



Gloucestershire

Gloucestershire Cervical Screening Programme

Annual Report

April 2006 - March 2007

and

April 2007 – March 2008

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Executive Summary

This report provides information on the activity, achievements and challenges of the Gloucestershire Cervical Screening Programme during 2006/07 and 2007/08.

The programme functions as part of the nationally coordinated NHS Cervical Screening Programme (NHSCSP), governed by set quality standards and guidance.

Though the programme's coverage continues to exceed the national target of 80%, there has however been a fall in coverage of about two percentage points over the past five years. The younger age bands show lower coverage rates in line with national trend, while some practices in areas with high diverse populations have relatively lower coverage rates.

In the period under review, the programme successfully implemented the centralisation of invitation and result letters as recommended by the South West Quality Assurance Reference Centre (SW QARC). Almost all of the recommendations from the 2005 QA visit have been implemented with the few outstanding ones being progressed.

The laboratory has a high workload in terms of cytology and histopathology samples but nonetheless remains an effective service. The Colposcopy service also performs well on national standards.

The downward trend in incidence of and mortality from cervical cancer in Gloucestershire is a good indicator of the effectiveness of the programme.

The programme has either met or well on its way to meeting the priority objectives set by the SW QARC for the period under review.

The main issues for the programme in 2008/09 relate to:

- Planning to meet the 14-day turnaround target
- Maintenance of a robust register of sample takers
- Improving coverage rates
- Having sound failsafe systems

- Appropriate ceasing of women
- Participation in the invasive cancer audit
- Colposcopy result letter target

1. Background

The aim of this report is to provide information on the activity, achievements and challenges of the Gloucestershire Cervical Screening Programme during 2006/07 and 2007/08. The programme had in the past provided annual reports detailing the status of cervical screening in Gloucestershire, the last of which was in 2003/04. It is hoped that this will resume on an annual basis from now on.

The programme operates as part of the nationally coordinated NHS Cervical Screening Programme (NHSCSP) whose aim is to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all women between the age of 25 and 64 to identify those at risk so that conditions, which might otherwise develop into invasive cancer, can be identified and treated. Early detection and treatment can prevent 75 per cent of cervical cancers developing

2. Gloucestershire Cervical Screening Programme

The delivery of the programme in Gloucestershire involves several health professionals and agencies. All General Practices in Gloucestershire participate in the programme with laboratory and clinical services (colposcopy) services being provided by the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT). Though practice nurses and doctors in primary care take the majority of samples, samples are also taken in the Sexual Health and Genito-Urinary clinics. The Family Health Services (FHS) are responsible for patient data management, including call and recall.

The Gloucestershire Cervical Screening Steering Group which meets quarterly, oversees the running of the programme by:

- Setting local policy and guidelines
- Monitoring the performance of the programme against the policy and guidelines as well as against national standards
- Producing an annual report

Appendix 1 gives details of members of the Steering Group, and this includes representatives of the above services.

2.1 Services making up the Gloucestershire Cervical Screening Programme

The services that make up the Gloucestershire Cervical Screening Programme are:

Family Health Service

- Running of the call and recall system from the National Health Applications and Infrastructure Services (NHAIS) `
- Running screening programme failsafe
- Maintenance of up-to-date records of cytology sample results
- Provision of information on different elements of cervical screening

GP Practices

- Taking cytology samples
- Sending invitation and result letters
- Provision of information on different elements of cervical screening

Genito-urinary Medicine and Sexual Health Clinics

- Taking cytology samples
- Provision of information on different elements of cervical screening

Gloucester and Cheltenham Laboratories

- Reporting cytology samples
- Direct referral to Colposcopy
- Failsafe of cases referred to colposcopy
- Provision of information on relevant elements of cervical screening

Gloucestershire Royal Hospital and Cheltenham General Hospital

- Taking cytology samples
- Investigation and treatment of screen-detected abnormality (colposcopy)
- Failsafe for women attending colposcopy
- Reporting of biopsies (histopathology)
- Specialist treatment for cervical cancer
- Provision of information on different elements of cervical screening

Stroud General Hospital, Bourton Hospital, Cirencester Hospital

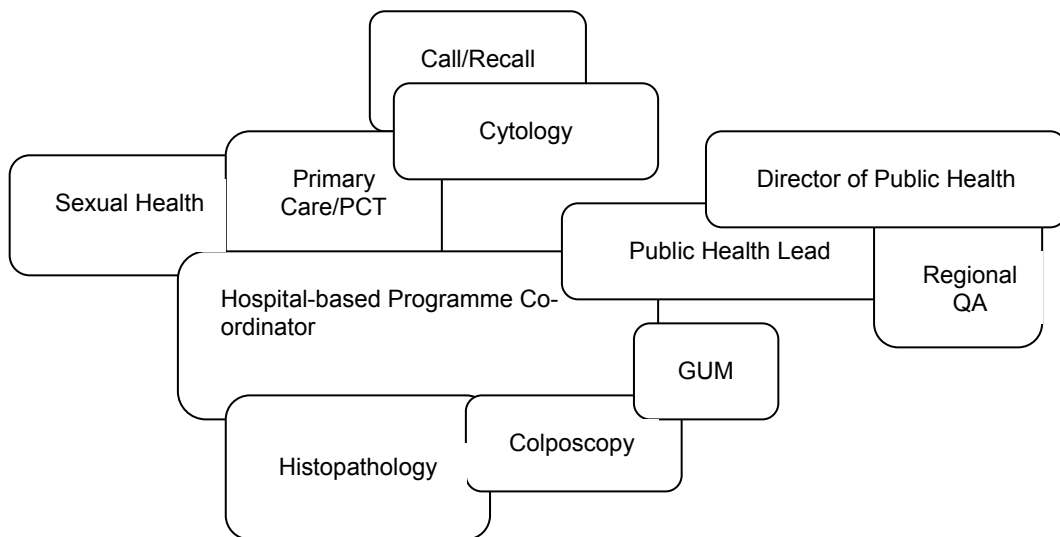
- Taking cytology samples
- Investigation and treatment of screen-detected abnormality (colposcopy)

- Provision of information on different elements of cervical screening

Hospital Based Programme Coordinator

- Co-ordination of the clinical and management components of the Cervical Screening Programme – including cytology, histology and colposcopy
- Point of contact for the Screening Commissioner and QA teams
- Ensure regular Multidisciplinary team meetings to manage discrepant cases

Figure 1: Accountability Arrangements



3. Activity and Performance

3.1 Screening

On notification from the FHS of eligible women (aged 25 to 64 years) due for screening, invitation letters **were** sent by GP practices and the Sexual Health Clinic during 2006/07 to the women (aged 25 to 64 years) to attend for their cytology samples to be taken. This arrangement changed in March 2008 when the FHS took over the issuing of invitation letters, following the recommendations of the South West Quality Assurance Reference Centre. Cervical cytology samples are taken in a variety of settings as indicated in **Table 3**, with result letters being sent to women by the sample takers in 2006/07, and the FHS taking over this responsibility from April 2008.

The KC53 returns are produced from the 'NHAIS' GP registration computer system that is used for running the call and recall system and sent quarterly to the South West Quality

Assurance Scheme. This data is used to produce the coverage or uptake statistics. The Gloucestershire programme continues to exceed the national coverage¹ target of 80%, as it has done for a number of years (Table 1). It also exceeds the regional average.

Table 1: Cervical Screening Coverage levels in the South West by PCT, 2002/3 to 2007/8

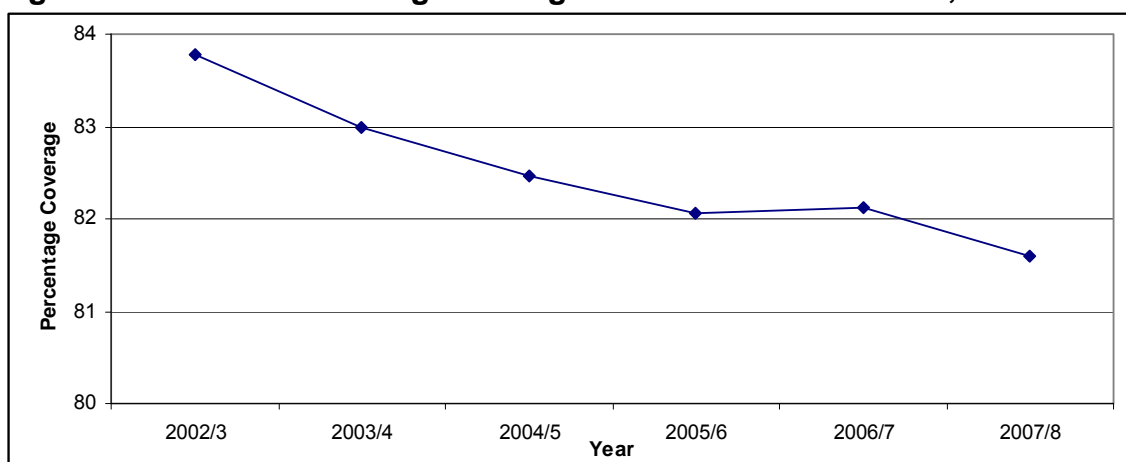
Organisation	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8
South Gloucestershire	82.2	80.83	80.36	81.94	81.96	81.94
Plymouth	83	81.89	81.72	81.34	81.21	80.25
Bath & North East Somerset	79.4	78.2	77.89	78.7	78.76	78.46
Swindon	80	78.95	79.24	78.88	77.94	76.35
North Somerset	81.3	80.59	79.07	80.37	80.3	80.02
Gloucestershire	83.77	83	82.47	82.07	82.13	81.6
Bristol	76.9	75.24	74.99	74.27	74	73.55
Wiltshire	80	77.89	79.31	80.93	80.85	80.2
Somerset	82.95	81.77	82.35	82.76	82.61	81.78
Dorset	87.4	86.8	82.47	84.57	83.9	83.3
Bournemouth & Poole	87.25	86.53	85.81	84.55	83.89	82.66
Cornwall & Isles of Scilly	82.33	81.51	81.41	81	80.7	80.44
Devon	82.33	81.72	81.71	82.2	82.09	81.81
Torbay Care Trust	83.3	82.53	82.08	81.89	81.26	80.61
South West					80.83	80.21

Source: South West Quality Assurance Reference Centre

Over the past five years however, there has been a fall in coverage by about 2 percentage points (

Figure 2) and this needs to be addressed.

Figure 2: Cervical Screening Coverage in Gloucestershire PCT, 2002/3 to 2007/8



The breakdown of coverage figures by age bands (**Table 2**) shows lower coverage figures for the women in the 25 – 29 age band in keeping with national trends.

¹ Coverage – Percentage of eligible women with an adequate test in the last five years.

Table 2: Cervical Screening Coverage in Gloucestershire PCT by Age Bands, 2006/07, 2007/08

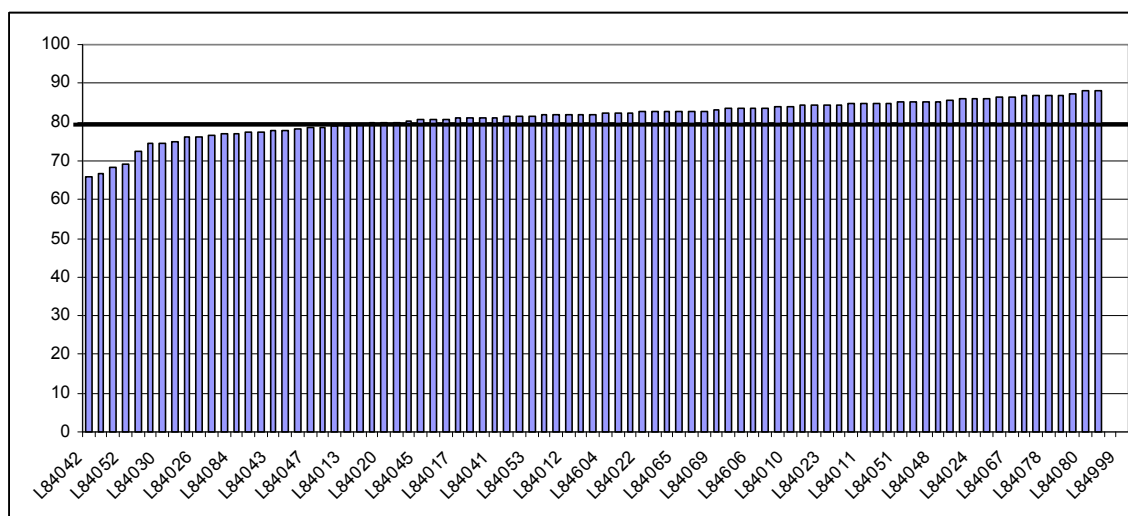
	2006/07		2007/08	
Age Group	Eligible Population	% Coverage	Eligible Population	% Coverage
25-29	17215	73.52	17824	71.93
30-34	17442	82.67	16951	81.72
35-39	21486	85.98	20952	85.32
40-44	22913	83.58	23060	83.18
45-49	19811	84.16	20373	84.12
50-54	16327	83.49	16673	83.33
55-59	15816	82.59	15366	82.78
60-64	13917	78.77	14630	78.67
Total (25-64)	144927	82.13	145823	81.60

The challenge for Gloucestershire will be to continually meet/exceed the coverage target in all age groups. This will necessitate specific interventions targeted at young women to raise awareness of the value of cervical screening. Action in this regard will be in line with priorities identified in the Cancer Reform Strategy².

Figure 3) shows that majority of GP practices exceed the 80% coverage standard.

² Department of Health. Cancer Reform Strategy. December 2007. London. Department of Health

Figure 3: Cervical Screening Coverage in Gloucestershire by GP Practice 2007/8



In 2006/07 22 GP practices (excluding the Vaughan Centre) in the county did not meet the 80% coverage standard. This increased to 26 practices in 2007/8. This fall in coverage would necessitate targeted work with practices perhaps also through the Quality and Outcomes Framework to ensure that these practices deliver an accessible service to the population they serve.

3.2 Cytopathology

3.2.1 Laboratory Workload

Table 3 shows that the total number of cervical cytology samples examined by Gloucestershire laboratory laboratories increased from 2006/07 to 2007/08.

Table 3: Source and Number of Cytology Samples in Gloucestershire, 2006/07 and 2007/08

	GPs		Sexual Health Clinics		GUM Clinics		GHNHSFT		Private		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2006/07	36675	95.2	793	2.1	146	0.4	813	2.1	91	0.2	38518	100
2007/08	40058	96.1	729	1.7	174	0.4	652	1.6	74	0.2	41687	100

Source: KC61

The great majority of cytology samples continue to come from GP practices, increasing from 95.2% in 2006/07 to 96.1% in 2007/08. The proportion of private samples remain the same at 0.2%

Inadequate sample³ rates have reduced as a result of the introduction of Liquid Based Cytology (LBC) instead of the conventional sample. The lower the rates, the lower the need to invite women for a second sample to be taken, thereby reducing the resultant anxiety. The inadequate sample rate was 3.28% for GP and community clinic tests in Gloucestershire in 2006/7 (1235 samples out of 37614) and it improved to 2.43% in 2007/08 i.e. 997 out of 40961 samples (**Table 4**).

Table 4: Results of GP and Community Clinic Tests for Women aged 25-64 (excluding negative results) 2006/07 and 2007/08

Test result	2006/07	2007/08
Inadequate result	1235	997
Borderline	1247	1672
Mild	517	700
Moderate	245	280
Severe	183	189
Severe ?invasive	3	10
? Glandular neoplasia	24	19
Positive predictive value	84.47% (69% - 85%)	85.38% (69% - 90%)

The South West QARC compares the reporting profiles of all laboratories in the region with national figures for England. There are ranges (representing the 10th and 90th percentiles) set annually within which the proportions of positive samples (and inadequate rates) are expected to lie in. National figures on inadequate rates were not defined for 2006/07 due to the introduction of LBC. **Table 5** details the performance of laboratories in the South West for the period 2006/07 and 2007/08. The effectiveness of the screening programme essentially depends on the identification and treatment of CIN3 which is largely achieved by the recognition of severe, and to a lesser extent moderate dyskaryosis on cervical samples. Gloucestershire rates fall well within the nationally defined figures suggesting that our laboratory is performing to quality standards.

³ Inadequate samples are those where no result can be issued and include those where blood or other matter in the sample makes it impossible to see the cells on the slide properly. In these cases, women are invited back for a second test.

Table 5: Reporting Profiles for Laboratories in the South West

	% Inadequate ⁴		% Borderline Changes/Mild Dyskaryosis ⁵		% Moderate Dyskaryosis or worse ⁶	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
Bath	1.76	2.53	2.83	3.22	1.15	1.20
Bristol	2.71	3.69	4.20	4.64	1.13	1.27
Cornwall	2.81	2.02	5.21	6.69	0.99	1.45
Exeter	0.99	2.10	4.34	5.75	1.22	1.79
Gloucestershire	3.24	2.15	4.33	6.20	1.11	1.36
Plymouth	2.63	3.04	4.68	4.83	1.06	1.33
Poole	7.87	4.95	3.14	4.66	0.71	1.16
Salisbury	4.55	3.57	3.54	3.92	0.73	0.77
Swindon	3.55	2.17	4.89	5.99	0.93	1.20
Taunton	3.35	3.50	4.04	5.85	0.84	0.90
Torbay	0.85	2.33	3.95	5.26	1.24	1.33
National	-	2.9	3.4 -7	3.6 – 7.4	0.7 – 1.4	0.7 – 1.4

Source: South West Region. Cervical Screening Quality Assurance Reference Centre. Annual Report, 2006/07 and 2007/08

The positive predictive value of a ‘test’ tells how well a positive result correlates with presence of the disease itself. The PPV⁷ relates the cytology test results of moderate dyskaryosis or worse with the histology from outcomes of referral (i.e. CIN2 or worse). The values for Gloucestershire for the two years in question fall within the set ranges for the respective years (**Table 4**).

3.2.3 Result Notification

National targets on result notification are that at least 80% of results should be reported within four weeks of test date, and 100% within 6 weeks. **Table 6** shows that Gloucestershire improved in 2007/08 with a total of 99.9% of results been reported within 6 weeks. This needs to be closely monitored.

Table 6: Cumulative Percentage of Samples Reported Within Different Time Ranges (From Date of Receipt of Tests to Date Report was Dispatched) 2006/07 and 2007/08

	Up to 2 weeks	Up to 4 weeks	Up to 6 weeks	Up to 8 weeks	Up to 10 weeks
2006/07	46.7%	92.8%	92.9%	100%	100%
2007/08	19.1%	91.7%	99.9%	100%	100%

⁴ Calculated as percentage of all samples

⁵ Calculated as percentage of adequate samples

⁶ Calculated as percentage of adequate samples

⁷ Calculated as percentage of women referred with moderate dyskaryosis or worse, whose biopsy is reported as CIN2 or worse

3.3 Histopathology

The histology samples are reported in the same laboratory that does the cervical cytology, and cervical cytology reports are available to histopathologist when reporting on histology samples.

The average turnaround times for cervical biopsies and loop excisions are detailed in

Table 7. Gloucestershire has a high workload and the turnaround times are below two weeks for both cervical biopsies and loop excisions. It is important that we ensure that the turnaround time for biopsies improve over the coming year. Improvement in both turnaround times would support the achievement of the colposcopy targets. Staffing levels are in compliance with RCPATH guidelines, and all pathologists participate in external quality assurance schemes.

Table 7: Histopathology Turnaround Times for Cervical Biopsies and Loop Excisions, 2006/07 and 2007/08

Laboratory	Number of Cervical specimens reported on		Cervical Biopsy average turnaround time (Days)		Loop excision average turnaround time (Days)	
	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
Barnstaple	216	279	3	2.56	5	3.75
Bath	964	807	4	5.7	5	6.5
Bournemouth	654	756	2	2	3	3
Bristol	750	971	4	4	4	4
Cornwall	1150	1177	14	21	14	14
Dorchester	250	250	7	7	14	14
Exeter	651	990	N/A	4	N/A	5
Gloucestershire	1666	1680	7	8	10	8
Plymouth	1094	1238	9	6	8	7
Poole	961	940	2	2	4	4
Salisbury	-	-	4	5.34	6	5.92
Swindon	834	1071	24	5	15	5
Taunton	520	332	18	13.1	8	6.7
Torbay	465	331	2	2.8	3	2.61
Weston	-	37	-	8	-	6
Yeovil	202	204	4	4.7	7	6.5

Source: SW QARC Annual Report 2006/07 and 2007/08

3.4 Colposcopy

GHNHSFT manages the colposcopy service with clinics held in hospitals in Gloucester, Cheltenham, Stroud, Cirencester and Bourton-on-the-water.

A direct referral scheme has been in operation since 2000 whereby a copy of every cervical cytology sample report generated by the laboratories with a recommendation for referral for colposcopy is sent directly to the colposcopy department. This ensures that referrals to colposcopy take place in a timely manner and within national guidelines.

Local performance (from KC65 returns) against the set colposcopy standards are detailed in **Table 8** (2006/07) and **Table 9** (2007/08).

Table 8: Colposcopy workload and waiting times 2006/07

KC65 Statistics	Gloucestershire	South West	England
Part A: 1st Appointment			
Total number referred	1,164	10,487	123,960
% referred because of clinical indication	1%	11%	16%
% of those with moderate or worse result offered appointment within four weeks	91%	69%	76%
% of those with severe or ?invasive result offered appointment within two weeks	100%	75%	84%
% of those with ?Glandular Neoplasia result offered appointment within 2 weeks	100%	70%	63%
Part B: Appointments for Colposcopy			
% Attendance	71%	73%	72%
% DNA	9%	9%	13%
Part C: Of all first referrals, percentage who had:			
No procedure	18%	33%	30%
Some procedure	82%	67%	63%
Diagnostic biopsy	57%	47%	45%
Ablation, no biopsy	0%	1%	1%
Ablation with biopsy	0%	0%	0%
Excision	25%	17%	16%
Other	0%	2%	1%
Part D			
Of those with biopsy, percentage informed of results within 8 weeks	100%	89%	89%

Source: KC65 Statistics, NHS Information Centre

Table 9: Colposcopy workload and waiting times 2007/08

KC65 Statistics	Gloucestershire	South West	England
Part A: 1st Appointment			
Total number referred	1236	11292	122672
% referred because of clinical indication	3%	12%	16%
% of those with moderate or worse result offered appointment within four weeks	94%	76%	83%
% of those with severe or ?invasive result offered appointment within two weeks	100%	79%	87%
% of those with ?Glandular Neoplasia result offered appointment within 2 weeks	95%	80%	76%
Part B: Appointments for Colposcopy			
% Attendance	76%	75%	71%
% DNA	9%	9%	13%
Part C: Of all first referrals, percentage who had: N=1220			
No procedure	14%	34%	36%
Some procedure	86%	66%	64%
Diagnostic biopsy	62%	44%	46%
Ablation, no biopsy	-	1%	1%
Ablation with biopsy	-	1%	0%
Excision	24%	17%	16%
Other	0%	4%	2%
Part D			
Of those with biopsy, percentage informed of results within 8 weeks	98%	96%	93%

Source: KC65 Statistics, NHS Information Centre

Gloucestershire meets the national standard of 90% of women with a test result of moderate or worse being seen within four weeks. This was 91% in 2006/07 and 94% in 2007/08. The two-week target for women with suspected invasive disease is also being met.

Colposcopy clinics are expected not to exceed the 15% DNA rate national standard, and Gloucestershire is performing well against this standard.

Majority of Gloucestershire patients referred undergo a procedure (a biopsy or an excision) on their first visit (82% in 2006/7 and 86% in 2007/08). The 'see and treat' policy enables women who have a high grade cytological abnormality to have an excisional biopsy (LLETZ) on their first visit.

The minimum standard of 100% of patients receiving their colposcopy results within 8 weeks slipped to 98% in 2007/08. This needs to be improved upon.

3.5 Audit of Invasive Cancer

Though incidence and mortality depict how effective the screening programme is, they do not tell how effective **it could be** if its activities were all **optimised**. It was in this light that new guidance on audit of invasive cervical cancers⁸ came into effect in April 2007. The purpose of cervical cancer audit is not only to monitor the effectiveness of the screening programme, but also to identify areas of good practice as well as where improvements can be made.

As at November 2008, a total of 226 cases of invasive cancer had been histologically diagnosed in the South West over the period April 1st 2007 to March 31st 2008 (**Table 10**). Gloucestershire has information outstanding on 26 out of 29 cases at the time of publication of the SW QARC 2007/8 Annual Report. This has been due to the difficulty of the then post-holder in fulfilling the role of the HBPC who has the responsibility of co-ordinating the audit. With a new HBPC in post from December 2008, it is hoped that the outstanding returns would be made to the QARC.

Table 10: Number of Invasive Cancers (All Cases) in the South West⁹

	Year of Diagnosis				
	2002	2003	2004	2005	2007/8
PCTs	2	1			
East Somerset NHS Trust	12	5	7	10	13
Gloucestershire Hospitals NHS Trust	22	27	28	23	29
North Bristol NHS Trust	19	22	26	26	27
Northern Devon Healthcare NHS Trust	7	5	5	5	9
Plymouth Hospitals NHS Trust	29	24	28	34	23
Poole Hospitals NHS trust	14	18	15	17	19
Royal Bournemouth and Christchurch Hospitals NHS Trust	7	4	4	11	
Royal Cornwall Hospitals NHS Trust	9	17	16	19	10
Royal Devon and Exeter Healthcare Trust	28	19	23	25	16
Royal United Hospital Bath NHS Trust	46	35	25	23	18
Salisbury Healthcare NHS Trust	8	2	4	7	7
South Devon Healthcare NHS Trust	12	9	10	8	7
Swindon and Marlborough NHS Trust	12	14	11	10	11
Taunton and Somerset NHS Trust	11	7	15	12	13
United Bristol Healthcare NHS Trust	33	33	17	23	12
West Dorset General Hospitals NHS Trust	8	4	6	3	7
Weston Area Health NHS Trust	3	4	2	2	1
Grand total	282	250	242	258	222

Source: South West Region Cervical Screening Quality Assurance Reference Centre Annual Report 2007/8

⁸ NHSCSP. Audit of Invasive Cervical Cancers. NHSCSP Publication No. 28 December 2006

⁹ 2002 – 2005 data collected from South West Cancer Intelligence Service data, 2006 data not available, 2007/8 data from SW QARC

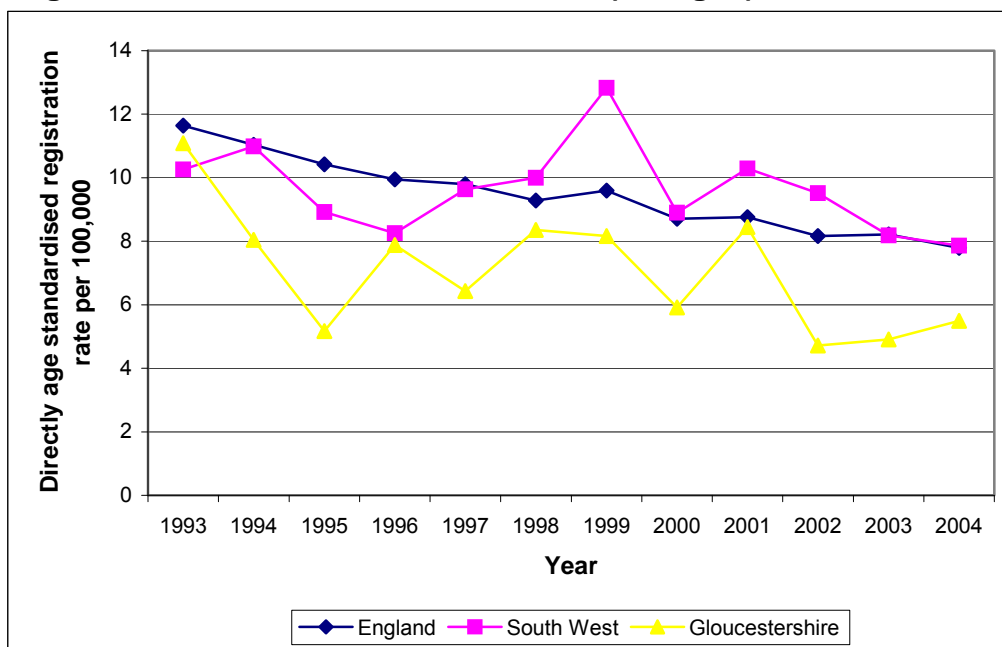
3.6 Failsafe Systems

The laboratory, the Family Health Service and the colposcopy service have systems in place to contact women who have an abnormal test and who do not attend for further investigations or treatment after an abnormal sample test result.

4. Cervical Cancer Incidence and Mortality

The objective of the NHSCSP is to reduce the incidence and mortality from cervical cancer. Judgment about the effectiveness of the Cervical Screening Programme would therefore depend on accurate data on incidence and mortality from cancer registries linked to individual level information regarding screening uptake and outcome.

Figure 4: Incidence of Cervical Cancer (All Ages) 1993 -2004

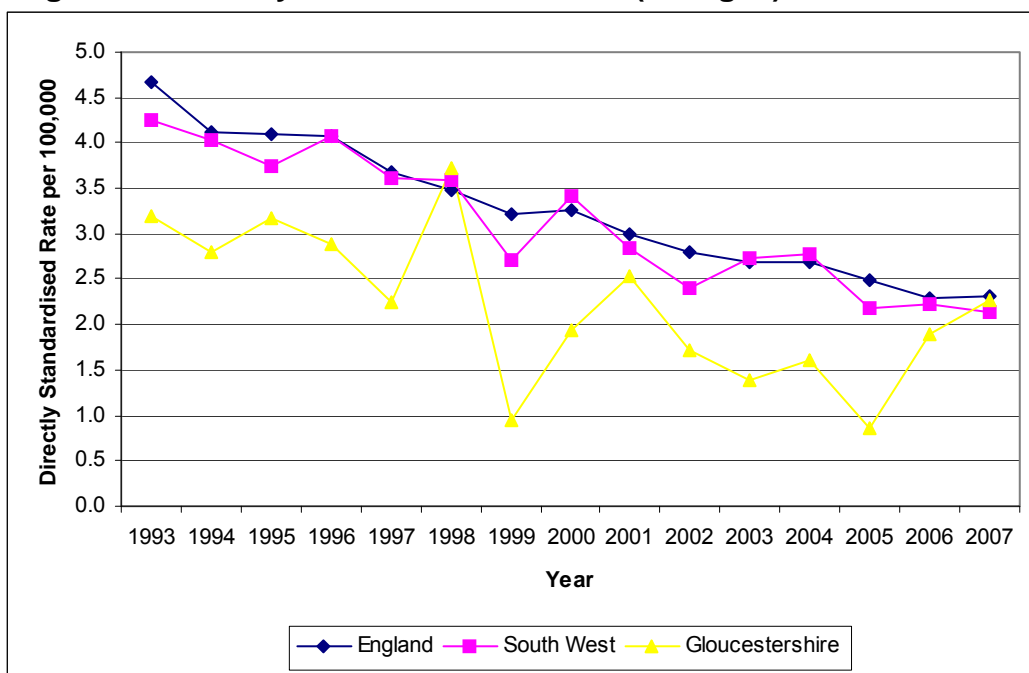


Source:

Compendium of Clinical and Health Indicators, July 2007

Figure 4 shows that the incidence of cervical cancer in Gloucestershire is lower than national and regional rates, and has been following a downward trend.

Figure 5: Mortality from Cervical Cancer (All Ages) 1993 - 2007



Source: Compendium of Clinical and Health Indicators, December 2008

Mortality from cervical cancer is lower in Gloucestershire than in the South West and England. There has also been a downward trend in mortality rates over the years (**Figure 5**). The fluctuating figures are due to relatively small numbers of deaths as shown in **Table 11**. Over a period of 15 years (1993 – 2007), deaths have been few and have mainly been in older women.

Table 11: Deaths from Cervical Cancer in Gloucestershire 1993 - 2008

Age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
All ages	12	12	15	11	9	17	<5	8	9	8	5	6	6	8	11	141

Source: ONS (Public Health Mortality file)

5. Progress against SW QARC Priority Objectives for the Year 2006/7

Gloucestershire made progress against the priority objectives identified for 2006/07 by the South West Quality Assurance Reference Centre as detailed below.

Priority Objective	Progress Made
All sites to ensure conversion to LBC by the national deadline of September 2008	Conversion of the Gloucestershire programme to LBC was completed in September 2006.
All PCTs should ensure sites have appropriate access to Open Exeter to enable monitoring of the programme and also appropriate recall dates to be set by the laboratories.	All GP Practices have signed up for Open Exeter, but not are all using it for the production of HMR101s as yet with uptake in the region of 95% The Laboratory is providing monitoring information to the Family Health Service to identify which practices continue to submit hand written HMR101s, so that these practices can be contacted and offered support. Training events for practices have also been arranged All laboratory staff have PC access to Open Exeter.
Sites should ensure that women are only ceased in line with national guidance.	The ceasing audit was undertaken during the period June to Oct 2007. All ceased women are confirmed as being ceased in line with national guidance. Robust ceasing paperwork is in place to ensure that only appropriate women are ceased from the screening programme either based on the screening history or when screening staff at the PCT are notified by a woman's GP that she should be ceased.
All Trusts should appoint a HBPC	GHNHSFT has a HBPC in place
All women should receive their results in writing in line with national guidance.	In Gloucestershire the production and mailing of result letters was delegated to GP practices. During 2007 all fringe practices were surveyed to establish compliance. The decision to centralise the production of invitation and result letters were made during 2007.
All sites should ensure that the wording of all letters complies with national guidance and appropriate leaflets accompany the communication	In-county practices were surveyed in 2005 and sample letters were obtained. The survey was due to be repeated, but was on hold pending a decision on the centralisation of result letters Letters for the Gloucestershire programme have been set up in consultation with QAT staff to ensure that the wording complies with guidance.
All colposcopy units <u>must</u> ensure that they can collect mandatory KC65 data and statistics for BSCCP accreditation.	The Cyres software enables services to easily collect KC65 data and statistics for BSCCP accreditation. It is expected that the software would be uploaded into the Hospitals Trust's computer by August 2007.
All programmes should ensure a register of all sample takers is maintained and ensure that all sample takers have accessed the appropriate training in line with guidance	In close liaison with the laboratory, a register of sample takers is being established which would enable us document training accessed by sample takers
The new PCTs must ensure that the role of the Cervical Screening Public Health Lead (Commissioner) is maintained with the adequate time and support for the role	The PCT has plans in place to appoint a Cervical Screening Public Health Lead/Commissioner
All sites should move towards electronic data transmission between the laboratory and NHAIS (Exeter system)	The Gloucester Laboratory currently transmit their data via the N3 Network. Cheltenham Laboratory submit their data via e-mail. Plans are in place to change Gloucester Laboratory to daily transmission from April 1 st 2007, with Cheltenham Laboratory switch to daily transmission via the N3 Network shortly after.

Improve coverage rates for cervical screening within the region	The coverage rate in Gloucestershire meets national standards
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6. Progress against SW QARC Priority Objectives for the Year 2007/08

The progress made in Gloucestershire against the objectives set for 2007/08 are detailed below.

Priority Objective	Progress Made
Ensure all women receive their results in writing within the 14-day turnaround time (Sample to Result) as defined in the Cancer Reform Strategy and national guidance	The Laboratory is bringing down its turn around time, while an action plan is being formulated with the PCT to ensure new national guidelines are met by December 2010
All sites should ensure that the wording of all letters complies with national guidance.	The wordings of letters have been reviewed and are compliant
Sites must ensure that the national leaflet(s) accompany the communication to women to ensure that all women are aware of the use of data for audit thus facilitating invasive cervical cancer audit.	National leaflets accompany communications with women
The Services must ensure that they can comply with the 62-day referral-to-treatment guarantee as set out in the Cancer Reform Strategy.	The Acute trust is working to ensure that robust systems are in place to track this.
All colposcopy units must ensure that they can collect mandatory KC65 data and statistics for BSCCP accreditation as facilitated by the regional rollout of CYRES data collection module.	Cyres software was uploaded into the Hospitals Trust's computer in August. This has been funded by SW QARC. As of Autumn 2009, the Trust will have to fund the annual licence for technical support and upgrades, estimated cost of £500 pa.
All sites must move towards electronic data transmission between the laboratory and NHAIS (Exeter system)	This is in place
Service Level Agreements/Memorandum of Understanding must be drawn up between purchaser and providers. These agreements must include reference to national targets including 62-day referral and 14-day sample to result.	The programme is exploring putting in place a Service Specification that would support the main SLA. between the PCT and GHNHSFT
Improve coverage rates for cervical screening across the region and particularly in those PCTs falling below the 80% national target	Coverage in Gloucestershire remains above national target. GP practices are being supported to improve their coverage rates
All programmes should ensure a register of all sample takers is produced and maintained and ensure that all sample takers have accessed the appropriate training in line with national guidance.	The register is being reviewed and work is ongoing to ensure sample-takers have accessed up-to-date training.

7. South West Quality Assurance Visit

A quality assurance visit is planned for the programme for June 25th and 26th 2008. The last QA visit was in June 2005. Almost all of the actions against the recommendations

made have been complete. The on-going/outstanding actions which are being addressed include:

- Extension of consultation and treatment room in Bourton Colposcopy clinic
- Consideration to be given to the fitting of an emergency button in the treatment room in Bourton
- Undertake strategic planning to facilitate the housing of both laboratories on one site.
- Rooms in Stroud clinic to have air-conditioning fitted

The recommendations relating to Bourton Clinic are being considered as part of the work on developments in the North Cotswolds being undertaken by the PCT

8. Human Papilloma Virus Vaccination

The Department of Health has agreed that the Human Papilloma Virus (HPV) vaccine should be given routinely to all girls aged around 12-13 years (school year 8) from September 2008 with a catch-up campaign for older girls, starting in Autumn 2009 and running for one year. Girls aged 14 years to 18 years will be offered the HPV vaccination in 2009/2010. Gloucestershire PCT has been working closely with the local authority, schools, parents and GP practices to ensure that the programme commences in September 2008. It is important to emphasise that women still need to be encouraged to attend for cervical cancer screening after this vaccination programme commences as vaccination will not protect against all forms of cervical cancer and women who have not had the vaccine will be unprotected. The cervical screening programme remains important in reducing the risk of cervical cancer.

9. Main Issues for 2008/09

The main issues for the programme for 2008/09 are as follows:

- 9.1 Continue to work towards ensuring that the programme achieves the target of all women receiving their results in writing within the 14 day turn around time by 2010
- 9.2 Establish a robust register of sample-takers to ensure that all registered sample-takers have the opportunity to develop and maintain knowledge and skills through training
- 9.3 Work with practices to improve/maintain their coverage rates.
- 9.4 Work with primary care and PCT staff to disseminate the Good Practice Guide for primary care
- 9.5 Work to improve screening coverage in women aged 25 to 29 years
- 9.6 Review and update the failsafe systems

9.7 Ensure that only appropriate women are ceased in line with national guidance

9.8 Ensure Gloucestershire participates fully in, and completes the necessary documentation for the invasive cancer audit

9.9 Ensure we work to meet the target on colposcopy result letters

10. Conclusion

Gloucestershire Cervical Screening Programme remains a high performing programme in terms of quality and effectiveness. It however faces the challenges of reversing the decreasing coverage rate; ensuring optimal coverage across all GP practices as well as in women aged 25 to 29 years of age, as well as ensuring we are well placed to deliver on the 14-day turn around target.

Appendix 1: Gloucestershire Cervical Screening Steering Group Membership in 2006/07

Cheltenham & Tewkesbury PCT

Jackie Huck	Director of Service Development
Shona Arora	Director of Public Health

Cotswold and Vale PCT

Dr Pauline Allen	Consultant in Family Planning
Dr Z Sulaiman	Consultant in Genito-Urinary Medicine

Gloucestershire Hospital Trust

Mr P. Bullock	Advanced Practitioner & Lead BMS in Cytology
Mr R Kerr-Wilson	Consultant Obstetrician & Gynaecologist
Dr K McCarthy	Consultant Pathologist
Professor N Shepherd	Consultant Pathologist
Mr G Swingler	Consultant Obstetrician & Gynaecologist

Family Health Services

Susan Thacker	Registration and Screening Manager
Ellie Burnell	Screening Co-ordinator
Julia Maclean	Head of Family Health Services

SW Region

Margaret Stoddart	Cervical Cytology QAT member
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General Practitioner, Gloucestershire LMC representative

Dr N Taylor

University of Gloucestershire

Adrienne Wilcox	Senior Lecturer (Nursing)
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Membership in 2007/08

Şola Aruna	Consultant in Public Health Medicine/Commissioner
Rachael Coker	General Practitioner/LMC Representative
Carole Davis	Colposcopy Data Co-ordinator
Preeti Kothari	Consultant Healthcare Scientist in Cytology
Richard Kerr-Wilson	Consultant Gynaecologist
Julia Maclean	Head of Family Health Service
Hazel Millar	Health of Health Improvement
Matthew Nines	Screening Co-ordinator
Karyn Probert	Cytology Sample Taker Training Co-ordinator

Carole Reader	Associate Specialist Contraception & Sexual Health
Pat Reid	Senior Nurse - Contraception Clinic
Kathleen Romain	Consultant Cytopathologist
Mike Rowell	QA Manager
Anne McCrum	Consultant Gynaecologist
Susan Thacker	Registration and Screening Manager

APPENDIX 2: GLOSSARY OF TERMS

Abnormal sample: Synonymous with low-grade sample

Biopsy: The removal of a sample of tissue from the body for examination

Borderline: A result category assigned to samples showing changes which cannot be said to be unequivocally dyskaryotic but which equally cannot be said to be normal.

Call: The process of calling a woman into the screening programme when she first meets the lower age criteria.

Cancer: An abnormal proliferation of transformed cells, which is locally invasive and may also spread to distant body sites.

Cervical screening: The process of testing an identified population of well women for cervical pre-cancerous changes.

CIN: Cervical intra-epithelial neoplasia. The histological manifestation of pre-cancerous changes in ectocervical squamous epithelium. Graded on a scale of 1 to 3 with 3 being the most severe.

Colposcopy: The use of an optical magnifying instrument to examine the cervix for patterns that may indicate the presence of pre-cancerous changes.

Cytology: The assessment of disease by microscopic examination of individual cells.

Dyskaryosis: The cytological manifestation of pre-cancerous changes in cervical epithelium. Graded as mild, moderate and severe.

Fail-safe: A safety net into which any failures of the system will fall.

Hist(opath)ology: The assessment of disease by microscopic examination of tissues.

Recall: The process of recalling a woman for subsequent samples once she has been called into the screening programme.