clinic should have a dedicated clerk and/or receptionist. This individual will be responsible for ensuring that the clerical needs of the service are met and will liaise with the Cervical Screening Administration Department (CSAD) to ensure that appropriate appointments are made through the direct referral system.

The clerk must:

- Be adequately trained
- Be familiar with CANISC
- Should receive update training as appropriate
- Ensure that woman records are available for the colposcopist
- Ensure that records are returned for filing following consultation processes
- Ensure that all records are kept up to date
- Ensure that results letters and leaflets are prepared for the woman

There must be adequate independent clerical support for the clinic clerk and adequate cross-cover in the event of the absence of the clerk.

Administrative Contact

Each colposcopy service or unit must nominate a named colposcopy service coordinator as the primary administrative contact.

The trust must provide adequate backup and continuity support to cover periods of planned or unforeseen absences.

The named administrative contact must:

- Act as a central point for all the administrative aspects of the service
- Act as the named recipient for colposcopy referrals from CSAD
- Liaise with the Lead Colposcopy Nurse in managing the clinic
- Ensure the smooth running of CANISC and of the Colposcopy Services
- Be familiar with CSW requirements and cascade information to appropriate staff, ensuring all administrative staff are aware of these
- Be trained and proficient in the use of CANISC
- Liaise with the lead colposcopist, CSAD, clinics, General Practitioners, clinical staff and other CSW staff to assist in the

provision of an effective service including dealing with practice updates and organising staff training and development

The clinic coordinator may also be required to:

- Provide secretarial support to the lead colposcopist
- Issue woman and GP letters and provide management information to pathology laboratories and CSADs
- Where appropriate, provide information derived from CANISC
- Ensure that a contact number is maintained for woman enquiries, outside of scheduled clinic times

Colposcopy Services must send a representative to the 6 monthly CANISC Colposcopy User Group meetings.

5C.10.8 Other Support Staff

Other support and ancillary staff will be involved in the process of providing an effective colposcopy service including:

- Porters
- Domestic staff
- Resuscitation and health and safety officers

These staff should be appropriately trained by the host trust.

Their training should take into account any special needs or conditions identified by the colposcopy service.

5C.20 EDUCATION AND TRAINING

The provision of a high quality service depends on the ability of staff to deliver the appropriate level of service. The provision of preliminary and ongoing education and training is vital in ensuring that the level of service is maintained and the team approach to the service is achieved.

The quality of the service depends on the practice of high quality basic and clinical science, the foundation of which is high quality education and training.

It is the duty of the lead colposcopist to ensure that appropriate training is available to all staff.

All staff should attend the mandatory training required by the employing trust, which may include fire lectures and Health and Safety training.

General

All staff must be made aware of contents of this Quality Manual and any future updates.

The lead colposcopist must chair, or designate a chairman for, multidisciplinary meetings between specialities (colposcopy, cytology, histology, and administration) held ideally at least monthly. Both clinical and management/administrative topics are to be covered. All colposcopists must attend and other medical, nursing, laboratory and administrative staff should attend (see 5C.195 Multidisciplinary Team Meetings).

The lead colposcopist must ensure that appropriate staff or representatives attend CSW update sessions. These sessions will cover clinical issues, administration and information technology.

Clinical staff must attend an emergency resuscitation course (CPR) at least once in 5 years.

It is the responsibility of the lead colposcopist to ensure that all new staff, either permanent or locum, are aware of CSW requirements.

Colposcopists

All practicing colposcopists must comply with current BS CCP requirements (see section **5C.10.5 Colposcopists**)

Trainee Colposcopists

All trainees (doctor or nurse) must register with the BSCCP as trainee colposcopists. A BSCCP approved training course must be undertaken. BSCCP/RCOG training requirements are:

All Trainees

- Must be registered with the BSCCP as a trainee
- Must follow the recommended BSCCP/RCOG training programme
- Must see a minimum of 150 cases
- The first 50 cases of which must be **supervised**, of which at least 20 must be new cases (of which 10 must be high-grade disease)
- Can only then proceed to indirectly supervised cases at the discretion of the trainer
- Must see at least 100 further cases under indirect supervision, of which 30 must be new cases, (of which 15 must be high-grade disease)
- Complete the Colposcopy log book (the electronic colposcopy log book if registering for training after 1st January 2009)
- Must undertake histopathological and cytopathological sessions (1 session of 5 hours in each laboratory for Doctors, and 3 sessions of 5 hours in each laboratory for Nurses)
- Must understand the principles of audit

The method of final assessment of colposcopy training is by Objective Structured Clinical Examination (OSCE):

- Trainees will sit this examination on completion of their training programme. The trainee will have completed their logbook of their 150 cases, attended pathology and cytology sessions and had their training signed off by their trainer

Prerequisites for sitting the OSCE are:

- Registration for training with the BSCCP
- Submission of training logbook of supervised and indirectly supervised cases (**please note:** no cases that have not been undertaken within the last 5 years will be acceptable)
- Submission of a certificate of attendance at a BSCCP recognised colposcopy training course (within the last 5 years)
- Submission of form BSCCP/AC/3 registering 'satisfactory completion of training' signed by trainee and trainer
- Completion of an **application form** to sit the OSCE with the examination fee

A trainee may change trainers during the training period, if necessary as part of a career move, but must inform the BSCCP of the new trainer's name and the new location. The trainee must also inform the original trainer of the changes arranged.

If a trainee is supervised by more than one individual the other person must be a registered trainer.

The trainee should complete training as soon as is practically possible. There is no limit, within reason, to the length of the training period. However, an appropriate training period should be agreed in advance with the trainee and trainer.

Trainee Nurse Colposcopists

Trainee nurse colposcopists follow the same basic training procedures recommended for medical staff.

The BSCCP recognises that a variation in the content of the basic training course is necessary for nurse colposcopists. This relates to the knowledge of histology and cytology required. The number of directly and indirectly supervised cases is unchanged.

Colposcopy Trainers

All trainers must:

- Be a BSCCP Registered Colposcopist
- Be on the BSCCP Register of Trainers
- Directly and indirectly supervise trainee cases
- Attend a Train the Trainer Course every 3 years
- A list of trainers and status will be held by the Screening Information Team
- Practice in a unit that is suitable to provide training
- Attend multidisciplinary meetings (see 5C.195)

Lead Trainer

Each unit should identify a Lead Trainer. The main role of the Lead Trainer is to co-ordinate the training process and to take responsibility for all training needs.

Nursing Staff

All nursing staff must:

- Be trained in the use of all equipment used in the Colposcopy Service
- Be trained in the use of CANISC/CSW digital imaging, as appropriate
- Attend multidisciplinary meetings (see 5C.195)
- Participate in relevant update courses

Administrative and Clerical Staff

All administrative and clerical staff must:

- Be fully trained in the use of CANISC
- Receive appropriate training in the use of appropriate software
- Be trained to use local management systems and procedures

Training Unit

To be recognised by CSW as a training unit the department must meet the following criteria:

- Use trainers recognised by BSCCP
- Be fully equipped, with access to at least one of following:
 - Teaching arm
 - Monitor attached to camera
 - Video or digital imaging system
- Ensure that all equipment is regularly maintained
- Routinely undertake at least one outpatient treatment modality, of which one must be LLETZ and a suitable ablative technique
- Actively monitor and appropriately act on CSW performance profiles provided by the Screening Information Team
- Should operate within established CSW operating policies and procedures

Personal Audit and Re-Certification

Registered colposcopists will be expected to gain re-certification every 3 years.

For individual colposcopists to remain on the register, the BSCCP requires:

- A period of personal audit to be completed and documented
- Evidence of attendance at a BSCCP approved colposcopy meeting

The Screening Information Team will provide the necessary audit data for individual colposcopists. Individual data cannot be derived from a departmental audit.

A colposcopist can approach the CSW information team for additional audit data, but queries will need to be run on a priority basis with the CSIP data reports taking precedence.

5C.40 ACCOMMODATION AND FACILITIES

5C.40.1 Area of Application

All colposcopy services and departments.

5C.40.2 Policy and Procedure

Colposcopy must be offered in a purpose designed environment which complies with BSCCP recommendations and CSW requirements.

Clinics which do not meet the minimum standards must plan changes to meet the standards within a reasonable timescale which must be agreed with CSW.

5C.40.3 Clinic Environment

The colposcopy area should:

- Provide a relaxing environment
- Be sympathetically decorated

Include a dedicated private area for the women:

- Women should not be expected to sit or wait in a public area once prepared for colposcopy
- Women should not be expected to pass through a public area once prepared for colposcopy:
 - Include private toilet and changing facilities
 - The toilet should be accessible to the women immediately before colposcopy is commenced
 - Provide a waiting area for relatives or friends accompanying the women
 - Include a suitable separate area for privately counselling women
 - Have direct access to a recovery area equipped with a suitable couch or bed, or immediate access to in-patient facilities
 - Have direct and immediate access to resuscitation equipment
 - Ensure that access to emergency transfusion facilities is available where treatment is undertaken

The host Trust must maintain facilities to agreed acceptable standards and effect necessary repairs or upgrades within a reasonable time scale.

5C.40.4 Furniture and Equipment

All equipment must be in good working order, be regularly maintained, and must not provide a hazard.

The Colposcopy Service must be equipped with:

- A suitable adjustable examination couch
- Suitable desks and chairs
- A suitable colposcope
- Appropriate sterilising facilities in accordance with local and national health and safety recommendations
- CSW approved imaging equipment
- LLETZ equipment
- Equipment for the delivery of analgesia, including provision for adequate pain control and local analgesia
- Adequate smoke extraction equipment
- Television monitoring facilities for women who wish to watch the procedure are desirable

In units offering a diagnostic service there must be automatic referral to a unit where treatment is available if required.

Alternative treatment modalities may also be available, including:

- Laser
- Cold coagulation
- LLETZ
- Cryotherapy

The host Trust must maintain colposcopy equipment to agreed acceptable standards and effect necessary maintenance and repairs within a reasonable time scale.

Maintenance must be to the manufacturers recommended standards and all maintenance must be recorded.

The local medical physics department (or supplier of the service contract) should inspect and approve all relevant equipment as suitable for use. Routine inspection data must be recorded and available for inspection.

5C 40.5 Visitors to clinic

Visitors to the unit should be limited as follows:

- Women should be able to have a friend or relative present if they wish
- The woman's permission should be sought prior to colposcopy if

- any additional staff non-essential for the purposes of performing colposcopy are present (ie trainees, undergraduates, visitors)

5C 40.6 Information Systems

The Cancer Network Information System Cymru (CANISC) must be available wherever colposcopy is practised. In addition the CSW digital imaging system must be available where colposcopy is performed. The minimum requirements are:

- An administration/reception terminal
- A terminal with imaging in every colposcopy examination room
- A nurse station terminal (if appropriate)
- All necessary ancillary equipment

5C.50 CLINIC ORGANISATION AND FUNCTION

5C.50.1 Professional Groups

Colposcopists
Nursing staff
Administrative and clerical staff
Other support staff

5C.50.2 Quality Standards

British Society for Colposcopy and Cervical Pathology (BSCCP)
The Royal College of Obstetricians and Gynaecologists (RCOG)
NHSCSP Publications.

5C.50.3 Area of Application

All Colposcopy Services and Departments.

5C.50.4 Referral Categories

Referrals may be categorised as CSW or non CSW.
CSW categorises referrals as immediate, urgent or routine.
Non CSW referrals should be seen by the lead colposcopist to assess their appropriateness for colposcopic examination and to determine their urgency.

Immediate Referral

An appointment should be offered within 2 weeks of receipt of referral by the colposcopy service in the following cases:

- Where invasion is suspected on a cervical smear
- Where abnormal glandular cells have been reported on a cervical smear
- Where invasion is clinically suspected by the referring practitioner

Urgent Referral

An appointment should be offered within 4 weeks of receipt of referral by the colposcopy service in the following cases:

- Where moderate or severe dyskaryosis is reported on a cervical smear
- Where borderline high grade dyskaryosis is reported on a cervical smear
- Where borderline endometrial cells are reported on a cervical smear
- Where high grade dyskaryosis cannot be cytologically excluded on a cervical smear

Routine Referral

An appointment should be offered within 8 weeks of receipt of referral by the colposcopy service in the following cases:

- Where low grade dyskaryosis is reported on a cervical smear
- For women with persistent cytologically inadequate smears

5C.50.5 Appointment Types

All women have an intended and actual visit type. It is essential that both types are appropriately reported on CANISC. The appointment types are as follows:

Colposcopic Assessment

Follows a new referral to the colposcopy service for a colposcopic examination with or without a punch biopsy/smear

Select and Treat

Where treatment is undertaken at the colposcopic assessment visit, see section below:

Planned Treatment

Follows a previous colposcopic assessment where the results have indicated that treatment is necessary. The intention is to treat at this visit. Treatment needs to be appropriate to the extent and grade of disease present and may be performed either under local or general anaesthetic. Types include:

- Cryotherapy
- Cold coagulation
- Laser
- LLETZ
- LLETZ + Laser
- LLETZ
- Knife cone biopsy

Non Treatment Colposcopic Follow Up

Follows a previous colposcopic assessment where results have indicated treatment is not necessary. This comprises colposcopic examination with or without biopsy/smear and is appropriate for:

- Review of untreated CIN1
- Current pregnancy
- cases not requiring immediate treatment at the discretion of the colposcopist/MDT

Post Treatment Colposcopic Follow up

Follows a previous treatment episode. This comprises colposcopic examination with or without a biopsy but including a smear. This includes all colposcopic follow up examinations within a treatment episode, and is appropriate for:

- Follow up of incompletely excised CIN2/3 or where margin status is unclear or unspecified
- Follow up of CGIN

- Follow up CIN2/3 treated by ablation

Smear Only

Any visit within the colposcopy setting where a smear is taken without a colposcopic examination. A genital swab may be taken at this time.

Swab Only

Any visit within the colposcopy setting where a swab is taken without a colposcopic examination.

Consultation only

Any visit within the colposcopy setting where no examination is undertaken. The woman may be invited to discuss her results or condition.

Post Colposcopy Complication

Any communication regarding a complication following a colposcopic episode.

5C.50.6 Procedures

Colposcopy Service times should be clearly detailed in local guideline documents.

First visit appointments will be made by the clinic clerk on receipt of a direct referral letter or fax from a CSAD following the established guidelines for abnormal cytology results or persistent inadequate cervical cytology.

Appointments may also be made in response to a referral from a General Practitioner, gynaecologist or other practitioner on clinical grounds.

Women are referred according to CSW policy or if cancer is clinically suspected (see Core Reference Section 2R).

First visits and treatment visits both take longer than follow-up and review appointments; adequate time must be allocated for these visits.

If women are to be seen on a select and treat basis extra time should be made for their appointment.

Women may be offered a deferred treatment appointment at a later date dependent on individual circumstances.

Women needing pre-visit treatment (such as oestrogen or antibiotics) should be informed in writing and the colposcopy deferred appropriately.

Some women may require or choose treatment as an inpatient with the use of a general anaesthetic (eg for cone biopsy or woman anxiety) (see 5C.90).

Select and Treat

Colposcopists may consider a select and treat policy at a first visit for women who present with a high grade lesion suitable for out-patient excisional treatment. If it is possible that the woman will be offered her treatment at the first appointment, she should be forewarned and adequately counselled. For treatment at the first visit to be appropriate:

- The referral cytology must be high grade (however, low grade referrals may occasionally be appropriate if the colposcopic appearance of the lesion appears to be high grade)
- Colposcopic impression must indicate a high grade lesion
- There should be no vaginal extension
- The woman must be fully informed about the procedure and appropriately counselled
- The woman must have confirmed her consent to the select and treat procedure at that visit, prior to commencing treatment
- All tissue must be submitted for histological examination
- The woman should if possible be accompanied and should not expect to drive following treatment
- The woman should be advised not to return to work for the remainder of that day following treatment
- Women declining treatment at initial colposcopy will be offered treatment at the earliest available date
- If women are to be seen on a select and treat basis, extra time should be allowed for the appointment

5C.50.7 Quality Control/Audit

The colposcopist should accurately predict a high grade lesion or worse in at least 65% of cases.

The histological diagnosis for select and treat women should confirm the cytological and colposcopic impression of high grade disease (see standard core section).

If the diagnosis is not histologically confirmed (see 5C.85) should be followed.

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

Clinics undertaking treatment at the first visit (select and treat) must audit the proportion of cases with CIN (see standard core section).

Histological diagnosis must be established prior to ablative treatment for abnormal cytology

5C.60 MANAGING NON-ATTENDERS, DNAs AND CANCELLATIONS

Default is considered a major problem within the screening programme. **The defaulting woman is considered to be a high risk woman within the screened population.**

Action must always be documented for all non-attenders. Every effort should be made to find out why a woman has defaulted and, where possible, another appointment should be offered that is appropriate for the woman.

All defaulting women will be offered a further appointment.

The notes of all defaulting women will be referred to and reviewed by the appropriate colposcopist.

5C.60.1 Key Action Points

A letter will be sent to the defaulting woman:

- If first non attendance woman reappointed
- If second consecutive non attendance no further appointment will be sent unless requested
- The CSAD is informed and the woman entered into ColpSafe

The woman's General Practitioner will be routinely notified of the woman's second consecutive non-attendance.

The referral source (if not the general practitioner) should be notified of the default.

The CSAD must be informed of the non-attendance and notified of the new appointment.

5C.60.2 Safety Net

The 'Safety Net' system, installed at the CSAD is designed to track the history of a woman referred for colposcopy as a result of abnormal cytology and ensure that no women will be lost to the treatment and follow-up process.

CSADs and laboratories also operate a separate FailSafe system to track women defaulting cytology. The greatest risk for the defaulting woman is the danger of the screening service losing contact with the individual.

The CSW FailSafe scheme is a dual-system based on the independent data bases of both the CSAD Exeter system and the laboratory information system.

5C.60.3 Cancelled Appointments

A cancellation can be initiated by either the woman or clinic, either at the time of, or prior to the clinic. The reason for the cancellation should be recorded by the clinic:

- If the woman cancels her appointment **up to 1 day before or on the day of the appointment**, this will not result in her being entered onto ColpSafe
- The woman should be offered an immediate re-appointment
- If the clinic is cancelled by the hospital attendance status must not be entered as DNA but entered as hospital cancelled appointment. The woman is reappointed

5C.60.4 Defaulted Appointment:

Woman did not attend (DNA)

A defaulted appointment (DNA) is defined as:

- No advance warning
- No reason for non-attendance

This is also the appropriate terminology when the woman rings on any day **following** her appointment. All information regarding default must be added to the CANISC.

All defaulting woman records must be reviewed by the colposcopist before action is taken. The colposcopist will assess the woman's condition and recommend further action/appointment. The action taken will depend upon:

- The type of visit
- Whether the woman has previously been a non-attender
- The woman's cytological and clinical history

The action taken is documented on the woman's CANISC records.

Where an individual woman's history or results confirm or suggest invasion or give cause for concern, direct intervention may be required by telephoning the General Practitioner and initiating CSW ColpSafe.

5C.60.5 Action for Defaulters

- Assessment
- All treatment
- Colposcopic follow up

When a woman defaults her first appointment:

1st non-attendance - Reappoint

- A letter is sent to the defaulting woman, including her new appointment date
- All information regarding her default must be added to CANISC

2nd consecutive non-attendance - do not reappoint:

- Discharge woman on CANISC to CSAD with recommendation for ColpSafe inclusion
- The woman is notified in writing of discharge from clinic
- The General Practitioner is notified in writing of discharge from clinic
- All information regarding her default must be added to CANISC
- The woman is entered into the ColpSafe scheme

5C.60.6 Action for Defaulters - Consultation Appointment

- Treatment follow up or discharge from the colposcopy service is planned as if the woman had the results or discussion appointment
- The woman and her General Practitioner are informed in writing of the results and proposed management plan
- All information must be added to CANISC

5C.60.7 Action for Defaulters – Smear Only Appointments

When a woman defaults her smear appointment the colposcopist will check her records to ensure she does not need any further colposcopic examination, the woman is then discharged to the care of her General Practitioner for follow up **cytology**:

- Letter is sent to the defaulting woman advising of action
- Letter sent to General Practitioner
- Information is added to CANISC

If the colposcopist considers it appropriate for her to remain within the colposcopy service she should be managed as 5C.60.5.

5C.60.8 Women who have smears in the community who have not been discharged from colposcopy

- CSAD informs colposcopy service of result
- Colposcopist to advise on further action

5C.60.9 Audit

A high default rate will undermine the success of the screening programme. A record of all defaults will be maintained and audited regularly by CSW and notified to the service.

The lead colposcopist should investigate high default levels to identify and address any problems detected.

If the default rate is high alternative practices may need to be implemented.

5C.70 HISTORY AND EXAMINATION

The woman's permission must be sought prior to consultation if any additional staff not essential for the purposes of performing colposcopy or treatment are present (ie trainees, undergraduates, visitors).

A maximum of one trainee, observer or visitor may be present in addition to the staff necessary for the running of the clinic.

A woman's partner, relative or a friend is welcome to accompany her during the colposcopy consultation and treatment.

5C.70.1 Consent

Information must be made available to all women prior to assessment at colposcopy. Verbal consent must be obtained prior to examination following confirmation that the woman has been adequately informed and understands the process. This must be recorded on CANISC.

For inpatient treatment written informed consent must be obtained and appropriately recorded.

For women who are unable to consent please follow procedure documented in the reference section.

Health professionals must apply the principles set out in the Mental Capacity Act 2005 and the Mental Capacity Act 2005 Code of Practice (see WHC 2008 036).

5C.70.2 History

The colposcopist's first task is to put the woman at her ease. The colposcopist must:

- Explain the reason why the woman has been asked to come to colposcopy and what is going to happen
- Explain the meaning of an abnormal cervical sample (if relevant)
- A relevant history is established including:
 - Cytological history
 - Symptoms of postcoital, post menopausal or irregular menstrual bleeding
 - Vaginal discharge
 - Previous cervical surgery
 - Whether the woman smokes
 - Relevant medical conditions and allergies
 - Medication

- The woman's sexual history should not be asked routinely in the Colposcopy Service unless relevant
- If additional tests are considered to be necessary (see below), their purpose and consequences must be fully explained to the woman

5C.70.3 Examination

During examination the colposcopist must explain the process before each step, performing the examination slowly and gently to minimise any discomfort.

If there is a recent history or clinical evidence of infection, appropriate swabs may be taken at the colposcopist's discretion. Adjunct testing does not form part of the cervical screening programme and subsequent management is the responsibility of the individual clinician.

Cytology at the first appointment is not required unless the woman is due for a repeat cervical sample under standard call and recall requirements, or there has been a significant delay from the previous sample.

At least 6 weeks must be allowed to elapse after the referring (index) cytology has been taken if cytology is repeated at colposcopy.

An image of the cervix should be recorded onto CANISC (see 5C.71 Colposcopy Imaging).

5C.70.4 Records

The following features must be noted:

- Whether the squamo-columnar junction (SCJ) was seen
- The position of the SCJ (in the canal, on the ectocervix etc)
- The presence of diagnostic features, detailed in the recorded image of the colposcopic examination (see 5C.71 Colposcopy Imaging). Alternatively a simple diagram should include:
 - Site and approximate size of the lesion
 - Additional features such as the presence of punctuation, mosaic and abnormal vasculature
 - The opinion of the colposcopist
 - Action and/or interventions
 - The management plan

The colposcopist must ensure that all forms are correctly and fully completed and samples properly identified (particularly histopathology requests and samples and cytology requests and samples).

5C.71 COLPOSCOPY IMAGING

A visual record in the form of a digital image of the condition of the cervix at colposcopic examination is considered best practice by Cervical Screening Wales (CSW). Such images may be used to assist in clinical management and MDT reviews. Colposcopy images are stored on CANISC.

Stored images may also be used for quality assurance, teaching, audit, research and publication. Images used in these supplementary procedures must be anonymised or pseudonymised as appropriate.

It is possible that 'hard copies' of selected images will be produced and retained. In some cases a photographic print may be required for clinical management. This may be stored with the woman's medical record (notes) or used in correspondence relating to the case.

5C.71.1 Consent for Imaging

Consent for imaging is covered by Trust policies in all acute Trusts in Wales, based on the Welsh Assembly Government guidance of 2002 (WHC (02) 42). This implementation guidance makes clear that both consent forms and consent policy should be recognisable across the NHS and that the text included in it should not be amended or removed.

The guidance requires that:

- Consent for imaging must be recorded on the appropriate section of CANISC
- The guidance also applies if images are used for education and research as long as all images are anonymised and that this policy is well publicised
- If images are intended for use for publication then express (written) consent for such a purpose must be obtained

5C.71.2 Consent Procedure

The CSW information leaflet (Your Colposcopy Appointment) advises women that imaging is a useful part of colposcopic assessment. The leaflet must be made available to all women before their colposcopy.

The colposcopist should check that the woman has understood the information relating to the use of imaging equipment during the procedure.

Verbal consent to store images (digital and/or printed) taken during the woman's colposcopic examination, as a part of her medical record, must be obtained. This consent will include the use of images in supplementary procedures (see Consent for Imaging).

Consent for imaging must be recorded on the imaging system, separately to the consent required for colposcopy. This will enable images to be recorded and transferred to CANISC where a record of the type of consent will be held.

Written consent must be obtained for publication of images. The consent must be retained in the woman's records and recorded on the system.

5C.71.3 Imaging Procedure

Ideally an image should be taken on each patient referred for colposcopic assessment. Images at subsequent appointments are taken at the colposcopists discretion.

Colposcopists are advised that they should print and file a hard copy image on patient's notes.

At least one image must be taken after application of acetic acid and prior to biopsy. The image of the cervix should be recorded and later uploaded onto CANISC. If colposcopist is unable to record an image this should be noted in CANISC.

Where possible the squamo-columnar junction should be identified on at least one image.

Further imaging of any vaginal extension, isolated vaginal abnormalities or endocervical extension of CIN/CGIN or carcinoma is recommended.

5C.71.4 Records

The method of recording images is shown in the Colposcopy Imaging Guide section of the CANISC User Manual.

Any punch biopsy sites should ideally be marked.

If the extent of a lesion is unclear on the image then the apparent extent according to the colposcopist's examination can be marked with a graphic tool. If the graphic tool is not used the extent of any lesion and the location(s) of any biopsies should be marked on a printed image or line diagram in the case record.

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 saved images become part of the woman's record. Faulty and duplicate images should not be saved.

5C.71.5 References

Publication Of Guidance About Consent For Examination Or Treatment For The NHS In Wales: WHC (02) 42

5C.75 BIOPSY AND HISTOLOGY

All women who have high grade cervical cytology (moderate or severe dyskaryosis or worse) should have biopsy material submitted for histological interpretation. Pregnancy is usually considered an exception.

All women who have had two or more borderline or mildly dyskaryotic, cervical samples and have a recognisable atypical transformation zone should have biopsy material submitted for histological interpretation. Pregnancy is an exception.

If punch biopsies are taken, 2 or 3 biopsies should be taken from an abnormal transformation zone, if possible.

Colposcopic biopsy may be a procedure from which bacteraemia may occur for susceptible individuals. Antibiotic prophylaxis may be appropriate for susceptible individuals if colposcopic punch biopsy or LLETZ is planned.

Women who are pregnant should not routinely be biopsied. If invasion is suspected these should be referred to the lead colposcopist and/or oncologist for subsequent assessment.

HPV change on biopsy without CIN in the absence of preceding high grade dyskaryosis is managed as borderline cytological changes requiring cytological surveillance. The woman may be discharged from colposcopy if follow up cytology is negative and no residual colposcopic abnormality remains. Further management is determined according to any accompanying cytological abnormality.

Women referred for colposcopic assessment due to persistent inadequate cytology or those who do not have an area of recognisable abnormality may not necessarily require a biopsy to be taken.

All women referred with abnormal cytology must have a histological diagnosis established prior to local destructive treatment.

All biopsy material must be submitted for histological interpretation:

- If more than one biopsy is taken from a single area of abnormality, these may be placed in one specimen container and noted on CANISC as one sample

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 multiple biopsies are taken from separately identified areas these must be placed in separate containers, labelled appropriately and noted on CANISC as multiple samples
- Where the biopsy is reported as inadequate it is the responsibility of the clinician to review the notes and determine further management

Liaison between the clinic and the histology/cytology departments will facilitate quality control and audit in colposcopy.

5C.80 EXPLAINING THE FINDINGS AND SUBSEQUENT MANAGEMENT

Following the visit, the colposcopist should explain the findings to the woman in a clear and uncomplicated manner. The use of drawings on the colposcopy sheet may assist in the process.

The colposcopist should include an explanation of all relevant terms (eg CIN, biopsy, LLETZ etc.).

If invasion is unlikely, then this must be clearly stated to reassure the woman and reduce anxiety.

5C.80.1 Explanation of Clinic Visit

Before the woman leaves the clinic she must be given the opportunity to discuss the visit and informed of:

- The procedure(s) undertaken
- Any side effects associated with the procedure(s)
- Who to contact about complications and concerns following the visit
- How and when she will receive results
- Preliminary indication of further management

This must be supported by the provision of appropriate written information.

5C.80.2 Communication of Management Plan

The outcome of the clinic visit and management plan should be communicated to the woman, the referral source and her General Practitioner as soon as possible:

- At least 90% of women should be informed of their results within 4 weeks of attendance at clinic
- 100% of women should be informed of their results within 8 weeks

When results of investigations (eg cytology, biopsies and swabs) are available correspondence is sent to:

- The woman
- The CSAD
- The General Practitioner
- Other referring clinician if appropriate

The lead colposcopist and the consultant responsible for the care of the woman should be informed as soon as possible if early invasive or invasive carcinoma is suspected after colposcopy or is diagnosed histologically.

The regional gynaecological oncologist *or* cancer lead must be informed to decide definitive management.

5C.80.3 Colposcopy Data

The woman's history, examination findings and results are recorded on CANISC and hard copies are placed in the woman's case notes.

If no tests are taken then appropriate correspondence can be sent as soon as possible.

For more detailed information see 5CA.

5C.85 MANAGING DISCREPANT RESULTS

5C.85.1 No Abnormality Confirmed

Where there is lack of correlation between the outcome of colposcopy and cytology for a woman who has a **high grade cytologic abnormality** identified in her referral or colposcopy cytology, but no obvious abnormality on colposcopic examination and/ or a negative biopsy, the colposcopist must reconcile the inconsistency **prior** to discharge from the colposcopy service.

In these circumstances it is essential that the colposcopist reviews the findings in relation to the woman's past history.

If the colposcopist is in a training position the records must be reviewed by a certificated colposcopist.

5C.85.2 Procedure

The cytology and histology reports **must** be reviewed.

Discrepancies must be discussed by a multidisciplinary team (see 8.195 Multidisciplinary Team Meetings).

The following must be taken into account:

- The biopsy may have missed the lesion
- The lesion may be endocervical
- The lesion may be on vagina
- The colposcopic impression may be inaccurate
- The cytology may be unrepresentative, imprecise or inaccurate
- The histology may be unrepresentative, imprecise or inaccurate
- The possibility that a small lesion may have resolved in the period between the referral cytology and the diagnostic colposcopy

If there is any doubt as to the accuracy of the colposcopic impression or results, a repeat colposcopy is necessary. This must include colposcopic examination of the vagina.

If the lesion is endocervical (or has an endocervical component) an excision biopsy is essential as a colposcopic punch biopsy may miss the abnormal area.

An excision biopsy is also essential if the colposcopy is unsatisfactory (SCJ not seen).

5C.90 INDICATIONS FOR TREATMENT

5C.90.1 Policy and Procedure

Treatment is required for:

- High grade CIN (CIN2/3)
- CGIN
- Persistent CIN1

For high grade CIN the recommended treatment is large LLETZ of the transformation zone (LLETZ). This modality usually ensures complete excision of the lesion whilst providing suitable material for exact histological diagnosis and grading.

Women aged 20-24 years with a small ectocervical CIN2 lesion may have further cytology and colposcopy after 6 months rather than treatment only after discussion and agreement with the colposcopy MDT.

For CGIN excisional treatment is recommended which may include LLETZ.

CIN1 can either be treated immediately or kept under close surveillance. This surveillance must include cytological examination.

If a woman with persistent CIN1 has been kept under surveillance in the Colposcopy Service for 2 years, and there is no sign of regression of the condition, treatment must be considered.

HPV change without CIN does not normally require treatment. If this result follows referral for a high grade smear further management must be decided at MDT.

Guideline note: HPV infection has a median duration of 8 months so persistent CIN1 indicates colposcopic/cytological or histological evidence of low grade abnormality for at least 12 months.

Women who are pregnant should not have their cervix treated as a routine; separate guidelines are described (see 5C.180, Managing Colposcopy in Pregnancy) for the management of such women.

If colposcopy is unsatisfactory and cervical cytology shows a high grade abnormality, excision is essential to determine the cause of the abnormal cytology.

Local guidelines should determine whether cold knife cone biopsy or deep LLETZ is the preferred method of treatment for lesions **incompletely visualised** at colposcopy.

Local policy must be determined in consultation with the lead colposcopist, lead pathologist and if appropriate the lead cytopathologist.

Rarely extensive disease requires larger excision of part or all of the vagina, usually by a gynaecological oncologist.

Treatment of VaIN and VIN is outwith the scope of the cervical screening programme and consequently, this document. This should, therefore, be discussed with the lead colposcopist. However, treatment of vaginal extension of CIN is usually ablated with laser in addition to LLETZ. Isolated vaginal disease can be excised or ablated. Prior to any ablation a vaginal biopsy is required and the result known to the treating colposcopist.

Concurrent colposcopic mapping of disease can be invaluable in providing complementary information for the treatment of VaIN/VIN.

5C.90.2 Treatment Modalities

1 Excisional methods

The major advantage of excisional methods is that the whole area of abnormality is available for histology. This reduces the risk of missing early invasive or glandular neoplasia.

If colposcopy is unsatisfactory in the absence of a significant colposcopic abnormality of the cervix or vagina in association with a high grade cytological abnormality, excision is essential to determine the cause of that abnormal cervical sample.

For women with high grade lesions, including CIN2/3 and CGIN, treatment should be by an excisional method, except where an experienced colposcopist makes a decision to use an ablative method (other than cryotherapy) in a premenopausal woman.

An excisional method of treatment should be used for lesions with extension high in the endocervix, where a glandular abnormality is suspected or where early invasion is suspected.

Excisional treatment must provide a specimen suitable for a tissue diagnosis.

Modalities available:

- LLETZ – for select and treat see 5C.50 Clinic Organisation and Function
- Cone biopsy
- Hysterectomy

2 Ablative treatment

The tissue in the area of treatment is destroyed. **A pre-treatment biopsy is essential** for women with an atypical transformation zone or prior cytological abnormality:

- Criteria specific to the modality to be used should be applied (see 5C.100, 5C.110 and 5C.115)
- There must be prior cytology, colposcopy and directed punch biopsy
- All results must be available at the time of treatment
- There must be no suggestion of invasive or early invasive disease
- There must be no suggestion of glandular abnormality
- The squamo-columnar junction must be visible colposcopically
- There should have been no previous treatment of the cervix for CIN/CGIN:
 - a low grade abnormality may persist or develop after treatment for high grade disease. If the above criteria are met, ablation may be appropriate. MDT could be used to discuss such cases

Any ablative treatment may be carried out in premenopausal women with minor abnormality (CIN1).

Ablative treatment (excluding cryotherapy) may be considered in premenopausal women with small CIN2/3 lesions or as an adjunct to LLETZ in dealing with large ectocervical high grade lesions with or without vaginal extension.

Ablative treatment should not be used in postmenopausal women.

Modalities available:

- Laser
- Cold coagulation
- LLETZ
- Cryotherapy (used for CIN1 or ectopy only, see 5C.115)

5C.90.3 Further Considerations

If a woman has an IUCD in situ, the device need not be removed if ablation or excision can be safely and completely performed around the coil stem. However, it may be removed if the woman

had not had intercourse 7 days prior to treatment. Suitable interim contraception is offered and an IUCD can be refitted 6 weeks later.

The woman must be given an explanation of the proposed treatment and written or verbal consent should be recorded in the notes.

The outcome of examination and plans for follow up must be communicated to the woman, her General Practitioner (and if different the referring practitioner) and the CSAD.

5C.90.4 Explanation of Treatment

Unless the treatment is performed as part of a 'select and treat' episode, the woman should be provided with written information prior to her visit.

The colposcopist should explain that the treatment carried out in the clinic:

- Is unlikely to cause discomfort
- Is unlikely to affect future pregnancies (see below)
- Is very effective

The woman should be warned of the risks and side effects of the procedure, including:

- Haemorrhage
- Infection
- Future pregnancy outcome
- Fertility
- Effects of anaesthesia/analgesia

The woman should be warned that there appears to be a slight increase in the risk of preterm delivery after a single LLETZ (increased from approximately 6% for the pregnant population in general to 10% after treatment). With repeated treatments the woman should be warned there is a risk of cervical stenosis/incompetence.

Treatment is normally carried out with local analgesia.

If this is inappropriate, general anaesthesia should be offered. Reasons for treating the woman under general anaesthesia should be recorded and include:

- Woman's personal anxiety
- Large areas with or without vaginal extensions
- Endocervical lesions inappropriate for outpatient treatment
- Inaccessible lesions

5C.90.5 Post Treatment Advice

Explain that following treatment:

- They may experience period like discomfort which may require analgesia
- There may be discharge and bleeding which may continue for 3-4 weeks, this may be unusually dark in colour.
- There may be a change in the menstrual pattern
- They should avoid sexual intercourse, use of tampons and swimming following treatment for 4 weeks
- Strenuous activities should be avoided for the first few days
- **Any offensive discharge or very heavy bleeding must be discussed with the colposcopy service. If out of hours contact their General Practitioner or local out of hours service**

Explain the importance of follow up cervical cytology

Where possible, those women who are planned for treatment under general anaesthesia will be given an admission date before leaving clinic.

If a biopsy result is awaited before deciding management then a date must be arranged at the earliest convenient time.

An area must be available for the woman to rest following examination or treatment.

5C.90.6 Local Practice Guidance

Variations in the equipment available may influence local practices.

Variations in practice should be minimised to prevent unnecessary variation in the quality of the service offered.

Variations in practice should not impact on the delivery of minimum CSW standards.

Detailed guidance on the operation of equipment should be established locally and be immediately accessible to the operator of the equipment.

Local protocols should be available to all staff.

Local training manuals should include comprehensive operating procedure guidance.

5C.90.7 Management Plan for Women attending colposcopy services

| REFERRAL SMEAR | MANAGEMENT AT COLPOSCOPY |
|---|---|
| Inadequate | Check cause of inadequacy. Repeat smear if > 6/52 since referral smear. Perform colposcopic examination and biopsy if necessary. Further cytological follow up determined by previous cytological history and colposcopic appearances (see 5C.165) |
| Abnormal smears of the following grades <ul style="list-style-type: none"> ▪ Borderline dyskaryosis (including borderline possible high grade and borderline changes in endocervical cells ▪ Mild dyskaryosis ▪ Moderate dyskaryosis ▪ Severe dyskaryosis ▪ ? invasive | No need to repeat smears if index smear <6 months before first appointment Biopsy all colposcopic abnormalities (unless pregnant) Consider LLETZ at first visit if high grade referral and high grade appearance If invasion is suspected urgent referral to oncologist If abnormal endocervical cells selective use of endometrial sampling |
| ?Glandular neoplasia of endocervical origin Grade 6 smear - abnormal endocervical cells | Need to exclude cervical neoplasia, but may need to also consider possibility of an endometrial abnormality if suggested by smear report Undertake colposcopy together with LLETZ or cone biopsy depending upon clinical situation |
| ? Glandular neoplasia or borderline abnormality of extra - cervical origin Grade 6 smear - abnormal endometrial cells | Need to exclude endometrial neoplasia or an abnormality of extra cervical origin. May also need to consider possibility of a cervical abnormality if suggested by smear report Undertake colposcopy and perform endometrial sampling or other investigations (endometrial biopsy, pelvic ultrasound scan) as appropriate. Consider punch biopsy/LLETZ if cervical abnormality seen |
| Histological Diagnosis | Management at Colposcopy |
| Nil significant | Dependent on previous cytology, colposcopic impression and previous histology. Where lack of correlation follow 5C.85 |
| Viral changes | Viral changes only with low grade or negative cytology should be managed by cytological surveillance |
| BAUS - basal abnormality of uncertain significance | BAUS only with low grade or negative cytology should be managed by cytological surveillance. Treatment not required |
| CIN1 | Can offer treatment or conservative management. Treatment recommended if persistent after 2 years Observation not recommended if likely to default or postmenopausal |
| CIN2/3 | Treatment usually recommended LLETZ/laser/cold coagulation dependent on abnormal area and woman's age CIN 2 may be monitored short term provided small lesion, woman under 25years and case discussed at MDT |

| REFERRAL SMEAR | MANAGEMENT AT COLPOSCOPY |
|---|---|
| CGIN | LLETZ or Cone biopsy depending upon clinical situation |
| SMILE – stratin mucin-producing intraepithelial lesion | Cervical neoplasia of both squamous and endocervical origin Treat as high grade disease excisional treatment recommended Follow up as high grade disease. Cytology must include an endocervical sample |
| Invasive disease | Refer to gynaecological oncologist or lead cancer surgeon |
| Extension of CIN to vagina and/or VAIN | Biopsy abnormal areas Discuss results with lead colposcopist or colposcopist with expertise in vaginal colposcopy |
| Non-CSW referrals | Management Management of non-CSW referrals is at the discretion of the colposcopist. However the following can be applied |
| Ectropion Women referred with symptoms and negative/no smear history | These should be ideally managed within the gynaecology service and only referred for colposcopic assessment where invasion is suspected Ensure smear history up-to-date and perform smear if necessary Take a full gynaecological history including contraceptive history and sexual history as appropriate Investigate as appropriate – this may include an infection screen Perform colposcopy to exclude CIN/CGIN/invasion If troublesome vaginal discharge or postcoital bleeding treat with cryotherapy/cervical LLETZ/cold coagulation (prior biopsy not needed if negative smear history and no colposcopic abnormality seen) |
| Symptomatic women | Women presenting with symptoms such as postcoital bleeding, intermenstrual bleeding and persistent vaginal discharge, should undergo gynaecological and colposcopic assessment as appropriate to exclude invasion Perform colposcopy to exclude CIN/CGIN/invasion Referral of younger women with postcoital bleeding to Sexual Health Clinic may need to be considered. |
| Abnormal looking cervix | Women with an abnormal looking cervix should undergo gynaecological and colposcopic assessment as appropriate to exclude invasion. Appropriate investigations should be undertaken |

5C.100 USE OF LASER

5C.100.1 Procedure

Use of the surgical laser in the Colposcopy Service must be in accordance with the Department of Health (DH) publication Guidance on the Safe Use of Lasers in Medical and Dental Practice, 1995.

A copy of the local rules, regularly updated operational guidelines and the DH Guidance must be kept in the treatment room.

Only nominated users may operate the laser beam.

Only the authorised named persons are to assist during the preparation of the laser, preparation of the woman, and during laser treatment.

The laser should **be** used in an area free of reflective or flammable materials.

The room is labelled with a warning notice and locked when operational to indicate the presence of a laser hazard. Ideally a warning light should be used.

The laser control area is defined as the whole of the room when the warning light is on.

Any window roller blind must be fully lowered.

The laser **must not** be moved during treatment. Great care must be taken not to knock the delivery arm or tube. Laser connection to the colposcope must only be by an authorised person.

All staff involved in the clinic must be aware of the local laser guidelines.

Laser protection rules must be strictly followed, including:

- The use of eye protection goggles as per regulations
- Appropriate positioning of laser equipment
- Use of a non reflecting speculum with welded smoke extraction tube

Alignment of the beam must be tested each time the laser is connected to the colposcope.

The laser unit **must** be switched off when not in use.

When the laser is in use, the room must be locked and a warning light or suitable notice must be clearly visible.

5C.100.2 Procedure

Ensure that all criteria are met for the use of ablative treatment (see 5C.90 Indications for Treatment).

The woman must wear the appropriate personal protective eyewear.

Operation of Laser

Before switching on:

Set up the laser equipment adjacent to examination couch. When connecting up the laser delivery system, site all equipment to ensure correct positioning for the operator and to avoid collisions and obstructions in use:

- Ensure that micromanipulator is attached to the colposcope
- Connect articulated arm to micromanipulator input
- Place footswitch in convenient and safe position
- Ensure stability of laser equipment
- Ensure all personnel are wearing protective eyewear

A suitable local analgesic, usually including adrenalin, is injected using a dental syringe. Two or three ampoules may be gently injected just under the cervical epithelium to provide local infiltration to the cervix. Women may experience mild and transient palpitations shortly after application. Paracervical infiltration is an alternative technique.

The laser must be operated under direct colposcopic vision. It should only be turned on after completion of the above.

It is advisable that the colposcopist operating the laser should verbally warn staff present when the treatment is to begin. The laser spot is adjusted to a diameter of about 2 mm, the power output set to 25 Watts.

The lesion is outlined by moving the beam round it.

A trench around the treatment area is created by the first slow pass and should be about 2-3 mm deep. Thereafter the whole area is slowly vaporised to a depth of 8-10 mm. Some operators may prefer a higher power to improve haemostasis.

Ensure that there is no excessive bleeding at the end of the treatment. If there is any persistent oozing of blood then silver

nitrate or cold coagulation may be used to obtain satisfactory haemostasis.

Always return to standby mode if treatment has to be stopped momentarily to avoid accidental emission of laser beams. Ensure the aiming and treatment beams are aligned at the outset of each treatment.

5C.100.3 Post-treatment Advice

Post treatment advice should be given in accordance with section 5C.90 A local clinic leaflet including a contact telephone number should be given to all women following treatment. Advice on alternative contacts outside clinic hours should also be given.

5C.100.4 General Safety Requirements

It is the duty of every person to protect him/herself and others from any hazard arising from laser use.

The laser must not be left unattended whilst activated.

5C.100.5 Authorised Personnel

The minimum number of staff must be present during laser treatment.

5C.100.6 Accidental Exposure

Any person suspected of receiving non-clinical exposure to the eye must be referred to a consultant ophthalmologist, as soon as possible, within 24 hours. The Laser Protection Adviser must be informed.

5C.100.7 Fire

Switch off the laser at the mains switch. See hospital fire procedure.

5C.110 USE OF COLD COAGULATION

The cold coagulator may be used by a colposcopist who is experienced to use this mode of treatment for CIN. It is usually used for treating cervical ectopy/cervicitis or CIN1 but can be used to treat small ectocervical CIN2/3 lesions in premenopausal women.

A pre-treatment colposcopy and biopsy must be performed and the histology documented. Cold coagulation is not suitable for lesions that extend onto the vagina.

The tissue in the area of treatment is destroyed. **A pre-treatment biopsy is, therefore,** essential for women with an atypical transformation zone or prior cytological abnormality. The common criteria for ablative therapy must be satisfied (see 5C.90).

5C.110.1 Procedure

The cold coagulator probe to be used is sterilised as per instructions by the manufacturer.

Colposcopy is carried out to locate the area for treatment

Any possibility of unsuspected invasion must be excluded.

The whole area must be visible and accessible to the probe. Lesions extending into the cervical canal for more than 3-4 mm are not suitable.

A suitable local analgesic, usually including adrenalin, is injected using a dental syringe. Two or three ampoules may be gently injected just under the cervical epithelium to provide local infiltration to the cervix. Women may experience mild and transient palpitations shortly after application. Paracervical infiltration is an alternative technique.

The transformation zone and the lower endocervix are treated at a minimum of 100°C by overlapping applications for 20 seconds each.

5C.110.2 Post-treatment Advice

Post treatment advice should be given in accordance with section 5C.90.

A local clinic leaflet including a contact telephone number should be given to all women following treatment. Advice on alternative contacts outside clinic hours should also be given.

5C.115 USE OF CRYOTHERAPY

Cryotherapy may be used by a colposcopist who is experienced in the use of this mode of treatment. It is usually used for treating cervical ectopy/cervicitis or CIN1. It must not be used to treat high grade CIN or CGIN.

A pre-treatment colposcopy and biopsy must be performed if the woman has previous abnormal cytology and the histology documented. Cryotherapy is not suitable for lesions that extend onto the vagina.

The tissue in the area of treatment is destroyed. A pre-treatment biopsy is, therefore, essential for women with an atypical transformation zone or prior cytological abnormality. The common criteria for ablative therapy must be satisfied (see 5C.90)

5C.115.1 Procedure

The cryotherapy probe to be used must be sterilised as per instructions by the manufacturer.

Any possibility of unsuspected invasion must be excluded.

The whole area must be visible and accessible to the probe. Lesions extending into the cervical canal for more than 3-4 mm are not suitable.

The area to be treated must be subjected to a minimum of two freeze-thaw applications for 20 seconds.

5C.115.2 Post-treatment Advice

Post treatment advice should be given in accordance with section 5C.90.

In addition women need to be informed that they may experience a watery discharge during the healing process.

A local clinic leaflet including a contact telephone number should be given to all women following treatment. Advice on alternative contacts outside clinic hours should also be given.

5C.120 USE OF LLETZ

If the woman is to be treated by LLETZ, prior colposcopic assessment is essential.

In selected cases LLETZ can be performed following colposcopy, at the first visit ie: select and treat, (see 5C.50).

A full excision of the transformation zone should not be performed if there is clinical evidence of invasion. Under these circumstances, the lead colposcopist and the consultant responsible for the care of the woman should be informed as soon as possible. The regional gynaecological oncologist or cancer lead must be informed to decide definitive management.

The treatment of large lesions, especially those involving the vagina, may be better combined with another treatment modality. In this situation the central area is excised with a loop and the peripheral area is ablated or excised.

General anaesthesia is usually required for treatment of vaginal disease, or for CIN if a woman is unduly anxious.

5C.120.1 Contraindications

There are no known contraindications to the use of electrosurgery. The use of external or internal pacemakers, monitoring equipment, and the woman's condition may require special precautions (eg anticoagulation, severe orthopnoea).

Colposcopic biopsy may be a procedure from which bacteraemia may occur for susceptible individuals. Antibiotic prophylaxis may be appropriate for susceptible individuals if LLETZ is planned.

5C.120.2 Equipment

An electro-surgical generator is used (eg ValleyLab or ERBE). The generator produces a high frequency (500 kilohertz) monopolar current in cutting and coagulation modes or combinations of these modes.

5C.120.3 Procedures

Manufacturers operating instructions and the NHSCSP Equipment report 0401: Guidance Notes on Electrical Safety in Rooms Used for Colposcopy and the Safe Use of Electrosurgery for LLETZ should be read or viewed and thoroughly understood by all personnel, before use of the equipment. Copies should be kept available in the treatment room.

Under no circumstances is an untrained person allowed to use LLETZ without supervision.

Under no circumstances must the active LLETZ or coagulation ball be energized within the vagina but away from the excision site. During surgical LLETZ, it is normal for sparking to occur at the active electrode. These sparks are easily able to ignite fluids or dry swabs. Therefore it is important not to use spirit based fluids or dry swabs near the active electrode.

A lowest power consistent with effective cutting and haemostasis should be used to ensure that the specimen is suitable for histology. A blend of cutting current (eg 35-45 Watts for the Valleylab) and coagulating current (eg 45-60 Watts for the Valleylab) is commonly used.

5C.120.4 Attachment of the Return Electrode

It is recommended that a disposable return electrode (thigh pad) is used, positioned properly in accordance with manufacturer's guidance.

Single use plates must not be reused since the conducting gel which is used to coat the contact surface would not be intact and result in impaired conduction of the return current.

Reusable return electrodes must provide whole area contact without wrinkles.

The return electrode should not be attached in the area of prosthetic inserts. In the case of women fitted with pacemakers, advice should be sought from the pacemaker manufacturers on the use of electrosurgery and recommended location of electrodes.

Where a choice of length and return electrode lead is available from the supplier, choose the shortest length that will allow the lead to run from the woman to the connection on the generator.

Any surplus lead must not be coiled, neither should the lead be looped to clip it to the women, couch or the generator trolley.

5C.120.5 Connection of the Active Electrode

Where a choice of length of active electrode lead is available from the supplier choose the shortest length that will allow the lead to run from the LLETZ electrode to the connection on the generator.

Any surplus lead must **not** be coiled. The lead should not be attached to the examination couch or the equipment trolley. Positioning of the lead should allow freedom of movement whilst minimising tension on the cable.

Before use, the LLETZ cutting loop should be carefully inspected and not used if the insulation is damaged. A holster, positioned within easy reach of the colposcopist, should be used to house the active electrode when not in use.

Where cutting or coagulation modes can be switched from the electrode shaft, the non active mode setting should be reduced to its minimum setting, until required for use, so that inadvertent operation of the switch does not cause harm.

5C.120.6 Lead Safety

Trailing leads on the floor of the treatment room should be avoided, particularly when the woman is being brought in and taken from the room. The use of reduction adapters must be avoided as they do not conform to basic safety standards for medical devices, due to the risk of electrosurgical burns. The risk is increased when using spade or hook connectors.

Only leads and connectors designed for direct connection to the equipment must be used and the manufacturer's recommendations about use, storing, cleaning and checking followed.

5C.120.7 Electrical Isolation of the Woman

When the active electrode is energised, the whole of the woman's body is available to act as a return path due to capacitive effects. Electrical isolation of the woman from metal parts of the couch and leg supports, by use of insulating mattresses and tape is the most effective way of avoiding possible injury from burns. A discharge occurring over a large area such as the whole hand might be harmless, whereas finger tip contact with an earth path such as a metal frame would result in a painful burn. As a general rule, small area contact with the woman, such as lightly brushing the face should be avoided, when the electrode is energised. Similarly, if contact has to be made with equipment whilst it is energised, use the full hand, not a single finger.

5C.120.8 Use of computers in colposcopy and associated electrical safety

The computer used for imaging should be connected directly to the wall mains supply and not to power sockets on trailing leads. Non medical equipment may not be included within the 'woman

environment' which encompasses a volume around the woman and couch.

5C.120.9 Colposcopist

Surgical gloves cannot be regarded as an effective insulator; similarly the use of a condom, with the teat removed, over the jaws of the speculum should be regarded only as a means of bracing the unsupported tissue rather than an effective means of insulation.

If a metal speculum is used, the colposcopist is brought into close contact with the source of the current and must take measures to ensure they are isolated from 'earthed' bodies. These include the examination couch and the base and supporting column of the colposcope.

The use of plastic or fully insulated metal specula, the latter being autoclavable, is advised where other means of isolation for vulnerable areas of the body are impracticable.

The eye piece of a teaching arm fitted to a colposcope should also be non metallic and may be safely touched by the observer, but the observer must take similar isolation measures to those taken by the colposcopist and not touch the woman when the electrode is energised.

5C.120.10 Smoke Evacuation

Use of a smoke evacuator to allow clear observation of the site and removal of the potential health risk to personnel is advised. The hospital vacuum system should not be used for this purpose. Portable suction units exhausting unfiltered air into the room should also be avoided.

5C.120.11 Precautions in the Use of Swabs and Solutions

Consideration should be given to labelling containers of spirit based cleaning and preparation materials and non water based lubricants, such as petroleum jelly, with a cautionary note about the danger of their use in conjunction with LLETZ.

Queries about suitability of fluids and lubricants from any source, for use in LLETZ, should be addressed to the hospital pharmacy department.

5C.120.12 Other Safety Measures

Routine maintenance of all equipment should be carried out at the intervals recommended by the manufacturer.

A contract schedule listing all checks to be carried out should be drawn up and dated. A signed report on the tests made and results obtained, where appropriate, must be provided by the service engineer at the conclusion of each visit.

5C.120.13 Technique

Colposcopy must be performed to visualise the abnormal area and plan the excision.

A speculum with a smoke extraction tube must be used. A suitable local analgesic, usually including adrenalin, is injected using a dental syringe. Two or three ampoules may be gently injected just under the cervical epithelium to provide local infiltration to the cervix. Women may experience mild and transient palpitations shortly after application. Paracervical infiltration is an alternative technique.

The colposcopist should aim to remove the lesion in one specimen if possible. Large areas may need to be removed in 2 or 3 pieces. The orientation of the multiple segments may be difficult from the point of view of histology.

A suitable sized wire loop is selected depending upon the size of the area to be excised.

The cervix is ideally positioned so that the whole lesion on the ectocervix is visible. The wire is allowed to sink at a right angle to the surface until the correct depth is reached.

Thereafter, progress parallel to the surface. This process is reversed when the loop is removed at the opposite edge of the lesion. The angle of the loop may need to be modified for eccentric lesions or if access is difficult.

For loop specimens involving the endocervical canal a further excision may be taken from the base of the crater using a smaller loop.

The loop crater is cauterised with the coagulating current. This aims to achieve good haemostasis.

Care must be taken not to touch the vaginal wall or speculum with the loop or LLETZ ball as this is painful.

All the samples must be sent separately identified, with appropriate labelling.

5C.120.14 Post-treatment Advice

Post treatment advice should be given in accordance with section 5C.90.

A local clinic leaflet including a contact telephone number should be given to all women following treatment. Advice on alternative contacts outside clinic hours should also be given.

The woman is informed of her results and management plan when the histology is available (see 5C.30 Administration of Colposcopy Services).

5C.130 CONE BIOPSY

Cone biopsy is carried out under general anaesthesia.

5C.130.1 Indications

Cone biopsy is indicated for women where colposcopic treatment is considered unsuitable:

- If an abnormal transformation zone extending high in the cervical canal is identified
- If an invasive or early invasive lesion is suspected within the endocervix

5C.130.2 Technique

A cone biopsy can be performed with a cold knife, laser or loop. The method used will depend on the individual circumstances as well as treatment modality available. Cervical stenosis and incompetence are seen in a small proportion of women after cone biopsy. These are complications not seen after LLETZ unless multiple treatments have been performed.

Knife cone biopsy has become less common as LLETZ may be used to remove lesions that are incompletely seen at colposcopy in the absence of suspected invasive disease.

The technique of haemostasis will depend upon the preference of the surgeon. No single technique appears superior. The woman may require approximately 2 weeks convalescence.

5C.130.3 Post-treatment Advice

Specific post treatment advice should be given before the woman leaves the hospital.

The woman is informed of her results and management plan when the histology is available.

5C.140 HYSTERECTOMY, MANCHESTER REPAIR AND CANCER OF THE CERVIX

Women may be advised to undergo hysterectomy in certain circumstances:

- Women with CIN with coincidental gynaecological problems such as menorrhagia or multiple fibroids may be advised to have a hysterectomy after discussion with the appropriate consultant

Early invasive glandular disease may require simple hysterectomy in its own right.

Carcinoma of the cervix stage Ia2, Ib or stage IIa may need Wertheim/radical hysterectomy.

Women who are diagnosed with invasive disease will not be further treated or managed within the cervical screening programme except those women who have conservative management of early invasive disease (Ia1).

The regional gynaecological oncologist or cancer lead must be informed to decide definitive cancer management.

Guidelines for the management of women with invasive disease require that they are managed according to local guidelines and are seen initially by the consultant responsible for the care of the woman or the lead colposcopist. Discussion should be either at the local cancer or colposcopy MDT meeting with a copy of the management plan sent to the local Regional Programme Coordinator (see 8.195.6 Multidisciplinary Team Meetings).

5C.140.1 Management Following Hysterectomy (see 4P.80) see flow chart Core reference section 2R.40

For further guidance see 2R.20.10

5C.140.2 Management Following diagnosis of invasive cervical cancer (see Core Reference Section 2R.33)

5C.145 MANAGEMENT OF WOMEN FOLLOWING FERTILITY PRESERVING TREATMENT FOR EARLY STAGE CERVICAL CANCER

The treatment of early invasive cervical cancer (FIGO stage Ia1, Ia2, Ib1, Ib2 and IIa) is outwith the responsibility of Cervical Screening Wales and consequently the outside the general scope of the colposcopy SOPPs. However, the following specific guidance applies.

If early invasive disease is detected, the lead colposcopist and the consultant responsible for the care of the woman should be informed as soon as possible.

The regional gynaecological oncologist or cancer lead must be informed to determine definitive treatment. Discussion must be either at the local cancer or colposcopy MDT meeting with a copy of the management plan sent to the local Regional Programme Coordinator (see 5C.195 Multidisciplinary Team Meetings).

5C.145.1 Follow-up of Stage Ia1 disease

The carcinoma is strictly confined to the cervix.

Stage 1a - the carcinoma is diagnosed only by microscopy with the deepest invasion <5mm and largest extension <7mm

1a1 disease: Measured stromal invasion of ≤ 3.0 mm in depth and extension of ≤ 7.0 mm, no lymphovascular space involvement).

1a1 disease: up to 3mm maximum depth of penetration, no greater than 7mm in any horizontal dimension, no lymphovascular space involvement).

If conservative treatment for cervical cancer has been performed leaving a residual cervix then cytological follow-up is identical to that for high grade pre-invasive disease.

Cervical cytology should be taken at 6 and 12 months post treatment followed by annual cytology for the next 9 years before return to 3 yearly recall to 65 years. Cervical Screening Wales will continue to provide recall arrangements.

1a2 disease: Measured stromal invasion of >3.0mm and not >5mm with an extension of not >7.0mm

If conservative management for Ia2 disease was by simple or radical trachelectomy then cytological follow-up is determined by the management policy of the gynaecological oncologist.

If residual cervix remains and the woman has not had radiotherapy then the cytological follow-up described in 5C. 145.1 applies.

Stage 1b - there is a clinically visible lesions limited to the cervix uteri or pre-clinical cancers greater than stage Ia

1b1 disease: Clinically visible lesion ≤ 4.0 cm in greatest dimension

If conservative management for Ib1 disease was by simple or radical trachelectomy then cytological follow-up is determined by the management policy of the gynaecological oncologist. If residual cervix remains and the woman has not had radiotherapy then the cytological follow-up described in 5C. 145.1 applies.

Follow-up of stage 1b2 and stage IIa disease (extension to adjacent vagina) is determined by the management policy of the gynaecological oncologist.

5C.145.2 Follow-up of stage Ia2/Ib1 disease

1a2/1b1 disease: greater than Ia1 disease but confined to the cervix with the primary tumour no greater than 4mm in diameter.

If conservative management for Ia2/Ib1 disease was by simple or radical trachelectomy then cytological follow-up is determined by the management policy of the gynaecological oncologist. Follow-up of stage IIa disease (extension to adjacent vagina) is determined by the management policy of the gynaecological oncologist.

If residual cervix remains and the woman has not had radiotherapy then the cytological follow-up described in 5C. 145.1 applies.

5C.145.3 Exceptional Reports

Cases of vaginal intra epithelial neoplasia (VaIN) Smears taken on women with a history of VaIN are reported by the laboratory. The management will be decided by the gynaecologist/colposcopist/oncologist responsible for her care.

5C.150 GUIDELINES FOR FOLLOW UP AND SURVEILLANCE

All women who are seen and/or treated at colposcopy should be followed-up or kept under cytological surveillance for the appropriate specified period (see core reference). Reasons for follow-up/surveillance include:

- Identification of residual disease
- Identification of new CIN or CGIN
- Identification of invasive carcinoma
- Reassurance for the woman that treatment has been effective

Follow-Up

- **All** women must be managed according to the CSW Quality Manual
- At least **85%** of treated women must have a follow up cervical sample, within 6 to 8 months following treatment
- In at least **90%** of cases, there should be no dyskaryosis on cytology in treated women at 6 months
- There should be no more than **5%** of cases with histologically confirmed treatment failures within 12 months of treatment

Cytological Follow-Up consists of a series of early repeat cervical samples, which must all be negative before a woman is returned to routine recall. The CSW follow-up protocol consists of:

- A cervical sample **6 months** after treatment:
 - Those who have had complete excision of a high grade squamous abnormality, or those who have had any form of treatment (excisional or ablative) for CIN1 or less may have this sample taken within the community
 - Colposcopy plus cytology is required at this appointment for the follow up of incompletely excised CIN 2/3 (or where the margin status was unclear or not specified) and cGIN
 - Follow up of CIN 2/3 treated by ablation must include a colposcopy
 - All other women should be followed up within the colposcopy service
- If the cytology is negative (and colposcopy if performed), then sample a **further 6 months later** (ie 12 months after treatment)
- If negative, then sample a **further 12 months later** (ie 2 years after treatment)
- If negative, **repeat samples annually to 10 years post treatment**
- If negative at 10 years, return to **routine recall**.

If a woman fails to attend for one or more of the above follow-up cervical samples, she may still be returned to routine recall if she has had at least **five negative samples**, each of which are at least 12 months apart, and the **final negative sample is at least 10 years post treatment**.

5C.150.1 Procedure

Management of women who have positive margins for disease following LLETZ treatment

For women who undergo LLETZ, negative excision margins on histology are associated with a lower risk of residual disease, compared to those with positive excision margins. Disease at the endocervical margin is associated with a higher risk of residual disease compared to involved ectocervical margins. Women 50 years or older are more at risk of residual/recurrent disease (NHSCSP No 20 9.1)

CIN extending to the excision margins results in a higher incidence of recurrence but does not justify routine repeat excision as long as:

- There is no evidence of glandular abnormality
- There is no evidence of invasive disease
- The woman is under 50 years of age

Provided the above criteria are met the recommendation is cytology plus colposcopy for first follow up (NHSCSP No 20 8.6.1)

If the woman is over 50 years of age, and disease extends to the endocervical margin, and satisfactory colposcopy cannot be guaranteed – the woman needs a repeat LLETZ (NHSCSP No 20 8.6.2)

Glandular disease / CGIN extending to the endocervical margin requires a further excisional procedure to obtain clear margins and exclude occult invasive disease (NHSCSP No 20 8.7.1)

Following treatment for CIN or CGIN, all women will require a follow up cervical smear at **6 months** post treatment.

Those who have had complete excision of a high grade squamous abnormality, or those who have had any form of treatment (excisional or ablative) for CIN1 or less may be discharged from the colposcopy service and followed up within the community.

All other women should be followed up within the colposcopy service.

An ectocervical sample should be carried out using a cervix brush:

- In view of an increased chance of an inadequate cytology following treatment every effort must be made to get a good sample from the squamo-columnar junction
- For follow up of glandular neoplasia, a borderline endocervical cytology sample or treated CGIN:
 - Both ectocervical and endocervical samples must be taken. This is carried out using a cervix sampler and endocervical brush. Both samples are placed in the same vial. The request form must be labelled as having **ecto- and endocervical sampling**
 - The sample *must* contain endocervical cells:
 - If this sample is inadequate due to the absence of endocervical cells then further management must be determined by a multi-disciplinary team discussion

Colposcopy is also required at this appointment for the review of untreated CIN 1; for the follow up of incompletely excised CIN 2/3 (or where the margin status was unclear or not specified); for CIN 2/3 treated by ablation and CGIN:

- BAUS (basal abnormality of uncertain significance) is treated as a negative biopsy from a clinical standpoint but for FailSafe is managed as if it were a low grade abnormality and cytological surveillance is commenced
- SMILE (stratified mucin-producing intraepithelial lesion) is regarded as a rare and unusual precursor of CGIN as a variant of atypical reserve cells which may coexist with CIN and CGIN. It is usually seen at excision biopsy and is regarded as a potential high grade lesion. Cytological follow up is recommended with a Cervex sampler *and* endocervical brush
- Cytological surveillance is required for the follow up of women investigated for **borderline high grade, borderline endocervical cells and borderline endometrial cells where either only CIN 1 or no abnormality was found after colposcopic** assessment (see 5C.90)

The woman and her General Practitioner will be informed of the result as soon as the cervical cytology result is available and the need for regular follow up/surveillance will be emphasised.

The woman will be discharged back to the care of her General Practitioner following negative colposcopy (if performed) and/or

cytology with advice to continue the recommended cytological follow-up/surveillance regime.

Subsequent cytology should not normally be taken within the colposcopy service.

An exception is, however, **where colposcopy is normal following a low grade cytological referral and the 6 month repeat cervical sample is borderline**, the woman can be discharged from colposcopy and re-referred as determined in appendix 3.4.

During the follow-up/surveillance regime invitations will be sent automatically by the CSAD.

Further follow up appointments in Colposcopy Service should not be offered to women with negative cytology following treatment unless there is a pressing reason for subsequent cervical samples not to be taken in primary care.

Further follow-up in Colposcopy Service is indicated:

- If the follow up sample is inadequate or abnormal
- If there is a perceived risk of recurrent CIN as stated above

Women who need to attend Colposcopy Service for further follow up must have this clearly stated in their notes and indicated in their management plan:

- A further appointment should be arranged on that day

Further treatment is recommended for:

- CGIN if the excision margins of the first treatment are involved, a further attempt at conservative excision should be offered to confidently exclude invasion and to obtain negative margins
- All women over 50 years who have CIN 3 at the endocervical margin in whom satisfactory cytology **and** colposcopy cannot be guaranteed

5C.150.2 Nurse Led Cytology Clinics

If cytology alone is needed for follow up the woman should be referred to a nurse led cytology clinic. A colposcopy nurse trained in smear taking would be suitable to run such a clinic.

5C.160 COMMON INFECTIONS

Incidental infections may be detected in cervical cytology samples. Some may require specific treatment or defined management. Such management is not strictly part of the cervical screening programme and is the responsibility of the individual colposcopist. For this reason, detailed management regimes are not specified in this document.

5C.160.1 Human Papilloma Virus (HPV)

No specific treatment is required for HPV alone.

Management is determined by the presence of dyskaryosis or the adequacy of the sample.

If repeat cytology shows persistent low grade abnormality (see core reference) the woman will be referred for colposcopic assessment.

If the colposcopic assessment is otherwise normal then no specific intervention is recommended.

If the biopsy shows evidence of HPV without dysplasia the woman should be managed as for borderline cytology.

Currently there is no need to consider HPV typing outside the remit of a research protocol.

5C.160.2 Bacterial Vaginosis (BV)

This is usually an incidental finding but can occasionally produce an offensive vaginal discharge. It is a common infection usually associated with *Gardnerella* spp., other anaerobes and facultative anaerobes.

Treatment is required if:

- The woman complains of a vaginal discharge
- Is pregnant with a history of idiopathic preterm birth/2nd trimester pregnancy loss
- Undergoing IUCD insertion/TOP

If the woman has cytologically identified borderline change or is awaiting colposcopic treatment then antibiotics may be useful. However there is no evidence to support the screening of asymptomatic women for vaginal or cervical infection prior to colposcopic treatment.

5C.160.3 Candidiasis (Monilia)

This should be treated if symptomatic or if the woman is awaiting colposcopic treatment.

5C.160.4 Actinomyces (ALOs)

Actionomyces like organisms (ALOs) are usually seen in women using an intra-uterine contraceptive device (including the Mirena IUS).

If the woman complains of specific symptoms the device may need to be removed, after first ensuring that the woman has not had sexual intercourse in the preceding 7 days. These symptoms include:

- Pelvic pain
- Deep dyspareunia
- Intermenstrual bleeding (after 6 months of a device being in situ)
- Vaginal discharge, dysuria or significant pelvic tenderness

Guidance on the management of ALOs on cervical smears is available from The Faculty of Reproductive and Sexual Health.

The specific guidance on IUCDs is at:

<http://www.ffprhc.org.uk/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf>, pages 11-12

5C.160.5 Herpes Simplex (HSV)

Women with a fulminant herpes simplex virus (HSV) infection will present with symptoms long before the cervical cytology report will be available.

All women should be referred to a local sexual health clinic.

Acyclovir is started if infection is suspected (there is no evidence that this drug is teratogenic, so it can be safely prescribed in pregnancy).

5C.160.6 Trichomonas Vaginalis (TV)

Asymptomatic detection of this protozoon merits treatment in all cases.

Referral is suggested to the local sexual health clinic for contact tracing.

The woman and her partner should be treated with metronidazole.

Cervical cytology with Trichomonas present may often be unsatisfactory due to the marked inflammation. TV should be first treated if repeat cervical cytology is required.

5C.164 MANAGEMENT OF THE WOMAN REFERRED WITH POSSIBLE GLANDULAR ABNORMALITIES

Women may be referred into the clinic with smears showing possible glandular abnormalities arising from either the endocervix or the endometrium.

These may be classified as:

- Abnormal glandular cells of endocervical origin – includes ?glandular neoplasia of endocervical origin (code 6GC) and borderline endocervical cells (code 8GC)
- Abnormal endometrial cells – includes ?glandular neoplasia of endometrial origin (6GM) and borderline endometrial (code 8GM)

There is a need to exclude both cervical neoplasia and endometrial neoplasia depending on the actual smear report. May also need to consider possibility of an endometrial abnormality if suggested by smear report.

Dependent on the smear report colposcopy / gynaecological examination should be undertaken together with selective endometrial sampling and/or other investigations (endometrial biopsy, pelvic ultrasound scan) as appropriate. Consider punch biopsy/LLETZ / cone biopsy if cervical abnormality seen, and dependent on clinical situation.

Follow up

If results show CIN2, CIN3, CGIN, woman should receive cytological follow up

Follow up after Borderline endocervical (8GC) where No abnormality found is by standard cytological surveillance

Follow up after abnormal endocervical (grade 6GC) where No abnormality found should be by cytological follow up (ideally these should be discussed at MDT)

Follow up after Borderline endometrial (8GM) or abnormal endometrial (6GM) where No abnormality found despite investigations, should be by standard cytological surveillance

Ideally, all Grade 6 smears where no abnormality confirmed should be discussed at MDT and CSAD informed of outcome.

5C.165 MANAGEMENT OF THE WOMAN REFERRED FOR INADEQUATE CYTOLOGY

Women may be referred into the clinic with inadequate cytology or where the smear taker has difficulty in seeing the cervix.

The following should be undertaken:

- Check cause of inadequacy
- Repeat smear may be taken provided at least 6 weeks since referral smear
- A sample must be appropriate to the condition of the cervix eg additional sampling for large ectropion, additional endocervical sample for type 3 SCJs (see CSW Smear Taker Guide)
- Perform colposcopic examination and biopsy if necessary
- Further cytological follow up is determined by previous cytological history, colposcopic impression and test results

If the cervical cytology remains inadequate, or cannot be taken, and the colposcopy examination is satisfactory and normal, then the woman can be discharged from the colposcopy service and returned to the appropriate recall interval.

The colposcopic visit in this situation will serve as a proxy for the cervical smear and the local CSAD must be notified to this effect.

In cases where the situation is not resolved by colposcopic assessment MDT discussion is advised.

5C.170 MANAGING THE POST-MENOPAUSAL WOMAN

Colposcopic examination of the postmenopausal woman may be difficult due to vaginal atrophy. Visualisation of the squamo-columnar junction may also be difficult. This protocol includes management of women with cytological abnormalities over 65 years of age.

5C.170.1 Procedure

Both of the above problems can be eased with a 10 to 14 day course of intravaginal oestrogen.

If there is indication the woman might benefit from topical oestrogen prior to colposcopy this should be arranged.

Ablative treatment should not be used in postmenopausal women with a high grade abnormality.

5C.170.2 Management of Low Grade Abnormalities

Management of persistent borderline change or mild dyskaryosis in a post-menopausal woman should be on an individual basis.

Colposcopy of the vagina may be recommended. Oestrogen pre-treatment may be useful. **Note** that colposcopy of the vagina can cause discomfort.

5C.170.3 Cervical Cytology taken after 65 years of age

If a woman is aged 65 years or over when a cervical sample is taken, referral to colposcopy is recommended for any grade of abnormality including borderline change.

If the sample is inadequate then cease from further recall as long as she is not under cytological surveillance or follow up.

For the management of cervical cytology from previously ceased women (see Core Reference Section 2R).

5C.180 MANAGING THE PREGNANT WOMAN

A woman who meets the criteria for colposcopy should be examined in the colposcopy clinic even if she is pregnant. The primary aim of colposcopy for pregnant women is to exclude invasive disease and to defer biopsy or treatment until the woman has delivered. (NHSCSP 20)

Pregnant women should be reassured that colposcopic examination will not affect their pregnancy.

Such women should **not** have their cervix treated as a routine.

Management of CGIN or suspected invasion in pregnant women must be discussed with the lead colposcopist/oncologist as appropriate.

5C.180.1 Procedure

If the woman is due for or awaiting routine or follow up cytology during the term of her pregnancy, these cervical samples should be delayed until at least 3 months postpartum.

If a woman has a suspected low grade abnormality in early pregnancy she should be seen at colposcopy at approximately 3 months postpartum for a further assessment

If the pregnant woman has a suspected or proven high grade abnormality at assessment or whose referral cytology was high grade she should be reassessed at colposcopy at approximately 28 weeks.

Colposcopy becomes progressively more difficult as pregnancy advances; some colposcopists may choose to defer further review appointments after the 28 weeks review

Women should be reassessed 3 months after delivery. At this point definitive treatment may be undertaken if appropriate.

If invasion is suspected **prior to biopsy the woman must be referred to a multidisciplinary cancer team:**

- A suitable biopsy for suspected invasive disease would be a cone, wedge or LLETZ
- There must be appropriate facilities readily available to deal with potential bleeding

For women undergoing assessment or review in a Colposcopy Service, further cervical cytology is not required during the course of pregnancy.

If a 1st follow up is required following treatment for CIN 2/3 (with involved or uncertain margin status) or CGIN then that visit should be in the middle trimester unless there is a clinical contra-indication.

If a review or post treatment appointment is due in late pregnancy, this can be delayed until 3 months after delivery.

If a woman first presents with high grade dyskaryosis in late pregnancy she should be colposcopically assessed.

Results must be sent to the woman's obstetrician.

5C.181 MANAGING THE IMMUNOSUPPRESSED WOMAN

Women who are immunosuppressed will be referred to colposcopy in accordance with Cervical Screening Wales' referral policy. All patients who are immunosuppressed must be managed in a centre with demonstrable skill and expertise

5C.181.1 Women with HIV

Women with HIV should ideally have an initial colposcopy after diagnosis, where resources permit. It is the responsibility of the clinician managing the woman's HIV disease to refer to colposcopy as CSW is unlikely to be aware of the woman's HIV status. Annual screening should be performed, undertaken in conjunction with the medical team managing the woman, although the age range screened should be as for the general population. Criteria for referral to colposcopy are the same as for the general population.

High grade CIN (CIN2+) should be managed in accordance with CSW guidelines (5C.90), although CIN1 or less should probably not be treated as this is likely to represent persistent HPV infection. Colposcopists should take precautions to reduce the risk of exposure to HIV-infected fluids and any specimens (cervical samples, biopsies) should be labelled as high-risk specimens.

5C.181.2 Women having renal dialysis

Women diagnosed with renal failure requiring dialysis who fall within CSW's eligible age range should have cervical cytology performed at or shortly after diagnosis. Ideally colposcopy should also be performed if resources permit.

Subsequent cytology should be performed as per the general population, however any cytological abnormality should be treated as high grade dyskaryosis and referred for colposcopy. Management at colposcopy should be as per the general population.

5C.181.3 Women on maintenance immunosuppressant therapy

Women taking maintenance immunosuppressant therapy post-transplant who fall into CSW's eligible age range should have cervical cytology performed as per the general population, however any cytological abnormality should be treated as high grade dyskaryosis and referred for colposcopy.

Management at colposcopy should be as per the general population as should follow-up and surveillance post-colposcopy.

All women about to undergo renal transplantation should have had cervical cytology performed within one year.

5C.181.4 Women on cytotoxic therapy for rheumatological disorders

Women receiving long-term cytotoxic treatment for rheumatological or autoimmune disorders should have screening as per the general population.

If the screening history is incomplete at commencement of treatment, they should have cervical screening, with colposcopic referral for any degree of abnormality.

5C.181.5 Women otherwise immunosuppressed

The following groups of women should receive cervical screening and referral to colposcopy as per the general population: -

- Women receiving cytotoxic chemotherapy for non-genital cancers
- Women receiving long term steroids
- Women receiving oestrogen antagonists such as tamoxifen
- Women with multifocal disease including vulval, vaginal and anal intra-epithelial neoplasia should be managed in a centre with expertise in this area

5C.190 INFORMATION AND COMMUNICATION

5C.190.1 Information to Women

All women must receive a personalised invitation letter prior to first visit. This must include:

- Date and time of appointment
- Location (include map)
- Contact telephone numbers for advice and administration

Verbal or written consent should be recorded.

Each clinic will provide a named contact nurse to handle queries from women.

The results of procedures undertaken and management plan should be notified to the woman as soon as practicable. This should include inpatient visits.

Where the woman receives her results and management plan verbally this should be confirmed in writing to the woman.

All women requiring treatment must have their treatment explained and receive the CSW leaflet 'Treatment following an abnormal cervical smear'.

Some clinics may choose to send this leaflet before the first appointment if 'select and treat' is offered.

Where 'select and treat' is offered, the woman must be fully counselled regarding treatment prior to proceeding to treat.

Following each visit the woman should be issued with both verbal and written advice on general care, the likelihood of common side effects or complications, and how to deal with these.

Each clinic should issue the woman with written contact numbers at the end of each visit for both clinical advice and administration. These should include:

- Who to contact out of hours
- Times when the contact numbers are manned

Each service should have access to information for minority groups, the visually impaired, the deaf and women with learning disabilities, in either written form or by use of interpreters or a woman advocate.

Each service must nominate a named administrative contact and deputies, to liaise with the CSAD and clinics.

5C.190.2 Information to General Practitioners and Referring Practitioners

The Colposcopy service must notify General Practitioners and sender (if not the General Practitioner), in writing, within 4 weeks in 90% and within 8 weeks in 100% of the woman's Colposcopy Service visit of:

- attendance, results and management plans
- discharge from colposcopy service
- all non-attendance for colposcopy, treatment or follow up

5C.190.3 Information to CSADs

The Colposcopy Service must notify the CSAD of a woman's appointment which may include the following information:

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

5C.190.4 Liaison with Other Services

Communication links should be developed and maintained between cytology, histology and colposcopy services.

Multidisciplinary meetings should be held at least monthly (see 5C.195 Multidisciplinary Team Meetings).

Complicated or difficult clinical cases should always be discussed with the lead colposcopist as and when they arise preferably before treatment.

5C.190.5 Dealing with Requests from the Public

All requests for information should be managed in accordance with the CSW 'Release of Information Policy'.

Results and management plans are only discussed with the woman.

Requests for information from solicitors or insurance agencies may only be given with the written and signed consent of woman.

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

Before information is released staff must be satisfied that the signature is genuine.

The Regional Programme Coordinator must be informed if a disclosure is requested which relates to Cervical Screening Wales.

Complaints and their appropriate responses should be discussed with the Director of Screening Services.

5C.195 MULTIDISCIPLINARY TEAM MEETINGS

Multidisciplinary case discussion is an essential part of the woman management process ensuring that appropriate care is in place for complex colposcopy cases and cases where there is a lack of correlation between the outcome of colposcopy and cytology, or other diagnostic or management dilemmas that may require further discussion.

5C.195.1 Quality Standard

The requirement for multidisciplinary case discussion is an essential part of the governance process.

5C.195.2 Responsibility

Overall responsibility for the processes involving MDT activity will normally lie with the lead colposcopist for the service.

The responsibility for the operational organisation of MDT meetings may be delegated to a Team Organiser by the Lead Colposcopist as appropriate to the individual service.

5C.195.3 Composition of Multidisciplinary team

The Lead Colposcopist, designated Team Organiser or authorised alternate will chair the MDT review meetings.

The review team should include:

- The Lead Pathologist
- The Lead Cytologist (if different)
- Colposcopists working within the service.
- The Lead Colposcopy Nurse
- Other pathology, cytology and nursing staff
- Clerical support for the meeting should be included (see 5C.20 Education and Training)

All staff present should sign a register of attendance.

The Team Organiser may be the Regional Programme Coordinator or an accredited colposcopist other than the lead. The minimum staff required must include a colposcopist (Lead or Team Organiser) and a pathologist.

5C.195.4 Frequency of meetings

MDT meetings must be conducted. The frequency of MDT meetings must be appropriate to allow for the expected case load and at least quarterly. More frequent meetings may be appropriate

for larger colposcopy services to ensure timely management decisions for women.

5C.195.5 Cases

The number of cases reviewed at each meeting may depend on the complexity of the case mix.

The case load may vary between colposcopy services and will be influenced by the frequency of meetings.

5C.195.6 Prioritising cases for review

Cases where there is no correlation between referral cytology and colposcopic impression and/or histology should normally be given priority over other cases such as management problems or unexpected results eg low grade cytology, high grade histology.

The Colposcopy Service in conjunction with the Pathology Service will determine the cases for review; appropriate cases are:

- Discrepancies of at least 2 grades between the referral cytology and pathology results
- Glandular abnormalities requiring management decisions, including ?glandular neoplasia and borderline glandular neoplasia (including those without evidence of CGIN/CIN or carcinoma)
- Other complex or interesting cases added at the request of MDT members

Review cases will include queries generated by the Colposcopy Highlight Rules (CHR) and referred by the Regional Programme Coordinator.

All management dilemmas must be resolved before a woman may be discharged from the colposcopy service.

Cancer cases must be discussed in the local or regional cancer MDT meetings but may be included for review in the local colposcopy MDT.

5C.195.7 Presentation of cases and MDT Support

A proforma must be completed for each case presented and should include the woman's identification, a summary of the case history and reason for review.

The name of the person requesting the review should also be recorded.

The review process must be supported by suitable clerical and secretarial support with an administrative process that documents cytology, pathology and colposcopy opinions, the decision of the MDT and subsequent management recommendations.

5C.195.8 Outcome of MDT review

Outcome of the MDT discussion must be:

- Logged on each woman's case record
- Entered onto CANISC. This should include a detailed management plan
- Forwarded as a management plan to the woman's General Practitioner
- Notified to the CSW Regional Programme Coordinator
- Notified to the woman if this affects her management

Any changes to her original management plan must be appropriately actioned.

Any amendments to cytology or histology reports must be agreed with the original reporting cytologist or pathologist.

A supplementary report:

- Must be provided for the woman's case record
- Must be sent to the local CSW Regional Programme Coordinator
- Must be sent to the woman's General Practitioner
- Must be sent to the smear taker where appropriate

All appropriate computerised records must be amended. This will include:

- Pathology LIMS
- CANISC
- CSAD NHAIS/Exeter

A schedule for review of all management plans must be in place to ensure that the appropriate action has been undertaken and that information is supplied to all who need to know. This is the responsibility of the clinician responsible for the woman's care.

5C.195.9 MDT Enquiries Generated by Colposcopy Rules (See 3A.361)

Colposcopy Highlight Rules (CHR) ensure that a query is generated by the 'Exeter system' when a woman's colposcopic management or discharge from colposcopy is at variance with the CSW recommended management or colposcopy SOPPs.

When a query is generated the Regional Programme Coordinator will check the woman's record to determine that all relevant information has been received and entered on the Exeter system.

This may include:

- Obtaining and checking histology reports
- Contacting pathology services, Colposcopy Services or General Practitioners

Any additional or new information is added to the woman's record and the rule is reviewed.

If the woman appears to have been managed appropriately according to colposcopy SOPPs, or additional information indicates clinical management is acceptable, the rule is considered inappropriate and is deleted.

If the woman has been managed outwith CSW guidance and there is no clinical explanation the rule is considered appropriate and further investigated.

The Regional Programme Coordinator may need to contact the Colposcopy Service to:

- Confirm management details
- Explain reason for enquiry
- Request information or further action
- Request outcome of any clinico-pathological discussions (discrepancy discussion)
- Request MDT referral if not already undertaken

The Regional Programme Coordinator must be informed of the outcome in writing of any queries passed to the MDT.

5C.200 QUALITY MANAGEMENT

Colposcopy services are assessed by monitoring colposcopy activity and performance as detailed in Appendix 1.

The information specified is produced by CSW on a routine basis using CANISC.

5C.200.1 Use of Monitoring Data

All registered colposcopists will receive data relating to their individual practice. This will also provide the minimum information requirements for registration with the BSCCP.

Lead colposcopists will receive data relating to their service.

The QA colposcopist, Programme Manager and Regional Programme Coordinators will receive routine monitoring reports of both the clinics and individual colposcopists.

Queries over results may be discussed with the QA colposcopist and Programme Manager.

Overall colposcopy performance data will be assessed at the All Wales Management Group (AWMG).

The performance of colposcopy services will be considered at regional CSW Local Management Groups (LMGs).

Quality assurance is designed to ensure a satisfactory service. Colposcopy datasets are designed to identify any performance issues within care pathways and identify the cause so that appropriate action can be suggested.

The information published by CSW is based on the requirements of the KC65 colposcopy return. This enables a valid comparison of All Wales data to be made with national service trends published by the NHSCSP.

It is recognised by CSW that the data produced are only an indicator of the performance of an individual or of a service. The data must be interpreted in relation to local situations and factors. A two way cooperative relationship is vital to a full understanding of the data.

Performance issues which have the potential to affect the care and management of women or performance which may compromise the service delivered must be identified to CSW.

5C.200.2 Poor Performance

Suboptimal performance does not necessarily indicate that woman safety has been put at risk although harm could subsequently develop without appropriate correction.

If a potential problem is identified a scoping meeting will be arranged by CSW.

Following the initial scoping meeting, a formal investigation may be initiated at the discretion of the QA team.

If following a formal investigation, corrective action is necessary, this will be initiated by the service provider in consultation with CSW.

The CSW and LHB risk management groups will be informed of performance issues.

5C.200.3 Investigating Incidents

All incidents must be recorded and reported to CSW as well as following local service policies.

The action required when an incident is suspected is defined in Screening Services documentation.

A decision may be made to set up a formal incident team following the Screening Services Incident Reporting Procedure if the service or woman is at risk or harm has resulted from potentially inappropriate care.

5C.200.4 Risk Management Procedures

The role of CSW and the LHB are defined in the LTAs established between the two parties. This is a mechanism for enacting clinical governance procedures.

Regular meetings of the RMG will assess strategies to avoid substandard performance developing into an incident requiring a formal incident enquiry.

Suggested changes of practice defined by the RMG will be incorporated into SOPPs.

5C.200.5 Contingency Planning

The LHB is expected to maintain the established level of staffing, to ensure that the level of service does not deteriorate.

Issues of staff shortfalls due to sickness or termination of employment must be addressed locally with the lead colposcopist within the relevant directorate or LHB.

CSW must be informed via the Programme Manager if a resolution is not quickly achieved as a failure to maintain adequate staffing is a significant risk to the service.

5C.230 EMERGENCY RESUSCITATION

There is a remote possibility of bradycardia or cardiac arrest during colposcopic examination, particularly whilst providing local infiltration to the cervix prior to treatment. All staff should be alert to this possibility and be trained in the appropriate action to take if this occurs.

An appropriate protocol must be displayed in the clinic which includes:

- A clear indication of the emergency number for the cardiac arrest team
- The name of the identified first aider for the clinic

All staff within the colposcopy service should be aware of the potential risk.

The lead colposcopy nurse must ensure that there is a resuscitation box in the treatment room and that it is regularly checked.

Clinical staff must attend an emergency resuscitation course (CPR) determined by local policy. The local policy must identify appropriate measures, which should include refresher training, to ensure maintenance of competence.

5CA.10 RECEIVING REFERRALS FROM THE CERVICAL SCREENING ADMINISTRATION DEPARTMENT (CSAD)

5CA.10.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Colposcopy Coordinators

CSAD Officer

QA Advisor

Head of Administration

5CA.10.2 Quality Standard

All women with a new abnormal or inadequate 'S' coded result are referred to the appropriate Colposcopy Service within 5 working days of the result arriving at the CSAD.

All referrals received at the Colposcopy Service are date stamped and entered onto CANISC within 2 working days of receipt at the Colposcopy Service.

5CA.10.3 Method

1. Action taken by Cervical Screening Administration Departments

Letters giving the details of women requiring colposcopy appointments are produced by the local CSAD on a daily basis. These are sent to a named contact in the Colposcopy Service by first class post. All letters are accompanied by a copy of the smear report form and any screening/referral/biopsy history.

Urgent referrals requiring an appointment within 2 weeks (see 5C.20) will be notified to CSAD by laboratory via telephone and fax. CSAD will in turn telephone the Colposcopy Service and notify them that an immediate 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.

It is the responsibility of the CSAD to confirm that the requests have been received by the Colposcopy Service by checking that the referral details have been entered and an appointment has been made on CANISC. If the requests have not been recorded as received within 3 working days, the CSAD will contact the clinic coordinator to establish whether the referral has been received. If the referral has not been received by the Colposcopy

Service, the CSAD will print off duplicate letters and mark all these letters as 'duplicate - original not received by clinic' and re-send to the clinic.

The letters contain the following details:

- Name
- Address and postcode
- Date of birth
- NHS number
- Registered GP
- Date of sample
- Previous sample result/referral/biopsy history (if appropriate)

Information sent in the letter to the registered GP and smear taker (if different to registered GP) by the CSAD:

- Notification of the referral
- Opportunity to alter the referral by contacting the CSAD
- Request that any relevant information about the woman should be sent directly to the Colposcopy Service

2. Action taken by the Colposcopy Service

All referrals are directed to the clinic coordinator.

- All referrals are date stamped and entered onto CANISC within 2 working days of receipt by the Colposcopy Service

Occasionally, colposcopy may receive the same referral twice from CSAD and the GP. In these cases only ONE referral must be logged and the date from the CSW direct referral letter must be recorded but the GP referral should be checked for any additional information.

5CA.10.4 Quality Measures

100% of referrals received at the Colposcopy Service are date stamped and entered onto CANISC within 2 working days of receipt by the Colposcopy Service.

100% of referrals sent to the Colposcopy Service are checked for receipt by the CSAD.

5CA.10.5 Quality Control/Audit

CSW information reports for colposcopy

5CA.10.6 Further Guidance

5C.60 Managing Non attenders, DNAs and Cancellations

Refer to CANISC User Guide

Section: When to add a new disease episode or a new referral

Section: Booking Appointments

Section: Booking a woman into Clinic

5CA.20 DEALING WITH REFERRAL ALTERATIONS

5CA.20.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.20.2 Quality Standard

All requests for a change to a referral are dealt with in line with CSW policy by the local CSAD and Colposcopy Services.

5CA.20.3 Method

GPs or other referring practitioners are free to arrange colposcopy appointments to alternative clinics at the request of the woman. All referral alterations must be notified to the CSAD for appropriate action to be taken.

1. Action taken by the CSAD

On receipt of a request for a change in referral from a woman's GP the CSAD will telephone the Colposcopy Service to check whether an appointment has already been issued to the woman.

If an appointment has not yet been issued, the CSAD will send the change of referral letter to the Colposcopy Service and to the woman and her GP.

If however an appointment has been sent to the woman, the CSAD will telephone the GP to confirm that the change is still required. If the change is to proceed, the CSAD will issue the change of referral letter to the GP, to the woman and to the Colposcopy Service.

The CSAD will arrange the referral to the new clinic and will copy all relevant documentation with the new referral (ie copy of referring HMR form).

2. Action taken by Colposcopy Service

On receipt of a change of referral letter from the CSAD the Colposcopy Service will immediately cancel the woman's appointment and discharge the woman from the clinic.

The appointment must be marked as being cancelled at the woman's request.

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

5CA.20.4 Quality Measures

100% of clinic re-referrals are actioned via CSAD

5CA.20.5 Quality Control/Audit

To be developed

5CA.20.6 Further Guidance

Refer to CANISC User Guide

Section: Running a Clinic

5CA.30 ACTIONING REFERRALS RECEIVED FROM CSAD

5CA.30.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.30.2 Quality Standard

All women referred for colposcopy must have their first appointment in a timely manner, in line with CSW Policy and Standards.

5CA.30.3 Method

1. Referral Categories

Referrals may be categorised as CSW or non CSW.

CSW categorises referrals as immediate, urgent or routine.

Non CSW referrals should be seen by the lead colposcopist to assess their appropriateness for colposcopic examination and to determine their urgency.

Immediate Referral

An appointment should be offered within 2 weeks of receipt of referral by the colposcopy service in the following cases:

- Where invasion is suspected on a cervical smear
- Where abnormal glandular cells have been reported on a cervical smear
- Where invasion is clinically suspected by the referring practitioner

Urgent Referral

An appointment should be offered within 4 weeks of receipt of referral by the colposcopy service in the following cases:

- Where moderate or severe dyskaryosis is reported on a cervical smear
- Where borderline ?high grade dyskaryosis is reported on a cervical smear
- Where borderline endometrial cells are reported on a cervical smear
- Where high grade dyskaryosis cannot be cytologically excluded on a cervical smear
- Abnormal endometrial cells of any grade should always be reported with a recommendation for urgent direct referral to colposcopy

Routine Referral

An appointment should be offered within 8 weeks of receipt of referral by the colposcopy service in the following cases:

- Where low grade dyskaryosis is reported on a cervical smear
- For women with persistent cytologically inadequate smears

2. Actioning a Referral

Colposcopy Services are advised to keep a receipt log of referrals received from the CSAD to ensure that all referrals received are recorded on CANISC.

Searching CANISC for a woman

The clinic coordinator will check the CANISC system to see if there are previous records for the woman either by searching on the woman number or by using the Woman Master Index (PMI).

Entering details against a new woman

Using the Administration menu, choose Referral, choose New woman, the wizard takes you to the PMI search before adding a new case note.

Woman registration details and clinical history are entered on to the CANISC system and an appointment letter created for the woman.

NB: An INTENDED visit type must be entered for each woman when an appointment is created.

3. Appointment Types – see 5CA.30

Select whether the appointment is for a new woman or a follow up visit.

Appointment letter and leaflet is sent to woman.

Depending on where the referral has originated the following must be recorded on CANISC:

- GP for all referrals originating from the woman's GP
- Senior partner for all referrals originating from a practice nurse
- Clinical person in charge or consultant in charge for all referrals received from gynaecology

5CA.30.4 Quality Measures

- **Routine Referrals:** >90% to be seen in less than 8 weeks from the date of receipt of referral by the colposcopy service
- **Urgent Referrals:** > 90% to be seen in less than 4 weeks from the date of receipt of referral by the colposcopy service
- **Immediate Referrals:** must be seen in 2 weeks from the date of receipt of referral by the colposcopy service
- 100% of appointments have the INTENDED visit type entered on CANISC

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 appointments record whether the visit is for a new woman or a follow up visit

5CA.30.5 Quality Control/Audit

CSW Information reports for colposcopy

5CA.30.6 Further Guidance

Colposcopy quality manual

Refer to CANISC User Guide

Section: Identifying a woman on CANISC

Section: Adding a new disease episode or a new referral

Section: Add a new woman

Section: Booking Appointments

Section: Booking a woman into Clinic

5CA.40 APPOINTMENTS AND VISIT TYPES

5CA.40.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.40.2 Quality Standard

All appointments are prioritised by the clinic coordinator and the accredited colposcopist is consulted where there is uncertainty.

The appointments must include the date, time and location (insert map) of visit together with contact telephone numbers for advice or administrative queries.

All appointment letters must be generated from the CANISC system, even where the trust may operate a partial booking system.

Appointment letters must be sent to the woman within 1 working day of the appointment being created on CANISC.

5CA.40.3 Method

Referrals may be categorised as CSW or non CSW.

CSW categorises referrals as immediate, urgent or routine.

Non CSW referrals should be seen by the lead colposcopist to assess their appropriateness for colposcopic examination and to determine their urgency.

Immediate Referral

An appointment should be offered within 2 weeks of receipt of referral by the colposcopy service in the following cases:

- Where invasion is suspected on a cervical smear
- Where abnormal glandular cells have been reported on a cervical smear
- Where invasion is clinically suspected by the referring practitioner

Urgent Referral

An appointment should be offered within 4 weeks of receipt of referral by the colposcopy service in the following cases:

- Where moderate or severe dyskaryosis is reported on a cervical smear

- Where borderline ?high grade dyskaryosis is reported on a cervical smear
- Where borderline endometrial cells are reported on a cervical smear
- Where high grade dyskaryosis cannot be cytologically excluded on a cervical smear

Routine Referral

An appointment should be offered within 8 weeks of receipt of referral by the colposcopy service in the following cases:

- Where low grade dyskaryosis is reported on a cervical smear
- For women with persistent cytologically inadequate smears

Appointment Types

All women have an intended and actual visit type. It is essential that both types are appropriately reported on CANISC. The appointment types are as follows:

Colposcopic Assessment

Follows a new referral to the colposcopy service for a colposcopic examination with or without a punch biopsy/smear

Select and Treat

Where treatment is undertaken at the colposcopic assessment visit, see section below:

Planned Treatment

Follows a previous colposcopic assessment where the results have indicated that treatment is necessary. The intention is to treat at this visit. Treatment needs to be appropriate to the extent and grade of disease present and may be performed either under local or general anaesthetic.

Types include:

- Cryotherapy
- Cold coagulation
- Laser
- LLETZ
- LLETZ + Laser
- LLETZ
- Knife cone biopsy

Non Treatment Colposcopic Follow Up

Follows a previous colposcopic assessment where results have indicated treatment is not necessary. This comprises colposcopic examination with or without biopsy/smear and is appropriate for:

- Review of untreated CIN1
- Current pregnancy

- cases not requiring immediate treatment at the discretion of the colposcopist/MDT

Post Treatment Colposcopic Follow up

Follows a previous treatment episode. This comprises colposcopic examination with or without a biopsy but including a smear. This includes all colposcopic follow up examinations within a treatment episode, and is appropriate for:

- Follow up of incompletely excised CIN2/3 or where margin status is unclear or unspecified
- Follow up of CGIN
- Follow up CIN2/3 treated by ablation

Smear Only

Any visit within the colposcopy setting where a smear is taken without a colposcopic examination. A genital swab may be taken at this time.

Swab Only

Any visit within the colposcopy setting where a swab is taken without a colposcopic examination.

Consultation only

Any visit within the colposcopy setting where no examination is undertaken. The woman may be invited to discuss her results or condition.

Post Colposcopy Complication

Any communication regarding a complication following a colposcopic episode.

Patient Focused Booking

CSW recognises the need to offer choice to women in attending colposcopy appointments but also needs to ensure that timescales for referrals are met and flexibility of appointment to clinics is maintained.

In order to meet all these criteria CSW's position is that patient focused booking should operate in the following way:

- Colposcopy services will offer an appointment date and time within the standard timescales but must make it clear that women have the option to change their appointment by contacting the clinic
- If colposcopy booking services are not available daily, the letter must clearly state when they can make contact
- Colposcopy services need to issue appointment letters from CANISC but liaise with the local service provider as to what information needs to be recorded on local patient administration systems (PAS)

The Colposcopy Service must query any information on the PAS system which differs from the referral information received from the CSAD. The Colposcopy Service must not alter information on CANISC or send out appointment details before the query is resolved.

Appointment letter and clinic information

Once an appointment has been booked, an appointment letter is printed from CANISC and sent within 1 working day of the appointment being created. If appropriate an information leaflet must be inserted with the appointment and any details for the local clinic.

All appointment letters produced from CANISC should be checked for accuracy before being sent to the woman.

Amendments

Amending a visit type, attendance status, discharge details or any specimen/result details has implications on the FailSafe process and the colposcopy service staff must notify the CSAD of any details that have been amended.

5CA.40.4 Quality Measures

- 100% of appointment letters are generated from CANISC
- All clinics must have a locally agreed appointment procedures with their local trust
- 100% of appointment letters are sent to women within 1 working day of the appointment being created on CANISC

5CA.40.5 Quality Control/Audit

- CSAD check lists of all referrals entered on CANISC and identifies discrepancies

5CA.40.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: Booking Appointments (Page 77)

Section: Booking a Woman into Clinic

Section: Printing Colposcopy Letters

5CA.50 PREPARING PAPERWORK FOR A CLINIC

5CA.50.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.50.2 Quality Standard

All clinic paperwork is prepared well in advance of the clinic date and must contain a copy of the woman's smear report, past screening history, CANISC proforma and clinic list.

5CA.50.3 Method

Following the booking of an appointment and the printing of an appointment letter the clinic coordinator must ensure that:

- Information is added to CANISC and to the woman's hospital notes. Some hospitals operate a system of separate colposcopy notes or sectionalised woman's records
- A copy of the woman's smear report and past history is inserted in the case records. If the actual smear report is not available the clerk should contact the CSAD
- The case notes are filed in clinic date order or as local procedures by the clinic coordinator

Prior to a woman attending colposcopy

The clinic coordinator will ensure that the clinic list, CANISC proforma and notes for a particular day, are sent to the clinic receptionist well in advance of the clinic. If any appointment details change from the time the clinic list has been sent, the clinic coordinator must inform the receptionist and ask her to update the clinic list manually. The clinic coordinator will then update the information on CANISC as required.

Tracking Notes

A system should be in place to ensure that when the notes are removed from clinic these can be tracked. This may be achieved by maintaining a record of removed notes and regularly checking status to ensure these are returned.

5CA.50.4 Quality Measures

100% of clinic paperwork prepared in advance of clinic and contains a copy of the woman's smear report, past screening history, CANISC proforma and clinic list.

5CA.50.5 Quality Control/Audit

To be developed

5CA.50.6 Further Guidance

CANISC User Guide – Colposcopy Administration

Section: Printing a Clinic List (Page 99)

Section: Printing a Proforma (Page 113)

5CA.60 DEALING WITH WOMEN ATTENDING THEIR FIRST OR FOLLOW UP APPOINTMENT (NOT TREATMENT)

5CA.60.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.60.2 Quality Standard

All women who attend clinic will have the standard proforma completed by a colposcopist or nurse colposcopist. This information will be entered onto the CANISC system within 2 working days of the clinic.

5CA.60.3 Method

After a woman has attended Colposcopy Service the clinic coordinator will note her attendance either on a paper clinic list or on CANISC (dependent on local procedure).

The clinician will complete the following information for each woman's visit either by directly inputting into CANISC or filling in an CANISC proforma for the clinic coordinator to enter at a later time (depending on local procedure).

The CANISC proforma should include the following information:

- Clinic date
- Woman's ID details
- Latest available sample date and result
- Clinical History
- Colposcopist code and accreditation status
- Supervising colposcopist code (if applicable)
- Examination details
- Details of cervical/vaginal/vulval lesion
- Investigations
- Treatment
- Complications
- Visit type
- Future management plans
- Next appointment date

NB: The visit type at this stage will be the ACTUAL visit type which is a mandatory field on CANISC. An INTENDED visit type will have previously been entered for each woman in a separate field.

At the end of the consultation, hard copies of the history and examination findings are placed in the woman's case notes and recorded on CANISC. Correspondence is sent to the general practitioner and/or other referring clinician, to the CSAD and to the woman when the results of investigations (eg smears, biopsies and swabs) are available. If no tests are taken then the appropriate correspondence should be sent out within 2 working days of the clinic.

The attendance status for each woman must be recorded and entered onto CANISC within 1 working day of the clinic.

If it was the woman's first appointment and she will need to return to the clinic the notes must be filed in 'results awaiting' by the next clinic date. The clinic notes will be checked weekly. If no results have been received within a week of the test being taken, the clinic coordinator must inform the colposcopist of any delays.

Entering biopsies – when a multiple punch biopsy is taken as one sample and the pieces entered into one pot, this is treated as one biopsy (not multiple). More than one histology result can be added to a sample, without having to enter the sample multiple times.

Supervising colposcopist – all trainee colposcopists that have seen the woman and been supervised by another clinician must be recorded appropriately on CANISC. For purposes of BSCCP accreditation, the woman will count both towards the figures for the trainee and the figures for the supervisor.

DNA appointment – see 5CA.90 Women who do not attend.

Cancelled clinic – if a clinic is cancelled by the hospital, the attendance status must not be entered as DNA but entered as a 'hospital cancelled appointment'.

5CA.60.4 Quality Measures

- 100% of women attending clinic will have a proforma completed for them (either paper or electronic)
- 100% of paper proformas must be entered onto CANISC within 2 working days of the clinic
- 100% of attendance status must be recorded on CANISC within 1 working day of the clinic
- 100% of records of women who have attended must have the ACTUAL visit type field completed on CANISC

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 records of women who have attended must have the Colposcopist CSW ID code completed on CANISC

5CA.60.5 Quality Control/Audit

CSW Information reports for Colposcopy

5CA.60.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY CLINICAL DATA

Section: Add Colposcopy Clinical Proforma Data (Page 4)

Section: Running a Clinic (Page 98)

Section: Booking a Woman into Clinic (Page 99)

5CA.70 DEALING WITH BIOPSY RESULTS

5CA.70.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.70.2 Quality Standard

All biopsy results must be seen and authorised by a colposcopist before entering on to CANISC.

All biopsy results are placed in the woman's notes and must be authorised by a colposcopist within 5 working days of receipt. These should be entered onto CANISC within 2 working days of authorisation by a colposcopist and prior to the woman's next appointment.

5CA.70.3 Method

The colposcopist will either enter the result onto CANISC directly or sign the paper copy of the results to confirm that the result can be entered onto CANISC.

If the colposcopist is in a training position or is junior, the records need to be reviewed by a more senior colposcopist.

5CA.70.4 Quality Measures

- 100% of biopsies should be authorised by a colposcopist within 5 working days of receipt
- 100% of authorised biopsies should be entered onto CANISC within 2 working days of authorisation

5CA.70.5 Quality Control/Audit

Routine monitoring processes

5CA.70.6 Further Guidance

5CA.80 TREATMENT APPOINTMENTS

5CA.80.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.80.2 Quality Standard

All appropriate information must be prepared prior to the appointment to ensure this is available to the colposcopist at the time of the visit.

Where treatment is carried out under general anaesthetic a system must be in place to ensure that notes and information are returned to the colposcopy service in a timely manner. This may be achieved by maintaining a record of removed notes and regularly checking status to ensure these are returned. GA visits must be entered onto CANISC.

The woman and her General Practitioner are informed in writing of the results and proposed management plan.

5CA.80.3 Method

A log is kept by the clinic coordinator and is checked on a weekly basis to identify any treatment information which has not been returned to the colposcopy service. During the clinic or following attendance, the CANISC system is updated by the colposcopist directly or by the clinic coordinator using the CANISC proforma within 2 working days of the clinic.

Actual visit type and Colposcopist name must be entered onto CANISC (mandatory field).

For non attenders see 5C.90.

If a biopsy is taken at the treatment appointment the clinic coordinator must file the woman's notes in 'results awaited following treatment' and check on a weekly basis.

5CA.80.4 Quality Measures

- 100% of appropriate information must be prepared and made available prior to the appointment

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 all records must be updated following treatment in a timely manner
- The woman's GP and the CSAD will be informed of the treatment and the results of any biopsies in 100% of cases

5CA.80.5 Quality Control/Audit

To be developed

5CA.80.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: Booking appointments (Page 77)

Section: Printing Colposcopy Letters (Page 89)

Section: Investigations /Samples (Page 116)

Refer to CANISC USER GUIDE User Guide COLPOSCOPY CLINICAL DATA

Section: Add Colposcopy Clinical Proforma Data (Page 4)

Section: Investigations /Samples (Page 27)

5CA.90 WOMEN WHO DO NOT ATTEND AND CANCELLATIONS

5CA.90.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.90.2 Quality Standard

All cancelled and or non attended appointments will be actioned in a consistent way to encourage attendance and ensure records of women are not actioned appropriately.

5CA.90.3 Method

Cancelled Appointments

A cancellation can be initiated by either the woman or clinic, either at the time of, or prior to the clinic. The reason for the cancellation should be recorded by the clinic:

- If the woman cancels her appointment **up to 1 day before or on the day of the appointment**, this will not result in her being entered onto ColpSafe
- The woman should be offered an immediate re-appointment
- If the clinic is cancelled by the hospital attendance status must not be entered as DNA but entered as hospital cancelled appointment. The woman is reappointed

Defaulted Appointment

Woman did not attend (DNA)

A defaulted appointment (DNA) is defined as:

- No advance warning
- No reason for non-attendance

This is also the appropriate terminology when the woman rings on any day **following** her appointment. All information regarding default must be added to the CANISC.

All defaulting woman records must be reviewed by the colposcopist before action is taken. The colposcopist will assess the woman's condition and recommend further action/appointment. The action taken will depend upon:

- The type of visit

- Whether the woman has previously been a non-attender
- The woman's cytological and clinical history

The action taken is documented on the woman's CANISC records. Where an individual woman's history or results confirm or suggest invasion or give cause for concern, direct intervention may be required by telephoning the General Practitioner and initiating CSW ColpSafe.

Action for Defaulters

- Assessment
- All treatment
- Colposcopic follow up

When a woman defaults her first appointment

1st non-attendance - Reappoint

- A letter is sent to the defaulting woman, including her new appointment date
- All information regarding her default must be added to CANISC

2nd consecutive non-attendance - do not reappoint:

- Discharge woman on CANISC to CSAD with recommendation for ColpSafe inclusion
- The woman is notified in writing of discharge from clinic
- The General Practitioner is notified in writing of discharge from clinic
- All information regarding her default must be added to CANISC
- The woman is entered into the ColpSafe scheme

Action for Defaulters - Consultation Appointment

- Treatment follow up or discharge from the colposcopy service is planned as if the woman had the results or discussion appointment
- The woman and her General Practitioner are informed in writing of the results and proposed management plan
- All information must be added to CANISC

Action for Defaulters – Smear Only Appointments

When a woman defaults her smear appointment the colposcopist will check her records to ensure she does not need any further colposcopic examination, the woman is then discharged to the care of her General Practitioner for follow up cytology:

- Letter is sent to the defaulting woman advising of action
- Letter sent to General Practitioner
- Information is added to CANISC

If the colposcopist considers it appropriate for her to remain within the colposcopy service she should be managed as 5C.60.5.

Women who have smears in the community who have not been discharged from colposcopy

- CSAD informs colposcopy service of result
- Colposcopist to advise on further action

Cancelled clinic – if a clinic is cancelled by the hospital the attendance status must not be entered as DNA but entered as a ‘hospital cancelled appointment’.

Action at CSAD

When a woman has DNA’d two consecutive appointments and is discharged to CSAD her details are recorded on ColpSafe (part of Exeter) and the following action is automatically taken:

| TIMESCALE | ACTION |
|---------------------------------|---|
| 0 months | CSAD are notified of woman’s 2nd DNA and a ColpSafe episode is automatically created. Letter is sent to the woman together with a form for the woman to return. A copy is also sent to her GP with a covering letter. |
| 4 weeks after first letter sent | Query letter is sent to the woman’s GP |
| 9 weeks after first letter sent | Regional Programme Coordinator will review each record and decide on one of the following options: <ul style="list-style-type: none">▪ Send the disclaimer letter with a copy to the GP▪ Send a personal letter to the woman▪ Return the woman to colposcopy service▪ If the disclaimer letter is sent, the woman is re-invited for the next recall date by CSAD |

If a woman informs CSAD that she wishes to attend colposcopy at any point after she has entered ColpSafe the CSAD will:

- Re-refer the woman to the Colposcopy Service or another clinic of her choice
- Send the original report form and screening history to the clinic with the referral

The Colposcopy Service will:

- Treat the re-referral as a new referral
- Record the reason for referral on CANISC as “ColpSafe re-referral by CSAD”
- Enter the new referral data and new referral received date but keep the original referral sample date and result.
- The intended visit type must reflect her previous intended visit type
- The woman would need to fail to attend another TWO consecutive appointments before she is discharged to ColpSafe

5CA.90.4 Quality Measures

100% of women who have two consecutive DNA's will be discharged to CSAD and entered into ColpSafe

5CA.90.5 Quality Control/Audit

CSW Information Reports on DNA and cancellation rates

5CA.90.6 Further Guidance

CSAD Quality Manual – 6A.240

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: Printing from the Woman Specific Menu (Page 91)

Section: Running a clinic (mark a woman as a DNA) (Page 98)

Section: Printing letters (to woman and GP) (Page 89)

Section: Booking appointments (Page 77)

Refer to CANISC USER GUIDE User Guide COLPOSCOPY CLINICAL DATA

Section: Adding Colposcopy Clinical Proforma Data - Management Tab (to discharge a woman) (Page 4)

5CA.100 DISCHARGING WOMEN FROM COLPOSCOPY

5CA.100.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.100.2 Quality Standard

All women who are offered a colposcopy appointment are discharged from the clinic with an appropriate reason and within appropriate timescales in line with CSW policy.

All results and future management plans must be communicated in writing to the woman and her GP within 4 weeks of receipt of the result.

5CA.100.3 Method

The woman must only be discharged from the colposcopy service for one of the following reasons:

- If results are negative or borderline and there is no indication for the woman to remain within the colposcopy service
- The woman has DNA'd a second consecutive appointment and has failed to contact the clinic (will be included in the CSAD 'ColpSafe' programme)
- The woman requests a change of Colposcopy Service
- The woman moves to another area
- The woman is discharged to a gynaecologist /oncologist for further care
- The woman dies
- The woman's original referral was made in error
- At the woman's request
- Where the colposcopist considers that the woman may be appropriately followed up in the community (see 5C.150)

The woman, General Practitioner and CSAD must be notified of discharge from colposcopy service.

Prior to discharging a woman her identification details (name, dob and address) are checked by the clinic coordinator against paper records to ensure accuracy.

Once discharged, a woman's records should be archived. These must be retrievable.

Onward referral to gynaecology/oncology:

- If a woman is referred by the Colposcopy Service to a gynaecologist/oncologist for gynaecological care but is due to be seen again in the Colposcopy Service then the woman will be recorded as 'REFERRED elsewhere (specify)' on CANISC
- If the woman is not expected to be seen again in the Colposcopy Service then she must be recorded as 'DISCHARGED elsewhere (specify)' or 'DISCHARGED for cancer treatment' on CANISC

The CSAD will not discharge the woman from the SafetyNet system until they have received confirmation that a woman's referral has been received in gynaecology/oncology and that she is actually leaving colposcopy care. Colposcopy must send written confirmation to the CSAD after confirming receipt of referral with gynaecology/oncology.

5CA.100.4 Quality Measures

- 100% women discharged from colposcopy are done so appropriately
- 100% of women should be informed of their results within 8 weeks
- At least 90% of women should be informed of their results within 4 weeks of attendance at clinic

5CA.100.5 Quality Control/Audit

CSW Information Reports

5CA.100.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY CLINICAL DATA

Section: Add Colposcopy Clinical Proforma Data (Page 4)

Section: Add Colposcopy Clinical Proforma Data – Management tab (Page 13)

Section: Investigations /Samples (Page 27)

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: Printing Colposcopy Letters (Page 89)

Section: Admitting or discharging a woman to a ward (Page 104)

Section: Investigations /Samples (Page 116)

5C.80 Explaining the findings and subsequent management

5CA.110 CORRESPONDENCE SENT FROM, AND RECEIVED AT, COLPOSCOPY

5CA.110.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.110.2 Quality Standard

All correspondence sent from and received at the Colposcopy Service is dealt with appropriately and within CSW timescales.

All correspondence must contain the woman's NHS number.

5CA.110.3 Method

Correspondence sent from the clinic

All correspondence sent from the Colposcopy Service must be clearly marked for the attention of the recipient, whether that be the woman, her GP or the local CSAD.

Ideally, all information sent to the GP or to the local CSAD regarding a woman should be addressed separately to the recipient. If this is not practical and a copy of the woman's letter is sent to the GP or local CSAD, the recipient's copy must be highlighted to ensure all copy letters are not re-sent to the woman.

Window envelopes cannot be used for posting any copy letters as this could result in correspondence being sent to the woman herself.

All correspondence sent to other NHS premises must have a sticker or stamp on the envelope stating that 'If undelivered please return to Colposcopy Service address.' The use of these stickers is not appropriate for correspondence sent to the woman or to other non-NHS establishments.

All correspondence sent from the Colposcopy Service must be checked before being sent to ensure the content is accurate.

Correspondence received at colposcopy

All correspondence received at the Colposcopy Service must be date stamped and recorded in a receipt log.

Written complaints

All complaints concerning colposcopy services must be forwarded to the Director of CSW immediately.

5CA.110.4 Quality Measures

- 100% of complaints received concerning the colposcopy service must be forwarded to the Director of CSW
- 100% of correspondence contains the NHS Number

5CA.110.5 Quality Control/Audit

5CA.110.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION
Section: Printing Colposcopy Letters (Page 89)

5CA.120 TELEPHONE MESSAGES

5CA.120.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.120.2 Quality Standard

All telephone calls received at Colposcopy Services which result in an amendment to details on the CANISC database will be recorded on a telephone message sheet if the member of staff is unable to immediately update CANISC.

All telephone messages must be entered onto CANISC within 2 working days and filed in the woman's notes once action has been taken.

5CA.120.3 Method

All Colposcopy Service staff are trained during induction about the use of the telephone message sheet. Individual telephone message sheets are made available for all clinic staff to use.

Information on CANISC may be updated immediately by a member of staff but a note should be placed in the 'Other' tab on the CANISC case note.

The information contained on these sheets is as follows:

Telephone Message Form

Name of Woman:

Address of Woman:

Date of Birth:

NHS Number:

| |
|--|
| Call Received from: |
| Contact number/address (if appropriate): |
| Nature of enquiry/comment/complaint (delete as appropriate): (please provide written summary) |
| Written confirmation received? |
| Action taken: |
| Signed: _____ Date: _____ |
| Approved by (if needed): |

If approval is needed by the colposcopist for any action taken following the phone call, the member of staff must ensure that the 'approved by' box is signed before any action is taken.

A telephone messages 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.

Verbal complaints

All complaints concerning colposcopy services must be accurately recorded and forwarded immediately to the Director of CSW.

Filing of telephone messages

All telephone messages should be filed in the woman's notes and a note placed on CANISC if a telephone message was taken.

5CA.120.4 Quality Measures

- 100% of telephone messages are entered onto CANISC within 2 working days of the call being taken;
- 100% of telephone messages are filed in woman's notes once CANISC has been updated.

5CA.120.5 Quality Control/Audit

Incident reporting

5CA.120.6 Further Guidance

5CA.130 FILING

5CA.130.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.130.2 Quality Standard

All Colposcopy Services must have a filing system which will ensure that all woman information is filed correctly, can be retrieved easily and is in line with medical record requirements.

5CA.130.3 Method

All colposcopy services operate at different hospital sites and therefore filing requirements will vary from site to site depending on local procedure.

The filing systems used by the Colposcopy Services must ensure the following as a minimum requirement:

- All paper copies of information on a woman's Colposcopy Service visits are filed in notes
- All results for a woman must be signed by the clinician to indicate that they have seen and authorised the results
- All records must be easily retrievable
- All items in records must be stored in a standard way and in line with local medical record policy
- All ID labels filed in a woman's notes must be the latest versions (all 'old' ID labels must be destroyed confidentially as soon as the colposcopy service has been informed of a change of details)

5CA.130.4 Quality Measures

- 100% of paper copies of information on a woman's visit to colposcopy are filed in her notes
- 100% of paper results are signed by the clinician to verify they have seen the results and that CANISC has been appropriately updated

5CA.130.5 Quality Control/Audit

To be developed

5CA.130.6 Further Guidance

Local Trust medical and clinical record procedure

5CA.140 DATA ENTRY CORRECTIONS AND MERGING OF RECORDS

5CA.140.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Colposcopy Clerks

QA Advisor

Head of Administration

5CA.140.2 Quality Standard

Certain data entries onto CANISC cannot be deleted by the user:

- Referral
- Visit
- Sample
- Result

These data entry errors must be reported to the CANISC helpdesk for correction and audit purposes.

Any data entry change which could affect the FailSafe system for a woman must be notified to CSAD immediately.

Any duplicate records which require merging on CANISC must first have name and address details carefully checked by clinic coordinator.

5CA.140.3 Method

Data corrections

Amending a visit type, attendance status, discharge details or any specimen and result details has implications on the FailSafe process and Colposcopy Service staff must notify the CSAD of any details that have been amended.

If the data entry is something that could affect a woman's management (eg a result code), this must be logged with CSW as an incident and the clinic must ensure that the woman has the appropriate management.

To report data entry errors, the CANISC help desk can be contacted in any of the following ways:

E-mail: velindre.servicedesk@wales.nhs.uk

Phone: 029-20316939

WHTN: 1875-6939

When the help desk is contacted the colposcopy user must obtain a 'call number' and leave a contact phone number if the call cannot be dealt with immediately.

CSW can be contacted in the following ways:

E-mail: CSWInfo@wales.nhs.uk

Phone: 029-20787820

WHTN: 1670-7820

Fax: 029-20787900

Merging duplicate records

If the clinic coordinator becomes aware of any duplicate records for a woman the details in the record must be confirmed with that woman when attending clinic prior to a record merge taking place.

If clinic coordinator is in any doubt over details with a potentially duplicate record, CSAD must be contacted to establish if there is an address history which can be checked for both records.

To merge a record on CANISC, the CANISC Helpdesk must be contacted with the full details of both records to be merged together.

5CA.140.4 Quality Measures

100% data entry changes which could affect the FailSafe system for a woman must be notified to CSAD immediately

5CA.140.5 Quality Control/Audit

Certain data items can not be altered by CANISC users and requests must be made via the CANISC helpdesk

5CA.140.6 Further Guidance

Refer to CANISC USER GUIDE User Guide

Section: Add Colposcopy Clinical Proforma Data

5CA.150 REQUESTS FOR ACCESS TO CANISC

5CA.150.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.150.2 Quality Standard

The Director of Screening Services is responsible for the approval of all requests for access to the CANISC.

CSW must be notified as soon as a clinic becomes aware of any change of personnel to ensure user details are updated in a timely manner and CANISC access permissions removed for security reasons. CSW also need to ensure that enough licences are purchased to run the CANISC software.

5CA.150.3 Method

Any User who requires access to CANISC or changed access (eg different clinic or log on times) completes a User Access Request Form.

The forms can be found on the main Velindre Cancer Centre webpage where the main CANISC is accessed. See the section entitled '**CANISC Forms**'.

For Colposcopy Service staff, the form must be signed by the lead colposcopist to authorise. The form is then returned to the CANISC trainer at the following address:

E-mail:

Phone: 029-2078 7903

WHTN: 1670-7903

Fax: 029-2078 7900

Once received by CSW, the Director (or delegated member of staff) will approve all requests for access and the CSW information team will ensure that CANISC support team at the Velindre Clinical Information Unit is informed.

Once access has been granted, the CANISC trainer will then contact the individual to arrange training, the trainer will also set up the access to the CANISC system.

The information team at CSW must be informed by the Colposcopy Service of all colposcopists (including trainees and locums) who join or leave the clinic, as soon as the clinic is aware of the personnel change. This must include any change in their BSCCP accreditation status (eg from trainee to fully accredited).

The colposcopist information which the Colposcopy Service provide for CSW should include:

- Full name
- GMC number (if known)
- Locations(s) the colposcopist will be working at
- Smear Taker Code (if known)
- Date the colposcopist started / finished working at the location
- Status – lead, accredited or trainee colposcopist

CSW can be contacted in the following ways:

E-mail: CSWInfo@wales.nhs.uk

Phone: 029-2078 7812

WHTN: 1670-7812

Fax: 029-2078 7900

The CANISC Helpdesk staff are unable to update the entries relating to changes of colposcopy staff.

CSW need to maintain the smear taker database and location addresses for sending colposcopist's information. In addition, colposcopists must be added to CANISC before any clinical proforma data can be added for women that they have seen.

Colposcopists who leave the service need to be removed from the list of current colposcopists used when entering clinical data at local clinics but they will not be removed from the CANISC system.

Trainee Colposcopists

When a colposcopist supervises a trainee only one record should be entered onto the system for the woman's visit. For BSCCP accreditation purposes the woman will count towards the workload for the trainee and the supervising colposcopist.

When the trainee is undertaking indirectly supervised colposcopy, the record is entered for the trainee alone.

5CA.150.4 Quality Measures

- 100% of access requests to CANISC must be approved by the Director of CSW (or delegated member of staff)
- The Colposcopy Service inform CSW of all personnel changes immediately

5CA.150.5 Quality Control/Audit

To be developed

5CA.150.6 Further Guidance

5CA.160 UNDELIVERED RETURNED MAIL

5CA.160.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.160.2 Quality Standard

All mail sent from colposcopy which is returned undelivered to the hospital must be dealt with appropriately by the colposcopy coordinator.

5CA.160.3 Method

On receipt of returned mail the clinic coordinator will:

- Check the contact details against hospital computer system
- Check the contact details with the local CSAD and inform them that the mail has been returned
- Check the contact details with the woman's GP

If an alteration to an address is required, CANISC is updated with the new information and a new copy of the correspondence is sent out.

If no discrepancy in contact details is identified, the Regional Nurse Coordinator/Regional Programme Coordinator at the local CSAD must be consulted regarding the future management of that woman.

5CA.160.4 Quality Measures

100% of mail returned undelivered to the Colposcopy Service must be checked for discrepancy details and appropriate action taken

5CA.160.5 Quality Control/Audit

To be developed

5CA.160.6 Further Guidance

5CA.170 LOST AND BROKEN SPECIMENS

5CA.170.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.170.2 Quality Standard

Any specimen damaged in transit or not received in the laboratory must be recorded on CANISC and the woman managed accordingly.

5CA.170.3 Method

The laboratory will notify the colposcopy service of any slide which was damaged in transit or not received.

Any specimen damaged in transit or not received by the laboratory is recorded on CANISC with a result code of "Sample was damaged in transit" or "Sample was not received".

5CA.170.4 Quality Measures

100% of samples damaged in transit or not received in the laboratory must be recorded on CANISC

5CA.170.5 Quality Control/Audit

To be developed

5CA.170.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY CLINICAL DATA

Section: Investigation and Samples (Page 27)

Section: Printing Samples and Results (Page 35)

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: Investigations /Samples (Page 116)

5CA.180 WOMEN MOVING BETWEEN COLPOSCOPY SERVICES

5CA.180.1 Staff Responsible

Managerial Responsibility

Lead Colposcopist

Operational Staff

Clinic Coordinators

QA Advisor

Head of Administration

5CA.180.2 Quality Standard

CANISC information is maintained as accurately as possible for any woman who moves in or out of clinic area.

5CA.180.3 Method

Women who change area within Wales but remain within current colposcopy service

If the clinic is informed that a woman has moved area but that she wants to stay with the current colposcopy service:

- Her correspondence details will be updated on CANISC
- The CSAD is informed of the change of address and that she wants to remain with the current colposcopy service

If the woman moves within Wales the original CSAD will ensure that her details are forwarded to the appropriate CSAD to be entered onto their SafetyNet.

Women who change area and colposcopy service

If the woman moves area and changes colposcopy service the original colposcopy service must ensure that the CSAD is informed and the woman is discharged from CANISC.

The CSAD will arrange a new referral for the woman.

5CA.180.4 Quality Measures

To be developed

5CA.180.5 Quality Control/Audit

To be developed

5CA.180.6 Further Guidance

Refer to CANISC USER GUIDE User Guide COLPOSCOPY ADMINISTRATION

Section: When to add a new disease episode or a new referral (Page 60)

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

Refer to CANISC USER GUIDE User Guide COLPOSCOPY
CLINICAL DATA
Section: Adding Colposcopy Clinical Proforma Data - Management
Tab (to discharge a woman) (Page 4)