Handbook for Healthcare Professionals taking cervical screening tests

March 2023 **(version 7)**

DOCUMENT CONTROL

Key Personnel

Title:	National Sample Taker Advice
Author:	Ruth Holman
Approver:	Sample Taker QA Group
Owner:	NSD

Version History

Version	Date	Summary of changes
1.0	Jan 2018	
2.0	May 2018	Update to Management Algorithm for under 25's with intermenstrual, breakthrough or postcoital bleeding 6.6 Clinical observation '*(i.e. using your referral templates within GP Practice, etc) – this is your responsibility as a sample taker*' added to 'Note: ticking the 'suspicion of malignancy' or referral boxes in the Cervical Cytopathology Request does not generate a referral: this has to be made via the usual mechanisms'.
3.0	June 2019	Inclusion of sections 5.7 'Transgender participants' and 11 'How to access SCCRS reports'
4.0	March 2020	Update for hr-HPV Implementation
5.0	September 2020	Clarification of default labs
6.0	March 2023	Updates to links and clarifications throughout. Amended recommendation to 6 week cervical screen post partum/miscarriage. Management of under 25 algorithm updated

Distribution

Name
All Cervical screening programme groups

Contents

1. Purpose of the Handbook

This handbook aims to give Healthcare Professionals clear guidance as to what is expected of them when undertaking cervical screening within the Scottish Cervical Screening Programme.

Please note: Although the guidance uses the terms 'women' and 'woman', the guidance also applies to trans men and non-binary trans people who still have a cervix and therefore are eligible for cervical screening.

2. Staff Training and Competencies

2.1. All staff taking cervical screening tests must be appropriately trained

2.1.1. All staff taking cervical screening tests must undergo initial training in accordance with national policy[2].

2.1.2. Staff undertaking cervical screening must have a username for the NHS Scottish Cervical Call Recall System (SCCRS) so that tests they take can be submitted to the laboratory in their name. Best practice is that sample takers should complete the sample request form themselves at the time of taking the sample. If this is not possible there must be a robust system in place for ensuring samples are not mislabelled, and that information about last menstrual period (LMP), cervical appearance etc is correctly entered.

Staff should be able to use the other functions of SCCRS as appropriate to their role. The SCCRS training programme must be completed using the SCCRS sample taker manual available on http://www.sccrs.scot.nhs.uk/wp-content/uploads/2021/12/STUM_Release-3.0.doc

On completion of training a username and password allowing access to SCCRS is issued. Contact your local SCCRS authoriser for this. Contacts can be found here: Contact Us – SCCRS (scot.nhs.uk)

To access the clinical interface go to:
https://sccrs.nds.scot.nhs.uk/SCCRS/Login/Forms/Login.aspx

2.1.3. NHS Education for Scotland (NES) recommend that active cervical sample takers should undertake update learning every three years and undertake audit and reflection on recent cervical cytology activity.[2]

The content of the update training should include the following topics:

(a) A revision of anatomy and physiology to recognise a healthy cervix and apply skills in the role of the health care professional in cervical screening
(b) A clinical update of Human Papillomavirus (HPV) and the principles of taking a correct cervical
(c) Person centred focus for all consultations to initiate effective health education based on the health beliefs of the person and supportive conversations for any previous negative experiences and trauma informed practice
(d) All Scottish cervical call recall system (SCCRS) user updates
(e) Education of primary HPV testing, results, colposcopy pathways and treatment options
(f) Discussion on the barriers and enablers to participating in cervical screening
(g) Sharing best practice across the profession.

2.2. Responsibilities of sample takers:

- Keep individual professional practice up to date (see paragraph 2.1.3 above)

- Deliver an accessible, patient focussed cervical screening service ensuring informed consent is discussed
- Explain how the patient will receive result
- Explain normal and abnormal results to patients
- Understand the impact of an abnormal result on a patient
- Understand the reasons for non-attendance for a test
- At every opportunity, encourage non-attenders to fully understand the reasons behind cervical screening and thereby consider using the service
- Maintain appropriate communication with the local call recall office, cytology laboratory and colposcopy clinic
- Promote health education programmes which give accurate information and advice about the prevention of cervical cancer
- Signpost or provide information about health issues which may come up during discussion with patients: e.g. chlamydia, cervical screening, thrush
- To be sensitive to communication needs: e.g. other languages, signing, low literacy.
- To be sensitive to religious and/or cultural issues which may impact on cervical screening: e.g. choice of gender of Healthcare Professional
- To be sensitive to physical and learning disability that makes it difficult for a patient to be treated/examined requiring adaptations to be made
- To be sensitive to issues that may cause the patient to find the procedure distressing such as a history of sexual assault/abuse, Female Genital Mutilation (FGM), termination of pregnancy/miscarriage
- To be trans-aware
- To use non-sexuality specific language when asking patients about their sexual history, and where sexuality may be relevant, to give tailored advice and information
- Take the cervical sample in the appropriate manner
- Ensure adverse events are recorded, notified, and investigated
- Monitor SCCRS alerts and action as appropriate.

3. Indications for a Cervical Screening Test

The Scottish NHS Cervical Screening Programme offers tests to people with a cervix, between the ages of 25 and 64 years of age who

- Have never had a cervical screening test
- Are due for a routine repeat cervical screening test after five years
- Are due for an earlier repeat cervical screening test as requested by the laboratory
- Are due for a cervical screening test requested by the colposcopy clinic after the patient has been seen there[5].

Note: people who undergo subtotal hysterectomy still have a cervix, and so remain within the screening programme.

Further guidance on follow up e.g. after treatment of an abnormal cervical screening test, or hysterectomy is in:

http://www.sccrs.scot.nhs.uk/wp-content/uploads/2023/03/Addendum-v1.2.pdf

3.1. A Cervical screening test is not appropriate in the following circumstances unless you think the patient will not re-attend:

Clinical judgement should be used in all circumstances.

- during heavy Per Vaginal (PV) bleeding (as the test may not be satisfactory due to the presence of blood)

There have been cases of cervical cancer where diagnosis was delayed because of persistent bleeding leading to a repeatedly postponed cervical screening test. Consider whether it is prudent to inspect the cervix if this scenario arises.

- if the patient is pregnant (defer the test unless clinical judgement indicates it is best to take one e.g. the patient has previously failed to respond to screening invitations and is very overdue cervical screening/never had a test)
- patient less than **6** weeks post-natal and miscarriage
- known vaginal infection present; treat the infection and take sample two weeks later.

If the opportunity arises to take a test from a patient who regularly defaults do so even if it is less than ideal circumstances.

3.2. A Cervical screening test is not a diagnostic test and so is not appropriate in the following circumstances:

- if a patient under the age of 25 attends with symptoms that could be caused by cervical disease
- if a patient of any age presents with symptoms or signs suspicious of cervical malignancy (Take a cervical screening test if it is due but **do not wait for the result before referring)** **https://www.gov.scot/publications/scottish-referral-guidelines-suspected-cancer-january-2019/#:~:text=The%20referral%20timelines%20used%20in%20the%20guidelines%20include%3A,all%20other%20referrals%2C%20and%205%20primary%20care%20management.**

4. Equipment and Chaperone

4.1. Equipment required

- Examination bed covered by paper bed roll
- Paper sheet to cover patient's abdomen
- Strong light whose direction can be adjusted
- Disposable non-latex gloves
- Plastic apron
- Speculum – a range of sizes should be available (virgin, small, medium, medium long, broad)
- Cervical sample pot
- Cervical broom
- Appropriate sample bag to send specimen to lab
- Water based lubricant – see notes on use of lubricant
- Clinical waste bin
- STI swabs
- Computer with access to SCCRS and label printer
- Access to patient notes.

4.2. Chaperones

National guidance is that all patients undergoing intimate examination should be offered a chaperone although experience shows that most will not wish one[7, 8].

If the patient does not want a chaperone record that the offer was made and declined. If a chaperone is present, make a note of the chaperone's identity. If for justifiable practical reasons you cannot offer a chaperone, you should explain to the patient and, if possible, offer to delay the examination to a later date. You should record the discussion and its outcome.

5. Consultation before taking sample

5.1. Log on

Log into SCCRS: https://sccrs.nds.scot.nhs.uk/SCCRS/Login/Forms/Login.aspx.

Ask the patient to state their name, address and date of birth to verify you have the correct person (anxiety can lead to people agreeing to incorrect information). Before going any further check, the person is eligible for a screening test at that time: e.g. is the person within the eligible age range and due a test?

If there is any difficulty accessing SCCRS follow local procedures for dealing with this.

5.2. Correspondence Address

At the patients request a correspondence address can be used to send the result to a different address from that stored as the main address on SCCRS. The correspondence address fields will only ever exist in SCCRS.

The correspondence address should be removed after the result is sent or a patient may not receive future invitation letters as they will continue to be sent to the correspondence address.

You will need to have a procedure in your place of work for remembering to remove the correspondence address after the result is issued. SCCRS will not over-ride a correspondence address if CHI is updated with a new address. A correspondence address will only be automatically closed down for a person where they are marked with any of the following CHI exclusions – Transferred out of Scotland; Transferred out by CHI; Transferred off as Untraced.

When a patient moves address permanently:

Practices should update the CHI address and a correspondence address should NOT be added. Refer to the user manual on the NSD website for further information on changing addresses.

Community Sample Takers (who cannot edit CHI) should enter the new address as a correspondence address and advise the person to tell their GP they have moved as they may miss out on other important correspondence from their GP and hospitals.

5.3. Temporary Residents

Temporary residents in Scotland accessing NHS services in primary and secondary care

'Temporary Resident' - Definition

'A person who is temporarily away from the person's normal place of residence and is not being provided with essential services (or their equivalent) under any other arrangement in the locality where the person is temporarily residing; or

Moving from place to place and not for the time being resident in any place' [1]

Categories of 'Temporary Resident'

- overseas visitor
- visitor from other parts of the UK
- visitor from one health board in Scotland to another Scottish health board
- homeless people
- travelling people
- refugees and asylum seeker

In the primary care setting, the GP may accept a temporary resident on to their list of patients and provide care for up to 12 weeks. The GP cannot create a record on CHI for the patient. The Cervical Screening test may be taken if appropriate. Where a person presents with symptoms, the GP may refer a temporary resident to secondary care services despite the fact they do not have a CHI number.

5.4. Assessment Process

The assessment process, prior to taking a sample for cervical screening, should include:

- General medical history – are there any factors that would make taking a test difficult or inappropriate?
- General assessment – are there any factors that would make taking a test difficult or inappropriate (for example extreme anxiety)
- Appropriate sexual history and risk assessment – are additional tests/advice to be offered? (see section 13)
- Menstrual history and date of first day of last period
- Seek symptoms of genital tract disease by asking if there has been any:
    - post coital bleeding
    - inter menstrual bleeding
    - post menopausal bleeding
    - unusual discharge

  (if **YES** to any of above seek local guidance on investigations/ referral to gynaecology guidance on management of vaginal discharge https://apps.nhslothian.scot/refhelp/ https://obsgynhandbook.nhsggc.org.uk/nhsggc-obstetrics-gynaecology-guidelines/guidelines-library/gynaecology/cg-vaginal-discharge-management-gynaecology/

- Experiences of having cervical screening tests taken in the past including any past difficulties in having a sample taken
- Understanding of the reasons for having a test and the possible outcomes
- Record relevant information on the SCCRS record to assist the laboratory in assessing the sample.

5.5. Explain the following points

- The purpose of cervical screening and its limitations
- What the test is looking for – explain HPV and why it is the first test done
- The likelihood of a normal test result (about 9 in 10 tests with enough cells collected)
- The meaning of a normal test result
- The likelihood of a failed test (1-4%)
- The meaning of being recalled following an abnormal test result: e.g. it is not a cancer diagnosis
- When and how test results will be made available
- Who to contact to ask questions about the result
- The importance of reporting any abnormal bleeding or discharge to a doctor.
- What you are going to do during the procedure and what to expect

- That screening is not a one-off event and they will be invited again in future
- Even if they have been HPV vaccinated they need regular tests.

Someone having a test for the first time may need a more detailed explanation, including an explanation of the speculum and the sampling device. Explain that they will have to remove their underwear and that the speculum will be inserted into their vagina.

You may need to explain that:

HPV vaccination protects against the high-risk HPV strains that cause most cervical cancers but even if someone has had HPV vaccination cervical screening is recommended to check for other high-risk HPV types that can lead to cervical cancer.

Having a family history of cervical cancer does not affect your chances of developing cervical cancer.

Gain informed consent to the procedure. The consent should be documented as in section 7.

5.6. Consent for people with learning disabilities

For people with learning disabilities, as with other people, valid consent is crucial. Adults must be assumed to have capacity to make their own decisions unless proven otherwise. Individuals must be given all practicable help to make their own decisions before it is concluded that they cannot do so.

The following points should be considered when assessing capacity to consent to cervical screening:

- Does the patient have a basic understanding of what cervical screening is, its purpose, and why they have been invited?
- Do they understand that the test does not always find something that is wrong?
- Do they understand that an abnormal test result will mean having more tests?
- Are they able to retain the information for long enough to make an effective decision?
- Are they able to make a free choice (that is, with no pressure from supporters or health professionals)?
- Do they have support to help them to reach a decision about screening? e.g Learning Disability team.

Learning disabilities alone are not a reason for not taking a cervical sample. NHS CSP materials are available to assist people with learning disabilities in making an informed choice about whether or not to participate in the Programme. See *An Easy Guide to Cervical Screening* at http://www.healthscotland.com/uploads/documents/24327-A%20smear%20test%20could%20save%20your%20life-March2020-Easy%20Read.pdf and *Consent To Cancer Screening, 2nd ed*, NHS Cancer Screening Programmes, 2009 (Cancer Screening Series No 4) at http://www.cancerscreening.nhs.uk/publications/cs4.html

Supporting documents - Adult support and protection: guidance for GPs and primary care teams - gov.scot (www.gov.scot)

5.6. Women with physical disabilities

Sample takers who work with women who are physically disabled should be confident and experienced in taking cervical samples. Some women's physical disabilities may prevent them from achieving a position where the cervix can be visualised, and a cervical sample taken. This may include women with severe arthritis or very severe obesity. The sample taker should consider:

- Access to the venue (can an alternative be offered?)
- The height of the examination bed
- The woman's physical limitations
- The possibility of a domiciliary visit
- The need for assistance
- Seeking specialist advice if necessary.

For paraplegic women, the sample taker may need to make special arrangements, for example with the local colposcopy service, to take a sample at a clinic where a hoist is available.

5.7. Points to note on participants who may have difficulty being examined because of past experiences

Some people may avoid cervical screening as an after effect of sexual assault or abuse, including female genital mutilation. Examples of ways to ask about this are:

"Has anything happened to you in the past that makes having a cervical screening test difficult for you? You don't have to give me details if you don't want to, but we can talk about things we might be able to do to help you have a smear test"

"In some cultural backgrounds women are cut/circumcised when they are young girls. Women who have experienced this can find a smear test more difficult. I appreciate this is a sensitive subject to talk about but is this something that has happened to you? Have you been cut/circumcised /closed when you were young?"

In circumstances where FGM is disclosed, you should record the diagnosis and types of FGM, together with any corrective procedures, in relevant clinical records, as requested in the CMO/CNO letter CMO (2014)19 Re: female genital mutilation.

You should be aware of your local processes if FGM is identified.

Government information and guidance is on:
https://beta.gov.scot/policies/violence-against-women-and-girls/female-genital-mutilation-fgm/

5.7.1. Consider this advice on intimate examination for people who have great difficulty with being examined because of previous sexual assault / abuse, including Female Genital Mutilation. With this type of vulnerability, examination should only be undertaken by experienced sample takers. Where appropriate participants can be signposted to 'My Body Back' clinics.

1. Take time. Book a double or triple appointment if required.
2. Ask patients if they are aware of any 'triggers', phrases or postures that are uncomfortable or may cause them distress.
3. Make it clear that patients can say 'stop' at any point, and keep checking how they are feeling throughout the visit.
4. Use a graded approach to having the complete cervical sample done: it might take a couple of appointments to work towards having any sort of examination. The goal of the appointment might be, rather than completing the cytology, to have a visit where the patient feels in control and listened to – and will come back. The woman may want to insert the speculum herself.
5. Frame the appointment in a way that makes patients feel as though you are working with them, rather than doing something 'to' them.
6. Use techniques such as mindfulness to encourage patients to focus on sensations in the present moment.

7. Ask the patient to describe what is happening as the examination proceeds. This active involvement of the patient helps minimise distress and encourages a sense of engagement and control.
8. Ask patients to rate their anxiety and discomfort – do not proceed if they rate it above seven or eight out of ten. Use this approach as a way of checking on the patient.
9. Encourage patients to keep their eyes open and engage with you as best they can. When keeping their eyes closed patients can dissociate or have flashbacks if triggers are present.
10. Be aware of your own feelings and responses. If you are frustrated or pressured for time to complete the examination, then pause and take time to stand alongside the patient.
11. Patients with a history of no penetrative sex or no tampon use due to moderate to severe vaginismus might need additional support and guidance or psychosocial intervention, or a review of the need for cervical cytology.
12. Bring a sense of warmth, support, and engagement to the appointment. It can be a great opportunity to provide education about genital anatomy and function.

5.8 Transgender participants

Trans men (female to male transition) are eligible for cervical screening if they still have a cervix. SCCRS has been developed to support male CHI numbers and therefore allow the system to invite transmen for screening. Trans men may not be on recall therefore it is important to have a conversation about screening and if they are eligible.

When a patient changes their gender from female to male, the GP Practice should notify the PSD that they are trans male and when the new male CHI No is created by PSD, PSD should add an informed screening marker to their new CHI Number, which automatically brings a participant into screening to be invited for Cervical Screening. If a patient attends GP Practice and wants to have a smear taken but have not been invited, SCCRS allows call recall offices to manually bring the patient into SCCRS to allow the Practice to process a sample. They will then be invited in future.

Trans women (male to female transition) - please be aware that trans women may appear on Recommended Call Lists (RCL) but have no cervical tissue (reconstructive surgery can create a vagina but not a cervix). SCCRS records can be updated by the patient's GP Practice with the relevant exclusion status "no cervix",

Non-binary people (do not identify solely as men or women and may or may not transition)
Please be aware that a non-binary person may or may not have a cervix. According to their individual needs, they can be included or removed from SCCRS in the same way as trans men and trans women.

For all of these people:

1. If uncertain, clarify which pronouns (she, they, he, etc.) are preferred. Once this is known, use affirming language and address as correct gender
2. Discuss the process beforehand as in 5.4
3. Discuss choices as to how the test is carried out, other positions may be more comfortable.
4. Remember that trans people may have had negative experiences of healthcare and may be nervous of the screening process
5. Do not reveal a person's trans status to other staff without their consent.

6. Taking a Cervical Screening Test

6.1. Preparation

- Check the expiry date on the pot. **It is completely unacceptable for a participant to have a repeat test because an out-of-date vial was used**

- Note that the date is in ISO format: i.e. year / month / day. Samples received in out-of-date pots will not be processed by the lab and it will be your responsibility to advise the patient and arrange for another test to be taken

- Write the person's name and date of birth on the pot to minimise any risk of error in case of a delay in accessing SCCRS and getting a label. Print the label after taking the sample, with the woman in the room. **Don't label pots before clinics – this has led to specimens getting mixed up**.

6.2. Hygiene and waste disposal

- Decontaminate your hands before and after the procedure in compliance with NHS National Hand Hygiene Policy [9]. Put on disposable examination gloves and a plastic apron[9]
- Discard the speculum, cervical broom, gloves and apron into the clinical waste bin
- **NOTE:** This procedure contains standard infection control procedures and therefore those with HIV do not need to be treated any differently, and specimens do not need additional labelling: e.g. with control of infection stickers.

6.3. Maintaining privacy and dignity

- Offer the chance to empty the bladder as a full bladder can lead to an uncomfortable examination. Ask them to remove necessary clothing and lie on the couch when they are ready. Give privacy while clothing is removed and ask them to lie on the couch and cover themselves with a paper cover before you return to the area. Give privacy for getting dressed afterwards
- Tests may be taken in any position according to patient and practitioner preference, although the recumbent position is most widely used
- For the recumbent position, the patient lies on their back with knees raised and separated. The feet may be placed with soles together ('frog position') or flat on the bed whichever is most comfortable.

6.4. Lubricants

- Lubricants can make a test unsatisfactory so only use it if necessary. If that is the case water alone is often sufficient. If required use a small amount of water-based lubricant on the blades of the speculum – avoid the tip
- Lubricants that are suitable for use must not contain Carbomers or carbomer polymers. The only product currently available is the Optilube Syringe
  (NB do not confuse with Optilube Active, which is not recommended as it contains local anaesthetic and chlorhexidine which could be irritant).

6.5. Speculae

- Have a full range of speculae available (virgin, small, medium, medium long and broad)
- Choose an appropriate size of speculum. Do not remove speculum from packaging until it is to be used
- If the vaginal walls are lax due to parity or obesity, a broad speculum may give a better view of the cervix
- A small speculum often gives a satisfactory view of the cervix in the post-menopause when a medium speculum causes discomfort because the vaginal walls are less stretchy due to atrophic changes
- Separate the labia and gently insert the speculum into the vagina. The vagina is H-shaped in cross section, so insert speculum horizontally – no twisting is required: this can catch hair or skin and cause pain
- Note that a common error is failure to insert the speculum far enough into the vagina
- When removing the speculum take care not to trap any hair or tissue.

6.6. Clinical observation

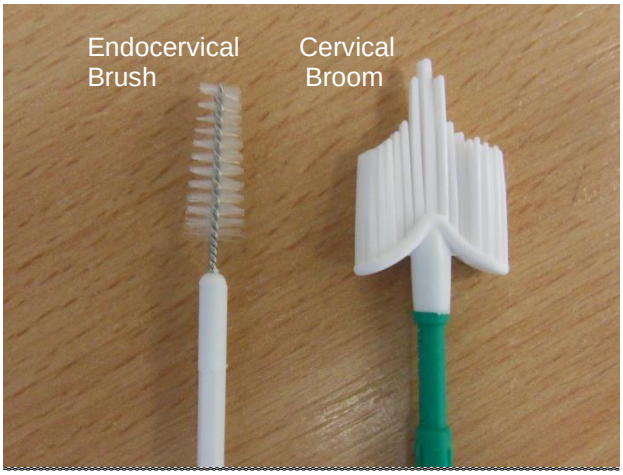
- Inspect the vulva. Note any warts, cysts, swellings, soreness, and bleeding, discharge or offensive odour and manage appropriately
- Using an appropriate size of speculum to ensure visibility, note any abnormalities of the vaginal walls such as prolapse or discharge. Manage or refer any abnormality as appropriate
- Visualise the whole ectocervix using a strong light and note any abnormalities, e.g. polyp, warts, ulcers
    - Note: Nabothian follicles and ectropion are physiological changes and not an indication to refer to Colposcopy. Do not use the factually inaccurate term “erosion” because it generates anxiety.
- Be aware that treatment can change the appearance of the cervix
- A chart showing normal and abnormal cervices is available here: http://www.healthscotland.scot/publications/cervix-chart
- Manage or refer any abnormality as appropriate. If cancer is suspected from the appearance of the cervix refer to colposcopy. Take a cervical screening test if it is due but **do not wait for the result before referring.** Advise the patient to attend even if they get a negative result
- Note: ticking the ‘suspicion of malignancy’ or referral boxes in the Cervical Cytopathology **Request does <u>not</u> generate a referral:** this has to be made via the usual mechanisms (i.e. using referral templates within GP Practice, etc) – this is your responsibility as a sample taker.

6.7. Use of cervical broom

- Put the cervical broom in contact with the cervix, with the long filaments in the canal, and rotate clockwise 360^0 x 5. Keep the broom in contact with the cervix, all of the time pressing firmly enough to detach cells. NB the broom is designed for clockwise rotation <u>only</u>
- Remove the cervical broom and push it into the bottom of the pot ten times, forcing the bristles apart. Swirl the cervical broom vigorously to further release any cells

- **<u>Tighten the pot lid so that the line on the cap matches the line on the vial</u>**. If the cap is too tight the processing machine can't open it. If it is too loose it may leak.

- Contact bleeding at the time of cervical sampling may occur, and is not an indication for referral to colposcopy in the absence of other symptoms[2]
- **Endocervical brushes must not be used in place of the cervical broom.** In colposcopy they may be used in addition to the broom to ensure endocervical sampling in cases of glandular abnormality



6.8. Swab tests

- If swabs are to be taken to look for infections, e.g. chlamydia, these should be taken <u>after</u> the cervical screening test in the usual way, explaining what is happening to the patient.

6.9. Completing Cervical Sample Request (CSR) in SCCRS

- You will already be logged into SCCRS to verify the patient's details and eligibility however if SCCRS has timed out log on again https://sccrs.nds.scot.nhs.uk/SCCRS/Login/Forms/Login.aspx and complete a CSR
- If there is any difficulty accessing SCCRS follow local procedures for dealing with this
- Print and apply the SCCRS label to the pot in the correct position and orientation.

6.9.1. Advice on completing CSR

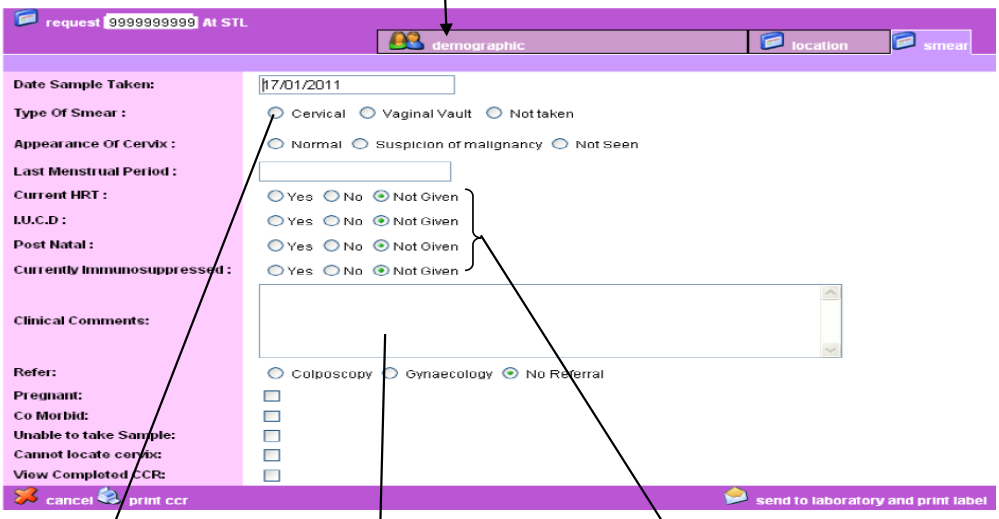
Check you have the right person

Why?

Because mix ups occur.

Real life example: A woman rang up to say she has had a result for a test she hadn't had. The practice nurse had to work out who she took tests from on the date of the smear, work out who hadn't had a result, ring to explain what had happened and do another smear test.

If tests are mixed up from two women who attend on the same day, the mistake may not be noticed: someone could get the wrong result – a woman with nothing wrong gets referred to colposcopy, a woman with an abnormality is told her test is normal



Choose correctly

Why?

The lab get tests marked cervix from women with a history of total abdominal hysterectomy

Why are these questions asked?

This information helps interpret the appearance of the cells on the slide

Use for relevant information

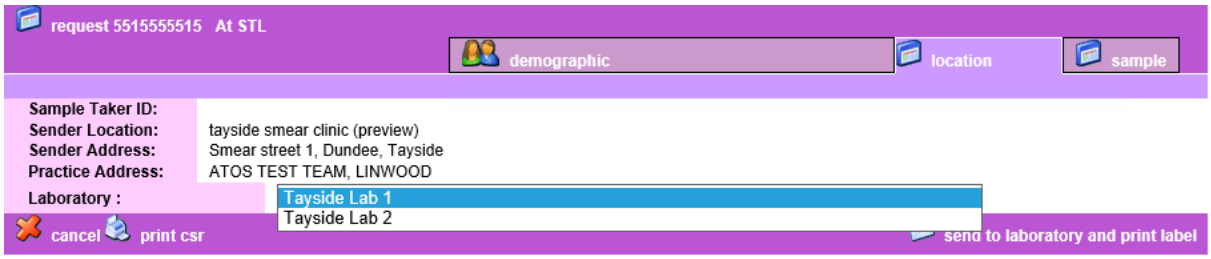
e.g patient on tamoxifen

Explain why 'suspicion of malignancy has been checked' for cervical appearance

The **location** tab of the CSR form (as shown) will allow users to check the Sample taker address details held and to see the default laboratory from the dropdown list. This is the laboratory where the Sample will be sent for processing.

Your default laboratory will be set to either Monklands or Glasgow. ***You should not change this default dropdown.***

The Practice address details displayed are what will appear on the various mailers when they are dispatched to the person. Below is an example of the view, although the details shown are from the test system.



For information please see below for each Health Boards default Laboratory

NHS Lanarkshire (Monklands)	NHS Greater Glasgow & Clyde
Contact Details: cervicalscreeningqueries@lanarkshire.scot.nhs.uk 01698 752359	Contact Details: Hpvlab.Enquiries@ggc.scot.nhs.uk 0141 354 9524
NHS Lanarkshire, NHS Lothian, NHS Forth Valley, NHS Borders, NHS D&G, NHS Highlands, NHS Western Isles, NHS Fife	NHS GG&C, NHS A&A, NHS Grampian, NHS Tayside, NHS Orkney, NHS Shetland

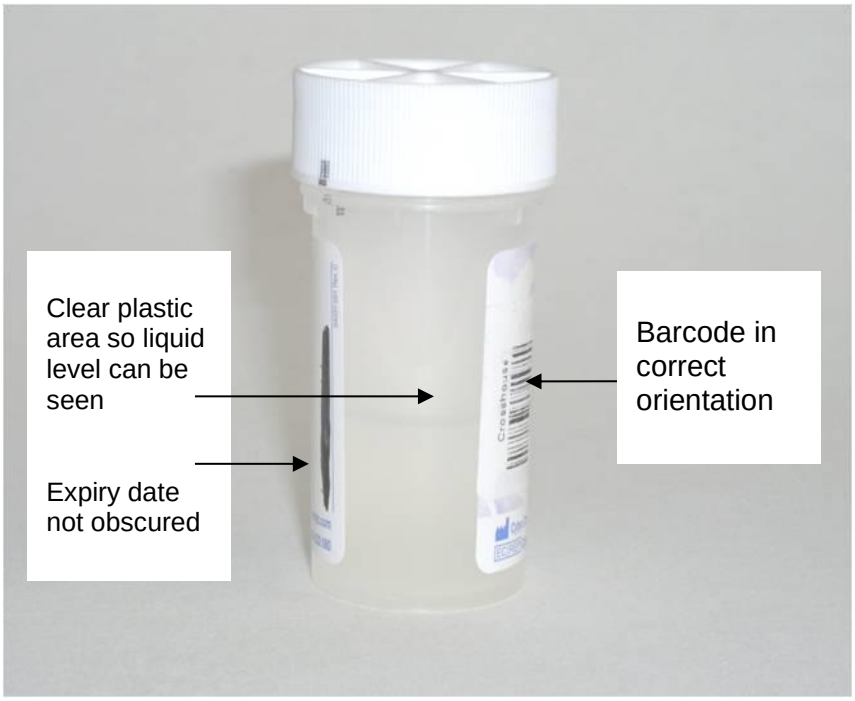
6.10. Applying barcode sticker

Make sure the pot is labelled with a SCCRS generated bar code label before it is sent to the lab!

There is only one correct direction for the bar code and that is vertical. This is because the pot is put directly into a processing machine which produces the slides for examination, and the machine identifies the sample by reading the barcode. The machine will not understand a barcode that is horizontal, misaligned, faded or illegible.

The SCCRS label should sit on the pot sticker so that neither the clear plastic area at the side of the pot nor the expiry date is obscured. This clear area is essential for the lab's processing machine to work. Also make sure that the barcode is the correct way round (see diagram 1).

Diagram 1: Applying SCCRS label to pot



Put the pot away from the working area so that it is not re-used by mistake.

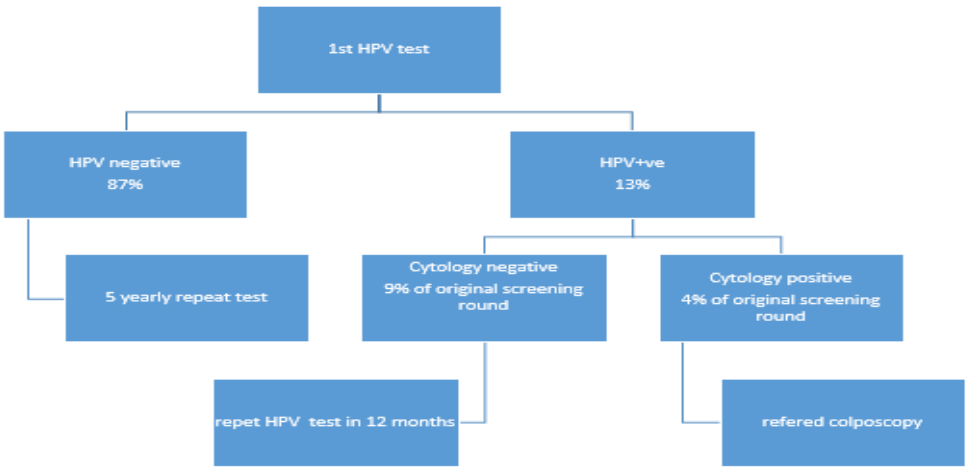
Put the pot in a polythene bag for transport to the lab only – only one pot per bag.

Some services print two labels and put one on the outside of the bag.

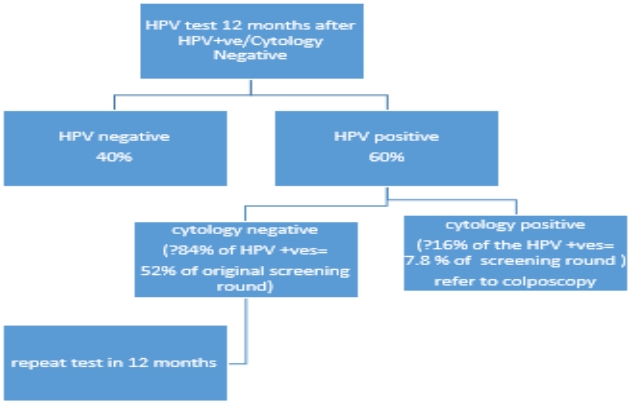
6.11. Results

Ensure that the patient knows when to expect their result and what to do if it is not received within the expected timeframe. SCCRS posts out results and national standards are that they should arrive within two weeks.

It is the sample takers responsibility to discuss results if the patient has questions. CRO staff are not able to answer clinical questions.



Someone getting a routine cervical screening test can be told that of 100 people tested, 87 will get a normal result (next test in 5 years) , 4 will get a colposcopy appointment as abnormal cells need to be checked out, and 9 will get a repeat test in a year as the HPV virus was found but the cells looked normal



Someone who has a repeat test after 12 months can be told that of 100 people tested, 40 in 100 will get a normal result (next test in 5 years), 8 in 100 will get a colposcopy appointment as abnormal cells need to be checked out , 52 in 100 will get a repeat test in a year as the HPV virus was found but the cells looked normal

7. Documentation

Document the consultation in the patient's records. The following points should be recorded as a minimum:

- Consent was formally obtained
- Cervix was fully visualised
- Date sample taken and by whom, clinical details (e.g. unusual appearances**)**
- Details of additional sampler, if used (N.B, this only applies to colposcopy)
- Details of last period
- Advise given on how to get results
- Chaperone attended/declined

8. Some Frequently Asked Questions

8.1. Should the patient refrain from sexual intercourse prior to a cervical test?

The general advice is to refrain from sexual intercourse for 24 hrs before the test as spermicides, barrier methods of contraception and lubricants contain chemicals that may affect the screening test.

8.2. What can you do if passing the speculum on a menopausal or post menopausal woman is too uncomfortable?

The main reasons for discomfort are vaginal atrophic changes that lead to vaginal dryness. In these situations, a small or even a virgin speculum often gives an adequate view (see advice on lubricant in Section 6.4).

If the vagina is atrophic and lubrication is not adequate for insertion of the speculum or visualisation of the cervix, then a short course of intravaginal estriol cream (Ovestin®) or estradiol vaginal tablets may be prescribed if not contraindicated. This helps to restore the vaginal epithelium so that a speculum may be passed and an adequate sample obtained. Give vaginal estrogen for a minimum of ten days before the test is taken, but advise not to put it in the night before the test in case presence of the excipients leads to an unsatisfactory result.

8.3. I can't find the cervix – what should I do?

Think about explanations and look for any notes made by previous sample takers.

- Previous colposcopy treatment or the menopause may have made the cervix smaller or flush with the vault.
- Previous pelvic bowel surgery can make the uterus very retroverted.
- Surgery for a uterine prolapse can shorten the cervix.

It may help to examine gently with one finger (no lubricant except water) to locate the cervix. If you can't find it run your finger along anterior wall as it may be very anterior. The uterus is retroverted in 20% of women – insert the speculum with the handle posteriorly (i.e. handle nearest the floor).

- Try a broader speculum if the walls are lax
- Use a longer speculum if the cervix is very posterior
- If the hips are fully flexed the pelvis is tilted more and the cervix is pushed forward. An examination bed with leg supports is ideal for this but, if you don't have one, ask the patient to pull their knees toward their chest with their hands (this means the feet have to come off the examination bed).

If you can't see the cervix NEVER take a blind sample. Seek advice and refer to colposcopy.

8.4 How do I manage someone with a double cervix?

A separate test should be taken from each cervix and put in a separate pot. Label each pot carefully with e.g. left /right or anterior/posterior and also note this in the free text of CSR in SCCRS. Each pot should have its own CSR. Both pots should be placed in the same plastic specimen bag as this helps the laboratory recognise that the two samples are from the same patient.

Refer to SCCRS NAP for further detail

Laboratory – SCCRS (scot.nhs.uk)

8.5. Does someone who had radiotherapy for cervical cancer get cervical screening?

Patients whose treatment for cervical and / or uterine cancer includes radiotherapy have follow up in a gynaecological oncology clinic, and should be ceased from the Scottish Cervical Screening Programme. Exclude as no further recall (NFR).

8.6. Does a patient who has had FGM get cervical screening?

Women who have had FGM remain at risk from cervical cancer and so should remain within the screening programme. Cervical screening may be a point of access to services (see Section 5.4). Taking a cervical sample in such cases should be handled sensitively and may not always be possible. Every woman should be considered individually.

8.7. Do people diagnosed with HIV get more frequent cervical screening?

Annual cytology should be performed for women living with HIV. This is an automatic process within SCCRS for those identified living with HIV, these patients if known to the laboratory will have a Flag 1B attached to their record.

Other causes of immunosuppression are not an indication for more frequent screenings

Individuals taking maintenance immunosuppression medication post-transplantation

Individuals taking maintenance immunosuppression medication after transplantation who have no history of CIN should have cervical screening in accordance with the national guidelines for the general population. Any abnormal screening result should be managed as per the current pathway

A variety of immunosuppressant drugs increase the risk of contracting hrHPV (for example, drugs used following organ transplantation, or for treatment of autoimmune or neurological disorders). However they have no impact on the rate of progression through hrHPV and CIN to cervical cancer, which takes many years. The increased risk of contracting hrHPV however means it is important that people taking immunosuppression medication engage with cervical screening when invited.

8.8. How do I manage requests for cervical screening from people outwith the screening programme ages?

They should not have a test. Find out what their concern is and see if it can be addressed. Patients do not have a right to a test if they do not fulfil screening criteria. If your patient has symptoms manage them / refer to the appropriate service e.g. gynaecology. In this case a cervical screening test is not appropriate as screening is for asymptomatic individuals within the eligible age range.

Tests taken from patients out with the eligible age range of age 25 -65 will not be processed by the laboratory and it will be your responsibility to advise the patient that a result will not be provided.

If you are unsure whether an individual is eligible for screening due to age, enter the CHI number onto SCCRS and check the date of birth. If the CHI number is not already on the system and you cannot bring the CHI number in, do not take the test.

8.9. What do I say to someone who wants cervical screening more frequently than the programme protocols?

Politely explain that the screening programme does not offer more frequent screening than policy sets out. Try and explore the patients concerns but do not take a test if it is not due.. Too frequent samples may lead to false positive results with consequent unnecessary investigation.

8.10. Should people with a terminal illness be excluded from screening?

For as long as possible, people with a terminal condition should continue to be treated in the same way as those who do not have a terminal illness. This includes being invited for cervical screening: it is then the individual's decision whether or not to attend. Care should reflect the individual's situation.

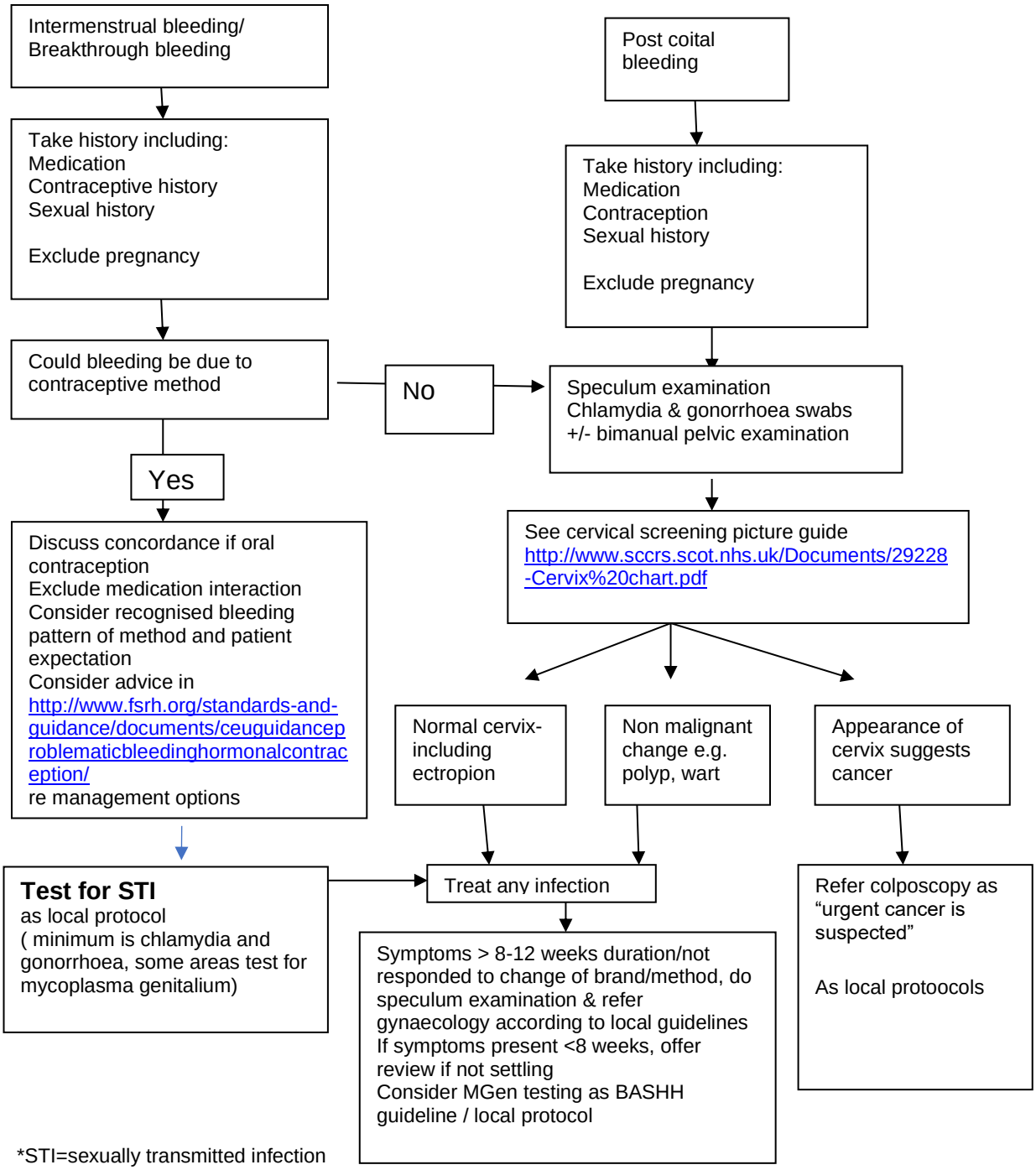
8.11. How do I manage young women (under 25 years old) with abnormal bleeding?

Bear in mind this information:

Probability that a woman developing cervical cancer in the community has cervical cancer (data from systematic review)[6]				
Age (years)	Annual cumulative incidence of PCB/100 women	Women with cervical cancer who present with PCB (%)	Annual incidence cervical cancer/ 100 000 women (England)	Probability that a woman developing PCB in the community has cervical cancer
20-24	12.6	11	2.6	1 in 44,000
25-34	7.2	11	11.7	1 in 5600
35-44	4.8	11	15.8	1 in 2800

45-54	3.4	11	12.7	1 in 2400

Management Algorithm for under 25's with intermenstrual, breakthrough or postcoital bleeding



*STI=sexually transmitted infection

refs

doh-guidelines-young-women.pdf (publishing.service.gov.uk)

https://www.cancerreferral.scot.nhs.uk/gynaecological-cancers/

http://www.fsrh.org/standards-and-guidance/documents/ceuguidanceproblematicbleedinghormonalcontraception/

29228-Cervix-chart.pdf (scot.nhs.uk)

https://www.bashhguidelines.org/current-guidelines/urethritis-and-cervicitis/mycoplasma-genitalium-2018/

8.12. My patient had a hysterectomy: why has she been told to get a vault sample?

If a hysterectomy showed CIN in the specimen vault tests are taken, see the Scottish Cervical Screening Programme Colposcopy and Programme Management Addendum to NHSCSP Publication No 20 Third Edition –Exceptions Applicable in NHS Scotland May 2017.

http://www.sccrs.scot.nhs.uk/wp-content/uploads/2023/03/Addendum-v1.2.pdf

Vault smears should be undertaken by local gynae/colp clinics and not in primary care.

9. Complications arising from the Procedure

Taking a cervical sample is a simple procedure yet some patients do become distressed. This may be caused by a previous difficult life experience making it difficult for them to relax, or to a physical problem: e.g. vaginitis, pelvic infection, vulvodynia, endometriosis. Psychosexual problems may present with vaginismus during cervical screening.

In the event of pain or distress, the possible reasons should be sympathetically explored and appropriate action taken. All that may be needed is to help them relax, although it may emerge that further help is needed: e.g. referral for psychosexual counselling or referral for rape counselling. It is appropriate to abandon a procedure because it is too painful or distressing to continue.

10. Discussing Results – sample scripts

Staff who take cervical screening tests are responsible for making sure the patient is able to get advice about the results. Within practices there should be an agreed procedure for dealing with requests for advice. Advise them who to call if they have questions – do **not** tell patients to ring the Call Recall Office. Results should be accessed through SCCRS.

10.1. What could I say to explain what a negative result means?

“There is a low risk (not no risk) of developing cancer before the next test is due so abnormal bleeding or discharge should be reported.

“The test can sometimes miss changes and changes can also happen between tests, so it is important for people to go for a smear test every time they are invited.”

10.2. What could I say to explain a result showing Hr-HPV but no abnormal cells?

“If your cervical screening test finds HPV, the cells in the sample are looked at next. If the cells look normal that is reassuring, and another test is done in a year to check if anything has changed. Often the body has got rid of the HPV and you go back to 5 yearly screening”.

“Most changes in the cells of the cervix are caused by a virus called the human papilloma virus (HPV). HPV is very common – 8 out of 10 people in Scotland will catch it at some point in their lives.

It is spread through close skin to skin contact during any type of sexual activity with a man or woman. HPV can stay in the body for many years. It can stay at very low or undetectable levels and not cause any problems. This means an HPV infection may have come from a partner a long time ago.

There are many different types of HPV, but only some high-risk types can lead to cancer. The types of HPV that cause cervical cancer do not cause any symptoms. In most cases, your

immune system can get rid of the virus without you ever knowing you had it. But sometimes, HPV can cause cells in your cervix to become abnormal.

Your body can usually get rid of the abnormal cells and your cervix returns to normal. But sometimes this doesn't happen, and the abnormal cells can go on to develop into cancer.

"There's no treatment to get rid of HPV. For most people their immune system will get rid of HPV – like getting rid of a common cold. Smoking increases the risk of cervical cancer because it makes it harder for your body to get rid of HPV infections". (offer smoking cessation support).

10.3. What could I say to explain a result showing Hr HPV and abnormal cells?

"Up to 1 in 10 cervical screening results have abnormal cells, so it is not particularly unusual. **It is extremely rare for an abnormality found at screening to be cancer. Nearly all abnormal results show no more than small changes in cells.** In most cases these changes would never develop into cancer, but as we can't be sure which cases will get worse everyone gets checked. Fortunately, it usually takes many years for cancer of the cervix to develop, so it is very rare, especially in people who have regular cervical screening, for an abnormal result to show that cancer has already developed."

"The test looks for changes that are so small they can only be seen with a microscope. Under the microscope a change in the appearance of the cells can be seen."

"When these changes are detected you are referred to a colposcopy clinic for examination to check whether the changes need to be monitored or treated."

"Minor changes often clear up on their own, and do not require any treatment."

"Sex does not make any abnormality worse, and you cannot pass abnormal cells on to your partner. Enjoy sex as usual."

10.4. What could I say to explain an 'unsatisfactory/unclear' result?

Occasionally a sample result may be called 'HPV fail'. This may be due to a technical problem, for example, if the laboratory cannot get an HPV test result from your sample. Occasionally a sample may be called 'unsatisfactory'. This may be due to insufficient cellular content in the sample*. If you have either of these results, you will be invited for another cervical screening test.

* Other possible reasons are detailed in the comments section of the report which can be relayed to the patient. If comments are not available then sample takers can contact the laboratory for further information.

The recommended timeframe from primary sample being taken is 3 months. This period allows the cervical epithelium to sufficiently recover to ensure a representative sample.

10.5. What could I say about reporting symptoms?

"There are usually no symptoms with changes in cervical cells and sometimes there are no symptoms with early stage cervical cancer. Let us know if you have any unusual discharge, or bleeding after sex, between periods or after the menopause."

10.6. What can I say to tell someone about the colposcopy clinic?

"A colposcopy is an examination of the cervix using a special microscope called a colposcope. The colposcope looks like a large pair of binoculars on a stand. It doesn't go inside you. The specialist will gently insert a speculum into your vagina and will look at your cervix through the colposcope.

The colposcope magnifies your cervix so that the specialist can see if there are changes, if applicable where they are, and what they look like. Detailed information about colposcopy will be sent to you with your appointment for the colposcopy clinic."

"A biopsy may be taken. This is a small piece of skin from the cervix about the size of a grain of rice, and the whole procedure takes 5-10 minutes. Sometimes patients have a little bleeding and some period pain-type cramps afterwards. Normal painkillers like Ibuprofen can be taken to help. Often treatment isn't necessary. If this is the case, the specialist will explain why and let you know when to have your next smear test. In some cases, you'll be asked to come back to the clinic for further colposcopy examinations."

"If treatment is necessary, you will have a local anaesthetic and you should feel no more than slight discomfort. The specialist treating you will explain what to expect. "

"Your follow-up appointment may be with your specialist; nurse or GP as is right for your case."

"Treatment, if needed, is simple and very effective. You will usually be treated as an outpatient. You can have sex again within a few weeks of treatment."

"Having an abnormal screening result does not affect your ability to have children. The colposcopist will discuss any effects treatment may have on pregnancy."

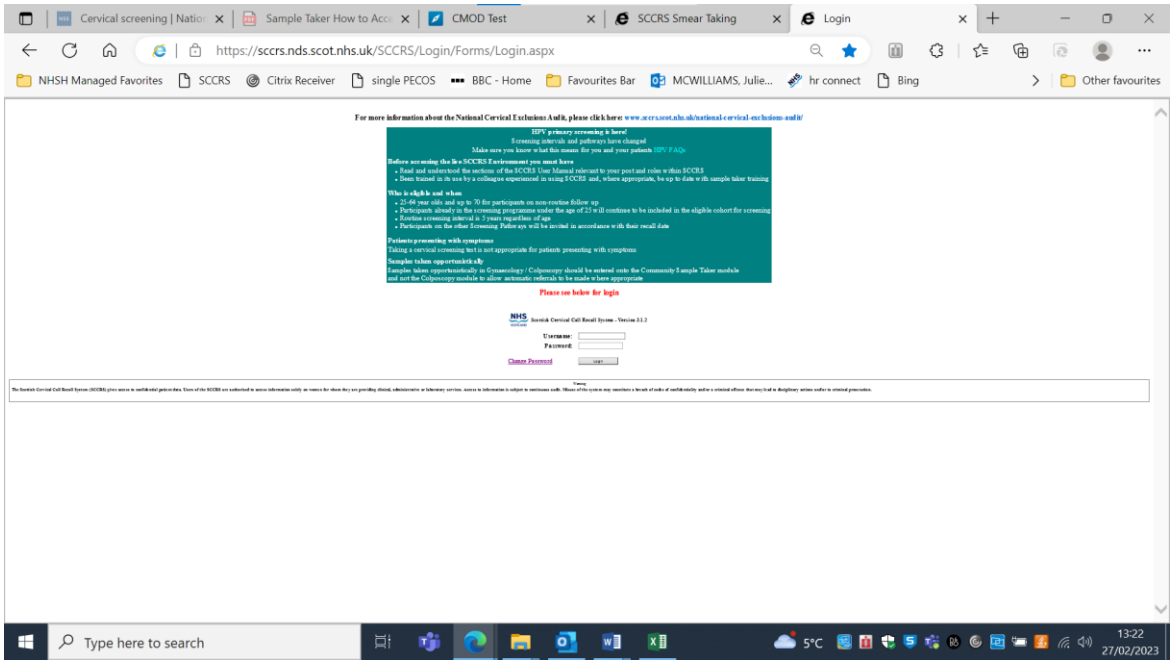
10.7. Common concerns

These may not be voiced but can be raised pro-actively, and include:

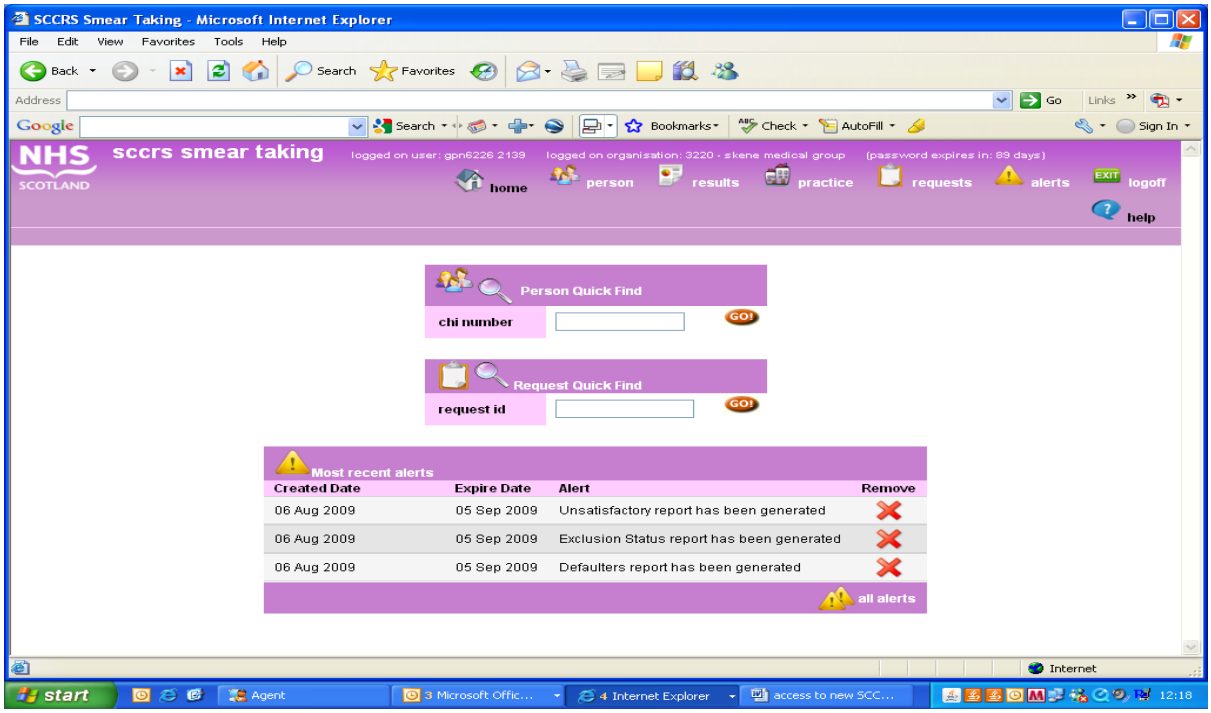
- I have cancer
- I will be infertile
- I will have to have a hysterectomy
- My relationship with my partner will be affected
- I will make my partner ill
- This means my partner has been unfaithful
- I am being punished for having sex with more than one partner
- Waiting for six months for another test is too long and things will get worse
- I am pregnant; will my baby be harmed by the abnormal cells / investigations / treatment?
- Will treatment change my periods?
- This is the fault of my contraception
- My abnormal cervical screening test result is linked to other symptoms
- Cervical cancer runs in families

11.How to access SCCRS reports

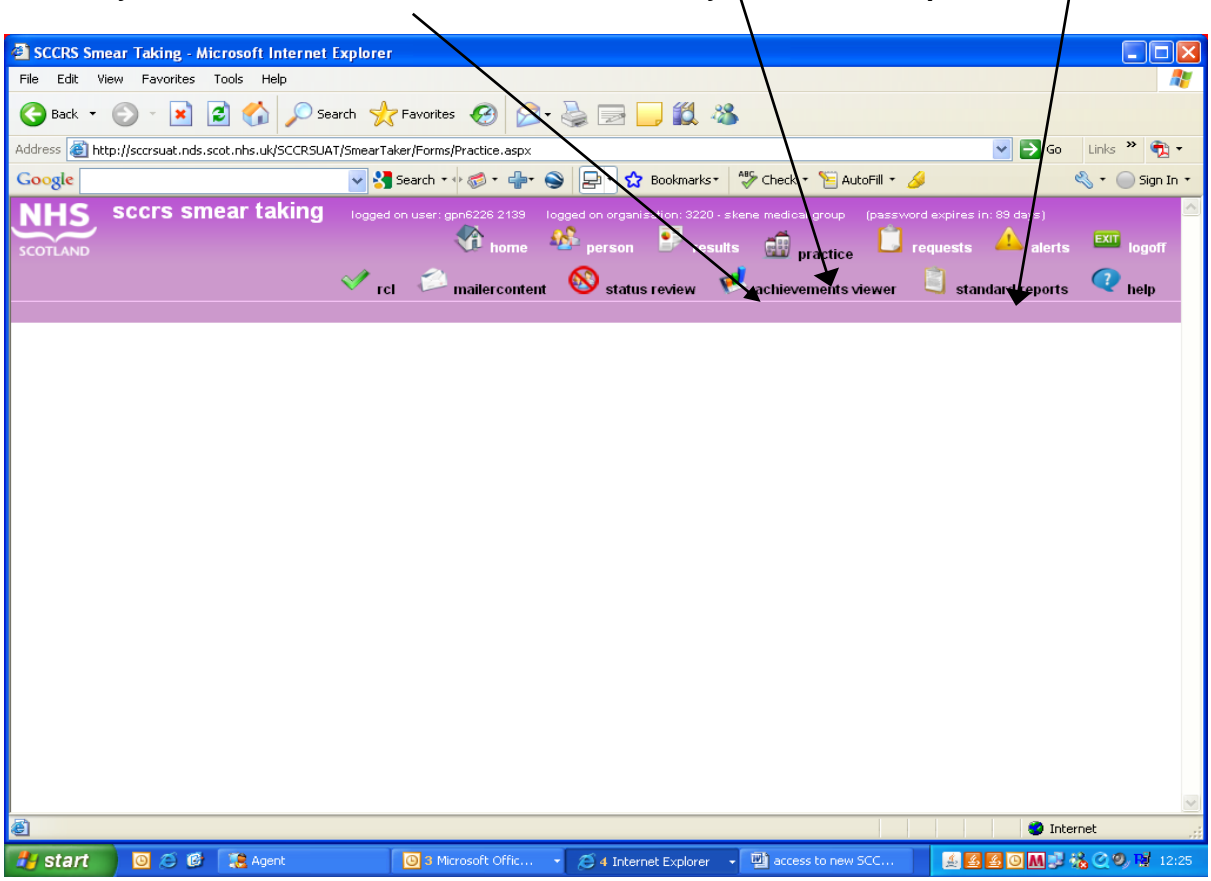
How to access SCCRS Reports



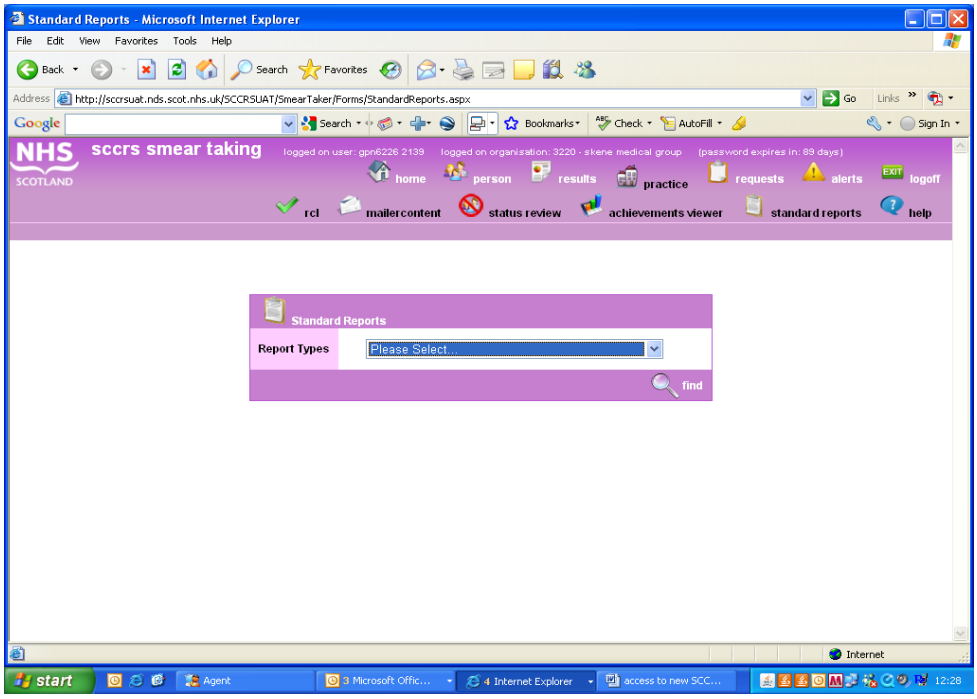
When you login your home page will look similar to this – please note that an alert will be created to inform you when a new report has been generated. You cannot access the report from this alert.



From the **'Home'** page you should click on the **'Practice'** tab. You will now see two headers, one which says **'Achievements viewer'** and one which says **'Standard Reports'**



When you click on the **'Standard Reports'** tab you will see the screen below.

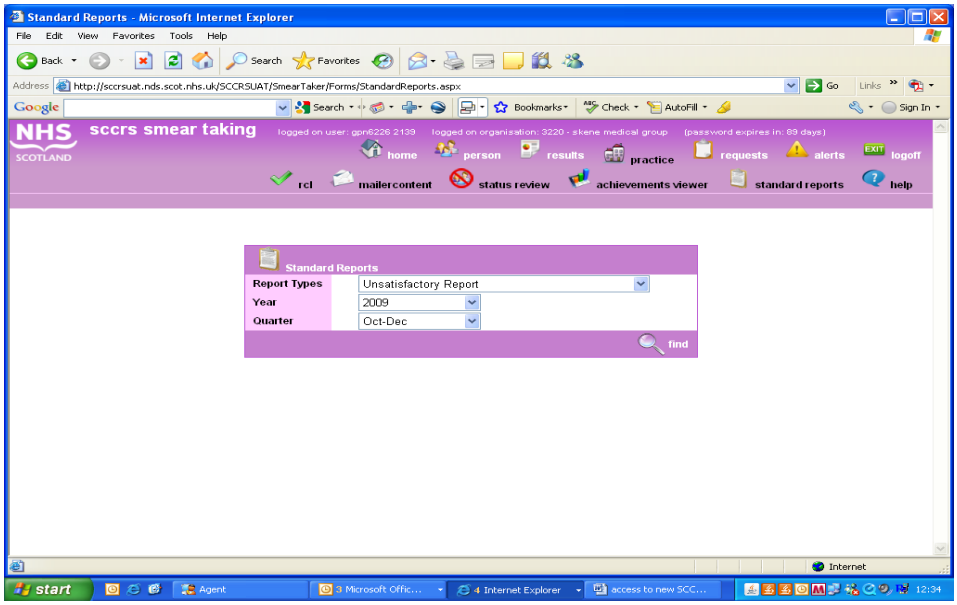


From this screen you can now choose which Report Type you wish to view from the **Unsatisfactory Reports,** or the **Defaulter Report.**

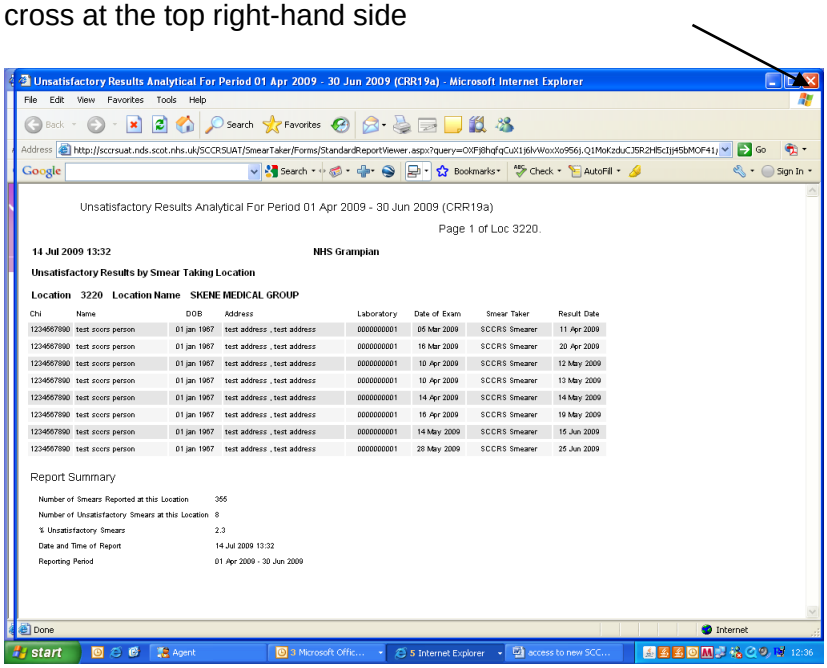
Please note that when you choose a report to view, a new windows page will be opened.

If you have any problems with viewing the report please check that **pop-ups** are not currently being blocked from this website.

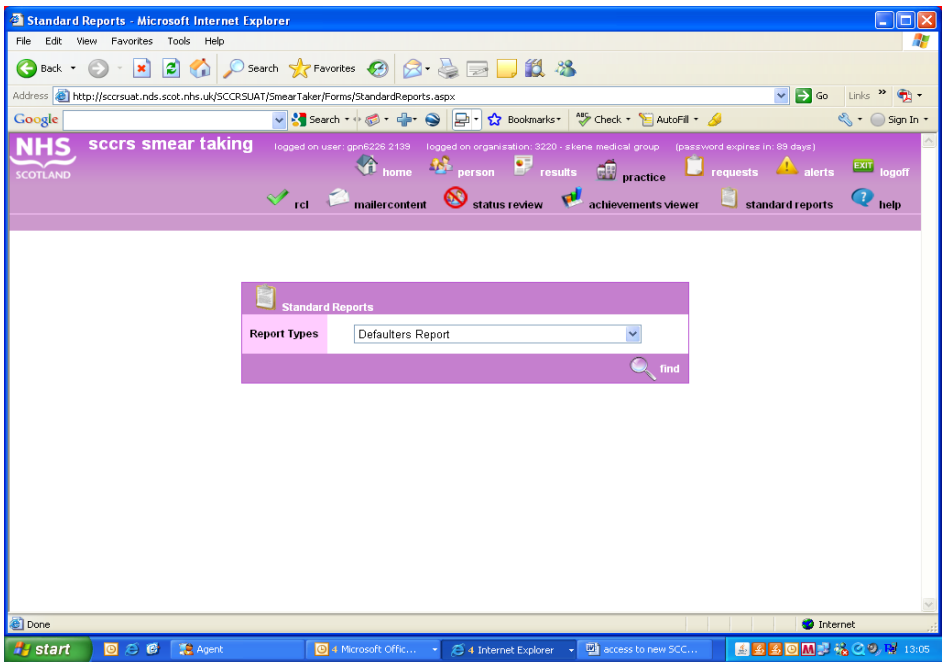
In the ‘Unsatisfactory Report’ you will be able to request which Quarter you wish to view.



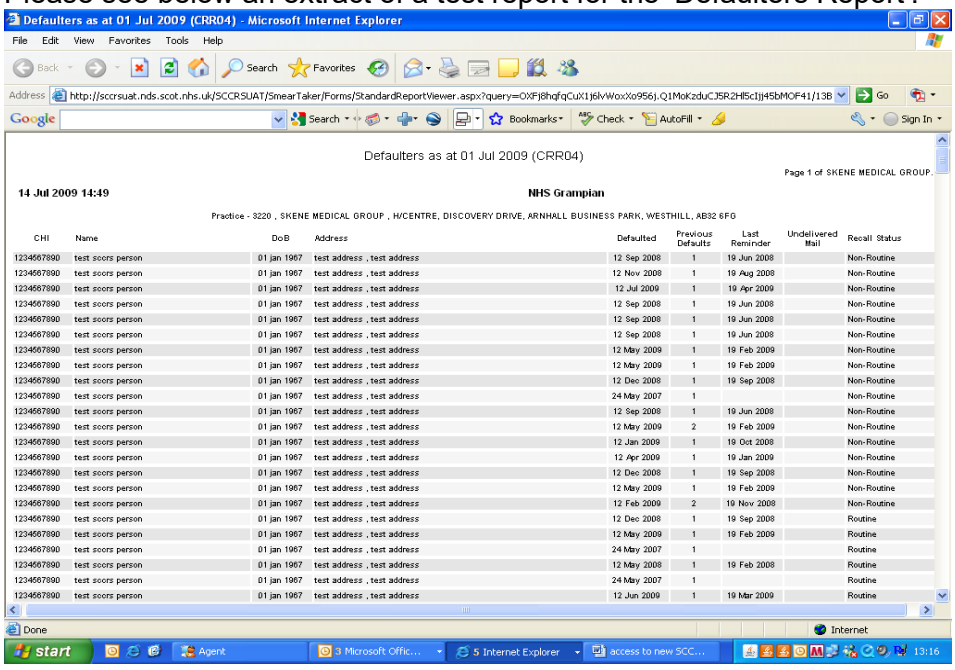
Please see below test page for ‘Unsatisfactory Report’. To close any report simply click on the red cross at the top right-hand side



In the ‘Defaulters Report’ you will only see 1 month at any given time as this report will contain everyone in your practice with a Defaulter Exclusion Status applied at the time the report is run.



Please see below an extract of a test report for the 'Defaulters Report'.



12. Ensuring a Failsafe Cervical Screening Programme

- It is the responsibility of the person taking the test to ensure the person knows how to obtain their result and what action to take if they do not receive it.
- If referral to colposcopy is required on the basis of the cervical screening test result this is done by the laboratory via SCCRS
- If you tick 'suspicious' for the appearance of the cervix at the time the sample is taken, you are responsible for making the coloposcopic referral. This will not be done automatically by SCCRS.
- SCCRS has 'failsafe' mechanisms intended to ensure that patients are invited to have a sample at appropriate interval, and to follow up abnormal results so that they do not go untreated

- Systems should be in place at a local level to provide regular audit and a named person within each practice/service should be responsible for an overview of the screening programme
- A number of alerts are generated within SCCRS. Systems should be place at a local level to ensure the alerts are reviewed and acted upon.

SCCRS Exclusions

There are two kinds of permanent exclusions which can be applied by SCCRS users:

- No Cervix
- No Further Recall

No Cervix

If a no cervix exclusion status is added by a GP practice and clinical evidence (Hysterectomy operation letter or discharge/clinic letter in relation to the surgical episode, reporting total hysterectomy -see below guidance for details of clinical evidence requirements) of the absence of the cervix is not provided, CRO will contact the user to provide clinical evidence. Previously GP practices were asked to provide two pieces of evidence, however one piece of clinical evidence is now sufficient. The reason for adding No Cervix is detailed below. The alert will remain open until evidence is received. If not received on the same day, CRO will close the exclusion and contact the GP practice to advise the exclusion has been closed and the patient will carry on being invited for screening.

USER PERMANENTLY EXCLUDES AS NO CERVIX	
Appropriately Excluded as No Cx	**Correct Action**
Total hysterectomy	Exclude as No Cervix
Female Transgender	Exclude as No Cervix. Add a Journal Note: "Patient has no cervix, never had a cervix."
Congenital absence of cervix or Rokitansky syndrome/Mayer-Rokitansky-Kuster-Hauser (MRKH)	Exclude as No Cervix

Type of document	Author	Content
Formal, **typed** discharge letter following hysterectomy • Excludes immediate discharge summary • Excludes discharge letter for a separate clinical episode (eg if hysterectomy is included in "past medical history" section)	Consultant gynaecologist or gynaecology registrar (or written by more junior doctor but checked by consultant)	Reference made to at least one of the following terms: o Total abdominal hysterectomy (TAH) o Total laparoscopic hysterectomy (TLH) o Laparoscopically assisted vaginal hysterectomy (LAVH) o Vaginal hysterectomy (VH)
Operation note • Includes hand-written and typed	Operating gynaecologist (consultant or registrar)	Reference made to at least one of the following terms: o Total abdominal hysterectomy (TAH) o Total laparoscopic hysterectomy (TLH) o Laparoscopically assisted vaginal hysterectomy (LAVH) o Vaginal hysterectomy (VH)
Gynaecology clinic letter • Includes correspondence from clinic to GP/other specialty relating to post-surgery follow-up • Excludes clinic letters related to other clinical episodes/procedures	Consultant gynaecologist or gynaecology registrar	Reference made to at least one of the following terms: o Total abdominal hysterectomy (TAH) o Total laparoscopic hysterectomy (TLH) o Laparoscopically assisted vaginal hysterectomy (LAVH) o Vaginal hysterectomy (VH)

No further recall (NFR)

The table below provides guidance for GP practice/CRO on when it is appropriate to apply the NFR exclusion

Appropriately Excluded As NFR	Not Appropriate	Seek Guidance	Correct Action
Pelvic radiotherapy treatment completed	Before treatment		Exclude as co morbid until treatment ends
	If patient has had other radiotherapy anywhere other than pelvic.		If patient wishes to pause due to other illness Exclude as co morbid
	During treatment		Exclude as co morbid until treatment ends

13. Health Promotion

Cervical screening offers an opportunity to discuss sexual health concerns and, as appropriate, contraception, safer sex and the menopause.

Routinely offering chlamydia tests to asymptomatic people at cervical screening is no longer advocated as a review of the evidence suggests chlamydia causes harm much less frequently than was thought in the past.

A chlamydia test should be done if there is intermenstrual or postcoital bleeding or if requested because of concern about a risk of catching a Sexually Transmitted Infection (STI). An STI screen can then be undertaken – discuss chlamydia, gonorrhoea, HIV and syphilis testing.

It is important to make sure the patient knows tests are being done, that these are STIs, how to get the result of the tests, where to get treatment if needed, and the need to treat a partner if an STI is found.

Women may not volunteer menopausal problems such as vaginal dryness causing sexual difficulties: a proactive approach is advocated.

14. Equality and Diversity Impact Assessment

- Patients/carers may require communication in an alternative format e.g. other languages or signing. Additionally, some patients/carers may have difficulties with written material. At all times, communication and material should be in the person/carers preferred format. This may also apply to patients with learning difficulties

- In some circumstances there may be religious and/or cultural issues which may impact on clinical guidelines: e.g. choice of gender of health care professional. Consideration should be given to these issues when treating or examining patients

- Some patients may have a physical disability or impairment that makes it difficult for them to be treated or examined as set out for a particular procedure, requiring adaptations to be made

- A patient's sexual orientation may or may not be relevant to the implementation of this guideline, however non-sexuality specific language should be used when asking patients about their sexual history. Where sexuality may be relevant, tailored advice and information

may be given. The most up-to-date advice is that all women should be offered cervical screening regardless of their sexuality.

15. References

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   http://www.healthscotland.com/documents/24327.aspx
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2. Standards for education providers: cervical cytology. NES 2013
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3. SCCRS smear taker manual http://www.sccrs.scot.nhs.uk/wp-content/uploads/2021/12/STUM_Release-3.0.doc
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4. Cervical Screening Programme HPV Introduction Final Version Questions and answers paper
   http://www.healthscotland.scot/publications/scottish-cervical-screening-programme-primary-care-resources
   Accessed 13/02/2023

5. Pubic Health England. Cervical screening: programme and colposcopy management Guidelines for commissioners, screening providers and programme managers for NHS cervical screening. *https://www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management Accessed 13/02/2023*

6. M Shapley, J Jordan, PR Croft : A systematic review of postcoital bleeding and risk of cervical cancer. *British Journal of General Practice 2006*; 56: 453–460.

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8. Intimate examinations and chaperones (2013)
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9. National Infection Prevention and Control Manual Health protection Scotland Version 3 April 2016
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10. Appendix 6 - Best Practice - Putting On and Removing PPE
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Hyperlinks

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Leaflets on STIs, Vaginal health (candida and BV), PMS (see list on right side of page – links to pdfs): http://www.healthscotland.com/topics/health/wish/resources.aspx *Accessed 24/06/2019*

Contraception and STIs- links to pdfs: https://www.sexwise.fpa.org.uk/
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NSD Website: https://www.nsd.scot.nhs.uk/index.html

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