Scottish Cervical Screening Programme

Report of Working Group on Call-recall Arrangements in the Scottish Cervical Screening Programme

Foreword and Acknowledgements

The Scottish Cervical Screening Programme (SCSP) was introduced in 1987 and is now well established. Over 87% of women invited for screening attend and the Programme has been successful in reducing incidence and mortality from cervical cancer by over 34% since 1986.

The Cervical Screening Programme is complex and involves many different people and professions. Over 400,000 women are invited each year for screening and this involves call-recall, smear takers, laboratory staff and sometimes gynaecologists. From the time a woman is invited for screening to the time she has received her result, and if necessary her treatment, all those involved in the Programme must work together to ensure that each step of the screening process is provided. The backbone to the Programme lies in effective management of call-recall. The call-recall service links together each of the necessary steps and ensures that once the screening process is completed for each woman, she is either returned to the system to be called again when her next smear is due, or removed so that she is not invited inappropriately. From the outset of the Programme, call-recall has been organised locally and as a result it is now somewhat fragmented which can present problems as women move home or change GP practice.

Following a Quality Improvement Review of Cervical Screening Call-recall Arrangements in Scotland, the Minister for Health commissioned further work on developing a standard, national approach to cervical screening. This Report represents the findings and recommendations of the Working Party on Call-recall Arrangements in the SCSP and I am pleased to present it to the Minister.

Using the baseline developed by the Quality Improvement Review, the Call-recall Working Group has gone on to develop a national framework for cervical screening in Scotland which includes standardising many of the local protocols and proposing strengthened management arrangements. This would not have been possible without the open and constructive involvement of those currently providing cervical screening. Their willingness to explore options, to embrace change and to work together has been vital to the success of this work and hopefully they will be fully involved in the implementation of the national framework.

Thanks are also due to the Working Group members who have given freely of their time and have provided valuable input. In particular, the support of the Scottish Screening Programmes’ Central Co-ordinating Unit and the Scottish Executive Health Improvement Strategy Division is acknowledged.

Trevor Jones
Chairman, SCSP Call-recall Working Group
November 2000
Scottish Cervical Screening Programme

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1. **Background**

1.1 Cervical Screening is a method of preventing cancer of the cervix by detecting and treating abnormal changes in a woman’s cervix which, if left untreated, may develop into invasive cervical cancer. The first stage in cervical screening is a smear test, which is a relatively simple procedure, usually carried out by General Practitioners (GPs), or more commonly, their practice nurses. The smear test is not a diagnostic test and if an abnormality is detected, the test may need to be repeated or followed by further investigation (usually colposcopy) to obtain a diagnosis. If the abnormality is confirmed to be pre-malignant, it can be treated easily on an out-patient basis and the development of invasive cancer should be prevented.

1.2 Cervical screening began in Scotland in the mid-1960s on an ad hoc basis. Although many women were having regular smear tests by the mid-1980s, there was concern that those at greatest risk were not being tested and those who had positive results were not being followed up and treated effectively. A Scotland-wide cervical screening programme was set up in 1987 when the Scottish Home and Health Department required all Scottish Health Boards to introduce computerised call-recall systems and to meet certain quality standards. The Boards were required to complete calling the first ‘round’ of women by 1991 and since then, the Programme has continued to develop. A summary of key events in the programme is shown at Appendix II.

1.3 The current policy in Scotland is that women aged 20-60 are invited to have a free cervical smear test at least once every five years. In practice, all Scottish Health Boards invite women every three years. The programme screens over 350,000 women each year and processes over 480,000 smears annually. Of the 1,178,395 women eligible for screening, over 87% have been screened in the last 5 years and it is estimated that up to 250 cases of cervical cancer are prevented each year. Since 1986, the incidence of invasive cervical cancer has fallen by 34% in Scotland and there has also been a 34% reduction in deaths from the disease.

2. **Organisation of the Programme**

2.1 The cervical screening programme is complex and many people and professions are involved in providing this service. They include those who take the smears, laboratory staff who interpret the smears, gynaecologists who carry out further investigations and provide treatment, the people who run the screening call-recall services and consultants in public health medicine who monitor the programme.

2.2 Unlike the breast screening programme, there was very little national co-ordination during the establishment of cervical screening and although smear-taking procedures and laboratory processes are fairly standard across Scotland, Health Boards made their own arrangements for the introduction of computerised call-recall systems. As a result of this, there is considerable variation in the organisation of call-recall across Scotland which is provided by Health Boards, Primary Care Trusts, GP surgeries and laboratories. There is not only variation in the organisation of these services, but also in the systems and
definitions used; even within each system there are variations in the way invitations, reminders and results are issued.

2.3 Until 1996, the Central Co-ordinating Unit (CCU), was mainly responsible for commissioning breast screening services and for monitoring the performance of the breast screening programme. From 1996 the CCU was expanded to include cervical screening. The CCU is based in the Common Services Agency (CSA) of the NHS in Scotland and is now responsible for improving the overall performance of the cervical screening programme by developing systems and guidance to support those running the programme and by establishing and supporting a quality assurance framework.

2.4 Much has already been done to improve the quality of smear reporting and laboratory processes, including the introduction of training for smear takers and of proficiency testing and internal quality control (IQC) procedures in laboratories. These quality improvements were introduced in part in response to problems identified in the way laboratories were run, and in part in response to the results of audit and monitoring. They have been very effective in introducing a more standard approach to cervical cytology across Scotland and have also strengthened the laboratory network across the country.

2.5 The CCU is now looking at other aspects of the screening process that may require strengthening and has identified call-recall arrangements as one of the most critical elements of the Programme. It is call-recall that knits together all the various health professionals involved in cervical screening and it is call-recall that has responsibility for ensuring that eligible women are invited and that the whole process of cervical screening works effectively for them.

3. Quality Improvement Review of Call-Recall Arrangements in Scotland

3.1 Of the cervical screening ‘incidents’ identified in Scotland over the last three years, most have involved the call-recall process and there have been several large-scale retrospective reviews undertaken to check that screening history records are correct and that women have been appropriately followed-up. Such incidents have the potential to affect public confidence in the screening programme and can also affect staff morale. In order to gain more understanding of why there appear to be problems with call-recall processes and systems and to address any common issues, the Minister for Health commissioned a Quality Improvement Review of the cervical screening call-recall arrangements in place throughout Scotland. This Review was led by Dr Jocelyn Imrie, recently appointed Quality Assurance Director for the SCSP, and was supported by a multidisciplinary Steering Group. The findings of this Review were reported to the Minister through the Scottish Medical and Scientific Advisory Committee (SMASAC) in March 2000.

3.2 The Quality Improvement Review found that adequate call-recall and follow-up arrangements have been established in all Health Boards in Scotland, and cervical screening co-ordinating groups have been established in every Board, except Orkney and Shetland who have established close and collaborative links with Grampian Health Board. Every Board area also has staff with specific responsibility for call-recall and follow-up arrangements, although in many Boards there is a high dependency on key individuals and limited cover during absences.
3.3 However the Review Team did identify a number of factors that currently impinge on the effectiveness of the call-recall arrangements in place in the cervical screening programme, in particular:

3.3.1 Call-Recall Systems in Use at Health Board Level: Some Health Boards had already introduced cervical screening before the national cervical screening programme was established. In particular, Tayside had developed a Board-wide call-recall system and Fife and Forth Valley subsequently took this on. This system is known as OCCURS (On-line Cervical Cytology Update and Recall System) and has been developed and supported by the three Boards since it was introduced. All other Health Boards use the Cervical Cytology System (CCS) which was centrally developed as an integral module of the Community Health Index (CHI). Both systems use the CHI as the basis for selecting eligible women for screening although functionally the systems are different.

Over time, there has been little opportunity to standardise the two systems. OCCURS support and development has always been funded locally and has competed against a range of divergent pressures, while the CCS was considered a ‘national’ system that was part of the CHI Community and Preventative Care (CPC) arrangements, and development and support have been centrally funded, managed and monitored from the outset.

The audit carried out by the Quality Improvement Review reflected a general acceptance that while it may have been appropriate to run two systems when the programme was first introduced, a technical and functional review is now required. There was also a lack of clarity about whose responsibility it was to ensure that all those involved in call-recall at an operational level (including systems developers and the primary care team) were aware of any changes in guidance and were given clear instructions on any implications for call-recall systems.

3.3.2 Call-Recall Arrangements in General Practice: Under the GP contract of 1990, GPs receive target payments for the screening of eligible women in their practice. They receive a basic target payment if 50% or more of these women have been screened in the last 5.5 years and a higher payment if 80% or more have been screened. When this was introduced, many GPs were keen to organise their own call-recall arrangements as they found the OCCURS and CCS listings inflexible and difficult to use. In order to support this, GPs led the development of call-recall modules for their GP practice IT systems (GPASS is in use in over 80% of practices) and since then there has been an increasing move to GP based arrangements in some areas. Both the Review Team and the Boards recognised that it is difficult to monitor GP call-recall activity directly, particularly for follow-up, and in some Boards, it is difficult to reconcile the various listings produced by call-recall and the GPs.

3.4 The Quality Improvement Review also identified a range of other factors affecting cervical screening arrangements, including the impact of the reorganisation of the NHSiS, the role of the Health Board Co-ordinators and the Central Co-ordinating Unit and the need to promote professional and public awareness of the programme.

In particular, those involved in providing cervical screening are keen to find ways of raising awareness about personal responsibility for attending for screening, as well as professional responsibility for providing screening services. The importance of presenting information in a way that allows people to make choices is recognised and more training and health promotion ‘tools’ are needed if this is to be effective. It is particularly important that GPs are not penalised for respecting choice.
3.5 The recommendations made by the Quality Improvement Review Steering Group fell into four categories:

- Guidance
- Computerised call-recall systems and the relevant interfaces
- Organisational and monitoring
- Strategic

3.6 The recommendations in each of these categories related to cervical screening, and in particular, the Steering Group found that the way in which call-recall is currently organised does not fully support the delivery of the cervical screening programme. They recommended that a full business requirements specification reflecting current (and future) requirements is drawn up and stressed that this specification should result in a consistent Scotland-wide call-recall system underpinned by the appropriate clinical data for the collection of monitoring statistics and other relevant information.

3.7 They also recommended that management responsibilities for running call-recall should be defined and should cover all those involved in cervical screening call-recall arrangements, namely:

- Health Boards
- Primary Care Trusts (including GPs)
- Acute Trusts (including laboratories)
- Practitioner Services Division
- The Central Co-ordinating Unit

3.8 To take this work forward, they proposed that a small working group should be established including representatives from primary care, public health, gynaecology, pathology and information services providers. The Minister for Health accepted this recommendation and the Working Group on SCSP Call-Recall Arrangements was established in June 2000.

4. Remit of the Working Group

4.1 The following remit was provided by the Minister:

- To develop a business case for a national screening call-recall system and to make recommendations on the development and implementation of the system with appropriate timescales and costs
- To make recommendations, taking into account the proposed national system, on the future management arrangements for cervical screening call-recall

Membership of the Working Group is given in Appendix I.
5. **Guiding Principles**

5.1 The Working Group’s Report has four sections:

- Section I: The Development of a Business Specification for SCSP Call-Recall
- Section II: Management of SCSP Call-Recall
- Section III: Information Requirements
- Section IV: Conclusions and Recommendations

5.2 In developing their findings, the Working Group observed certain guiding principles. Some of these were highlighted in the Quality Improvement Review and others emerged during consultation with the Service. These principles are summarised below:

5.2.1 **The Development of a National, Standard Approach to SCSP Call-Recall:** The main aim of the Group was to develop a framework for a national, shared approach to cervical screening call-recall in Scotland. This aim was maintained throughout the life-span of their work.

5.2.2 **Review of Current Systems and Arrangements:** The Working Group was committed to a review of the current systems and arrangements as many aspects of these work well and provide useful examples of best practice which could be developed across Scotland. In particular, it was recognised that a lot of time, money and effort had been invested in developing the existing systems and that this investment would guide future development.

5.2.3 **Monitoring and Evaluation:** It has never been easy to monitor the existing SCSP and the Working Group were keen to develop ways in which all SCSP service providers could receive useful, comparative feedback on their performance against the agreed UK NHSCSP standards. It was recognised that at present, many of the monitoring reports used by Health Boards are generated by gathering a range of information in different formats from different sources and then undertaking a time-consuming analysis, often involving the re-entry of data. Further, there is often dispute about reports as different assumptions, definitions, denominators and numerators are used by different organisations within the NHSiS.

5.2.4 **Reducing Duplication:** Consultation with the service flagged up the frustration felt by many at the level of duplication in call-recall. Not only was more than one (and up to four) different parts of the Health Service duplicating tasks, but the scope for error was considerable. All those involved were aware of this and were vigilant in making every effort to avoid mistakes, however they agreed this aspect of the current process was very vulnerable. The Working Group was keen to reduce duplication and to develop user-friendly ways of communicating between the different parts of the screening process.

5.2.5 **Consultation and Communication:** The Working Group was committed to open communication and consultation during the course of their work. To facilitate this a WEB forum was set up and all papers and minutes were posted on this for service users to read and comment on. The address was widely circulated and over 200 people logged on. This is a useful way to make sure there is convenient access to material during reviews and generated useful feedback. There were also several open meetings involving those providing cervical screening services where the Group’s views and findings were tested, shared and discussed. These meetings were stimulating and generated a lot of feedback.
5.2.6 **Scope of Cervical Screening Call-Recall:** When the Cervical Screening Programme was first introduced in Scotland, the main call-recall system in use was developed to handle only routine call-recall. Non-routine call-recall (call-recall for women with non-normal results) was therefore handled in various ways locally and the Working Group decided that in future, call-recall should cover both routine and non-routine screening.

5.2.7 **Providing Cervical Screening Services:** Although there have been recent incidents concerning cervical screening, the Working Group was keen to avoid developing a bureaucratic process of ‘special’ rules for cervical screening. Wherever possible, women using screening services should be treated in the same way as women using other well-women services and should not be treated as exceptions.

5.3 In order to keep this work on schedule and to achieve results in the given timescale, The Working Group formed three sub-groups:

- **Process Sub-Group:** This Sub-Group was responsible for developing a call-recall process flow chart which described every process involved in cervical screening and ensured that women could not ‘fall out’ of the system. They would also develop detailed definitions for each of these processes following extensive consultation.

- **Management Arrangements Sub-Group:** This multidisciplinary sub-group was responsible for determining the management options and for making recommendations for future arrangements.

- **Information and Monitoring Groups:** This sub-group was responsible for reviewing monitoring and information requirements and for specifying the core reports required at local and national level.

5.4 The outcome of the work undertaken in these sub-groups was then considered by the Working Group and is described in Sections I, II and III of this Report.
SECTION I: Business Specification for SCSP Call-Recall

6. Developing the Business Specification

6.1 The Process sub-group used the process flow chart developed during the Quality Improvement Review as their starting point (see Appendix III). This chart identified weaknesses in the way call-recall is organised and also provided a useful baseline for analysing the processes involved.

6.2 Call-Recall involves a range of processes, some of which are applicable at more than one stage. These were summarised in four main categories:

- **Selection** for screening
- **Invitation and reminder** for screening
- **Notification of results**
- **Follow Up of Non-Negative/ Non-Routine Smears**

6.3 The existing criteria for each process within each category were then defined and any issues associated with these criteria were identified. Responsibility for these processes was also identified. After discussion within the Working Group and with the service, revised criteria that would be applied nationally were proposed and this was reflected in an updated process flow chart. The Detailed Specification is shown in Appendix IV and the updated process chart is given in Appendix V.

6.4 When reviewing the existing criteria, it was clear that various definitions and assumptions were in use across Scotland, even for apparently straightforward aspects of the Programme such as the age range for invitation. In this instance, current policy states that women aged 20-60 should be invited and there was considerable debate about defining this exactly, particularly as the Statement of Fees and Allowances for GPs which calculates target payments by uptake was at odds with the way in which national policy was interpreted by the call-recall systems.

6.5 Working through the processes behind call-recall and the criteria that govern them provided a unique opportunity to revisit various wrinkles in the system and to address issues where there was no standard approach in place. As a result of this work it was possible to develop a standard approach for the following:

- Age Range
- Post-hysterectomy screening
- Abolition of the 'suspension' category and establishment of a postponement category with clear protocols for reinstatement and a default of automatic reinstatement
- Standard criteria for the 'cease' category
- Introduction of a category for review of cases who are not to be sent a routine letter with a default of automatic reinstatement
- Reminder policies for routine and non-routine screening
- Policies on the issuing of results
- Follow up of non-normal/ non-negative smears
6.6 Perhaps most importantly, it became clear that while call-recall for some 50% of GP practices is organised at Health Board level, many run their own discrete systems. In future, it will be important for all those involved in providing call-recall to work together, using the Scottish call-recall system, to provide an effective, national cervical screening programme.

6.7 It was also clear that the recent reorganisation of the NHSiS had impacted on the provision of call-recall in ways that had not been fully taken into account. In particular, the establishment of Primary Care Trusts had resulted in organisational change and a lack of clarity in line management for many call-recall offices. Further, as highlighted in the Quality Improvement Review, there is limited awareness of the cervical screening programme in some of these Trusts. The establishment of Practitioner Services Division (PSD) has also resulted in a degree of confusion as while it is responsible for the administration of the CHI and medical payments, much of their information comes from call-recall services. As a result, both PSD and call-recall offices now duplicate a range of tasks, notably the checking of target payment lists.

6.8 The Working Group felt there was an opportunity to address these issues, in line with the findings of the Quality Improvement Review. In particular it was important to raise awareness throughout the service about cervical screening as it straddles both the acute and the primary care sectors.

7. Next Stages

7.1 Now that a detailed specification of the business ‘rules’ associated with cervical screening has been developed, the next stage is to use these criteria to develop a specification for an information system. The business criteria have been specified in a way that will support national call-recall while maintaining the local flexibility required to make appointments for smear taking and treatment. During consultation on these criteria, it was clear that the service appreciated the opportunity to be involved in this. They were particularly keen to understand the detailed process of developing the information system as this understanding would allow them to use it more effectively. User Groups have already been established for the two existing systems and it is proposed that these should be merged to form a national User Group which will report to the CHI/CPC Programme Board and in turn to the IM&T Programme Board.
Section II: Management Arrangements for SCSP Call-Recall

8. Reviewing Management Arrangements

8.1 The Management sub-group also drew on the findings of the Quality Improvement Review. In consultation with the service, they identified the following issues:

♦ A fragmentation of services which resulted in duplication and gaps. Across the country different people and organisations were all involved in providing call recall with limited formal co-ordination.

♦ Much of what was already in place had been developed because of a genuine concern about ‘getting it right’. It was recognised that an enormous amount of effort went into this at every level and that ‘getting it right’ places considerable overheads on GPs, Trusts and Health Boards. Naturally there is defensiveness and resistance to change to different ways of working that have not yet been demonstrated as effective although it was useful to use other models such as breast screening when discussing options.

♦ Cervical Screening is generally associated with laboratories and there was limited understanding or awareness of the ‘big picture’, particularly in Primary Care Trusts. However, ‘joined-up’ services are part of the new modernisation agenda and the constraints facing cervical screening are no different to those facing the rest of the service.

♦ There is the perception of responsibility without authority. Again, this is an issue which faces the service generally, particularly as Health Boards develop a more strategic role.

9. Addressing the Issues

9.1 The Working Group spent some time discussing responsibilities for management and considering how best to deliver cervical screening using a system that would support monitoring nationally and locally, using well-defined, standard processes. They considered four options:

♦ A system run entirely at GP level: The advantage of this option would be that the responsibility for call-recall would be clearly defined and in many cases, systems were already in place. However, the disadvantages outweighed these as such a model would introduce even more variation, would not be easy to monitor and would present problems whenever women moved home or GP.

♦ A Health-Board area system: Again, the advantages lay in the experienced staff already in place and the opportunity to set up standard arrangements that could be monitored at Health Board and national level. There was concern however at the scope for local variation and for the potential problems that may arise if women moved to another area.

♦ A regional approach with a limited number of centres running call-recall tasks. Local arrangements would remain for smear taking and reporting. This model was attractive because it built on the PSD model and improved the chances of introducing a truly standard system. It would also free up staff time locally to work on quality assurance and monitoring. However a note of caution was introduced when considering the PSD
A Scotland-wide call-recall system run from a single site. This approach could be managed by identifying a lead Health Board (including the CSA) or Trust and would result in a national system. However, it would be remote from smear takers and laboratories.

9.2 The Working Group was initially attracted by a regional approach and spent some time discussing this with the service as it would result in considerable organisational change. From these discussions it was clear that this is a high risk approach for the following reasons:

- The current system is not fully effective at Health-Board area level across Scotland
- A range of new, standard criteria and protocols would have to be introduced
- A new IT system would be required to support these, with extensive interfaces to GPs, laboratories and colposcopy units
- The existing system would need to be maintained during the transition period
- Experienced local staff are critical to the delivery of a national, standard system for call-recall

9.3 Accordingly, the Working Group reconsidered the options and agreed that by addressing the lack of formal co-ordination of cervical screening services, it would then be possible to make recommendations about accountability, management and delivery of call-recall.

10. Addressing Co-ordination

10.1 The Working Group agreed that co-ordination of all cervical screening services was the responsibility of Health Boards for the following reasons:

- Health Boards are population based, as are screening programmes
- Health Boards can take a 'helicopter' view of services and are experienced in carrying out needs assessment
- It is useful, and feasible, to monitor services at Health Board level and to then compare Health Boards
- Any issues can be managed at this level using existing experience of co-ordination in the management of issues
- There is already an effective national forum for Health Board screening co-ordinators

10.2 The Group proposed that each Health Board should have a mandatory Steering Group with lead representatives from professions involved in cervical screening. The Steering Groups would report to Health Boards and Trusts, and would also report to the SCSP Quality Assurance Reference Centre which is currently transferring from the CSA to the Clinical Standards Board for Scotland (CSBS). Further, the Steering Groups would be underpinned by service specifications, many of which are already in place, and would facilitate regular CSBS QA peer review visits. This would strengthen the role of the co-ordinators and would introduce improved accountability.
11. Management of Call-Recall

11.1 The Group then went on to consider the management of call-recall, taking into account the risks of introducing too many changes too quickly. They concluded that call-recall element of cervical screening is a Primary Care Trust function and that managerial responsibility lies with these Trusts.

11.2 As it is essential to manage any risks to the Programme, and to continue to operate an effective service while the proposed national system is introduced, the Working Group recommended one call-recall service for each Health Board area. The site of this office was not important but the accountability of the Primary Care Trust should be recognised and promoted. Careful consideration was given to staffing in the call-recall services as it was recognised that there is considerable variation in staff grades and responsibilities at present. The Working Group concluded that it was important to reduce duplication of effort and to introduce strengthened monitoring of call-recall. The call-recall service could also support quality assurance activities.

11.3 The Working Group also stressed the importance of raising women’s awareness of their personal responsibility. While they could recommend a robust model for a standard approach to cervical screening call-recall in Scotland, successful implementation of this is dependent on public and health service awareness.
Section III: Information Requirements for Call-Recall in Cervical Screening

12. Information Requirements and Stakeholders

12.1 In order to support fully a national, population screening programme, information systems involved must yield data for the following purposes:

- Performance Monitoring
- Medico-legal Records
- Epidemiology
- Quality Assurance
- Administration

12.2 There are a number of stakeholders in the cervical screening programme requiring such information and these include:

- The Scottish Executive
- The SCSP Quality Assurance Reference Centre (CSBS)
- Health Boards (Public Health)
- Trusts: Primary Care and Acute (including Laboratories and smear takers)
- The public

12.3 For most applications the same information will be required locally and aggregated centrally. For local use these data should be available by the age of the female and by the source (i.e. each general practice, community clinic, hospital clinic) as this will help to identify any sub-populations which may need to be targeted differently.

12.4 The Information sub-group developed core data requirements (shown in Table 1, Appendix VI). The Working Group endorsed these and noted that the national system must be able to generate this information. It was also recognised that there is an opportunity to review the national data returns and to bring these into line with the returns used in England and Wales which would allow UK comparisons.

12.5 It was also recognised that while the Information and Statistics Division (ISD) produce regular Health Bulletins on the performance of the SCSP, and publish these data in Scottish Health Statistics, these data are not used to inform local or national quality assurance initiatives.
Section IV: Conclusions and Recommendations

13. Conclusions

13.1 The Working Group on SCSP Call-Recall Arrangements built on the work already undertaken by the Quality Improvement Review (QIR). They confirmed the findings of this Review and have been able to address their remit and to address other issues raised in the QIR Report.

13.2 In particular, the Working Group agreed with the conclusion drawn by the QIR that the existing call-recall arrangements do not fully support a national screening programme. Now that the Working Group has completed mapping the business processes involved in cervical screening call-recall, it is clear that it would be feasible to introduce a national system although the effectiveness of this will depend on participation across Scotland.

13.3 The service has been actively involved at every stage of this review and their input, support and challenging questions have introduced a necessary rigour. Their acknowledgement of the need to move forward and willingness to be involved has been critical to the success of the Working Group. The mature and responsible attitude of those providing cervical screening services has also made it possible to frankly review options and to open the door to managed organisational change.

14. Recommendations

14.1 The following recommendations are made:

14.1.1 Call-Recall forms the backbone of effective cervical screening. A national cervical screening call-recall information system should be developed which replaces the existing systems, including those used in General Practice. This system should include normal and non-normal recall and should incorporate the standard protocols proposed in the detailed business specification. The system should be developed in two phases:

♦ Phase I: The development of a core system, based on the business criteria developed by the Working Group, in association with the service. This includes data conversion (as required) and the introduction of an electronic infrastructure which can be accessed by smear takers, the national call-recall system and laboratories and will allow easy updating of the information required to support effective call-recall.

Phase I will also involve an extensive training and awareness programme covering the standard protocols and the use of the redeveloped system. Training will be provided for all those involved in providing cervical screening call-recall services.

♦ Phase II: This infrastructure will be further developed to include colposcopy units.

14.1.2 Phase I is likely to take approximately two years and work on phase II will be taken forward concurrently. Phase II is likely to be implemented 12 months after phase I is in place, resulting in a three year development period. Indicative costs are given in Appendix VII. The proposed introduction of a national system for cervical screening call-recall has the full backing of the service who recognise that the current arrangements do not provide a national screening programme.
14.1.3 The service (and the public) should be fully involved throughout the development of the call-recall system. Those already involved in using and developing the current call-recall arrangements should play a key role in this development as they have valuable experience and expertise.

14.1.4 Training on the use of the redeveloped system, and on the new standard protocols, should be provided to all staff involved in SCSP call-recall.

14.1.5 Current best practice and the effective elements of current systems should be taken into account.

14.1.6 All those involved in SCSP call-recall will use the national call-recall system.

14.1.7 A National User Group should be established to review and prioritise proposed changes to the IT system. This Group will report to the CHI/CPC Programme Board and the IM&T Programme Board. As it will no longer be possible to change the system locally, it will be important to ensure appropriate representation on this Group.

14.1.8 The redeveloped SCSP call-recall information system must incorporate the information and monitoring requirements specified in Appendix VI.

14.1.9 The redeveloped SCSP call-recall system should not seek to set up special arrangements for women attending for screening. Cervical screening is part of well woman services and women eligible for cervical screening should have access to the same level of service as those attending other well woman services.

14.1.10 Responsibility for the co-ordination of cervical screening services lies with Health Boards who should establish mandatory Steering Groups. Steering Group membership should include lead representatives of all those involved in cervical screening. These Groups should report to Health Boards and will facilitate regular CSBS QA visits to their area.

14.1.11 Accountability for SCSP Call-Recall lies with Primary Care Trusts. There should be one call-recall service for each Health-Board area although this should be reviewed once the new system is established. The Primary Care Trust may transfer responsibility for call-recall to other parts of the NHSiS but will retain accountability.

14.1.12 Risk assessment of SCSP call-recall arrangements should be an integral part of the next phase as it is important that the risks identified with the introduction of a national system are well managed centrally and locally.

14.1.13 CHI data quality targets should be introduced for Practitioner Services Division. This should be taken forward by the CHI Quality Assurance Group.

14.1.14 Guidance to the Service should be updated to reflect the introduction of standard protocols as described in Section I, paragraph 6.5.

15. The Future of Cervical Screening in Scotland

15.1 The future of effective cervical screening lies in the introduction of robust call-recall arrangements. There is wide recognition of the need for a national approach to cervical screening and of the role of the service in developing this.
15.2 Cervical screening is currently very dependent on key staff who are critical to the introduction of a national system. They must be involved and consulted at every stage as their experience and expertise is fundamental to the way forward.
Appendix I: Membership of the Working Group on SCSP Call-Recall Arrangements

**Chairman**

Mr Trevor Jones  
Chief Executive, Lothian Health (until Nov 2000)

**Members**

- Dr David Alexander  
  General Practitioner, Fife*
- Mrs Gwen Archibald  
  Call-Recall Manager, Fife (OCCURS)
- Dr Ken Brotherston  
  Senior Medical Officer, Scottish Executive
- Ms Christine Campbell  
  Chief Officer, Argyll & Clyde Health Council*
- Ms Citty Finlayson  
  UNISON Member
- Mrs Isabel Gavin  
  SCSP Project Director
- Mr Jim Hanlon  
  Business Manager, GPASS
- Dr Ken Harden  
  BMA Representative
- Dr Jocelyn Imrie  
  SCSP QA Director, CCU*
- Mr Chris Jowsey  
  Director, Practitioner Services Division  
  (until Sept 2000)
- Mr Peter Knight  
  Head, Hospital & Community Information Unit, ISD
- Dr Susan MacPhee  
  CPHM, Grampian Health Board
- Mrs Elizabeth Rennie  
  Call-Recall Manager, Lanarkshire
- Mr Gordon Sommerville  
  Manager, Contract Management Team  
  (NHSiS/SEMA Contract)
- Ms Jan Warner  
  SCSP National Co-ordinator (until Oct 2000)
- Dr Lesley Wilkie  
  Director of Public Health, Argyll & Clyde
- Mr Tony Wells  
  Chief Executive, Tayside Primary Care Trust

**Secretariat**

- Ms Morag Swankie  
  SCSP CCU
- Ms Irene Little  
  Health Improvement Strategy Division, Scottish Executive

**Notes:**

1. *Member of the SCSP National Advisory Group
2. Other sources of advice were co-opted onto the Group as required
3. Some members were appointed for their skills and experience and others as representatives of their profession or organisation
## APPENDIX II

### SCSP: Key Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>'Strong Report' issued by ad hoc group of the above committee</td>
<td>A parallel Group reported in England recommending that women aged 20-64 should be offered screening at least every five years</td>
</tr>
<tr>
<td>1987</td>
<td>SHHD circular issued to all health boards requiring them to establish computerised call-recall systems for cervical screening by 1988. (SHHD/DGM91987)74</td>
<td>Women aged 20-60 to be called at least once every five years. First round of screening to be completed by 1993</td>
</tr>
<tr>
<td>1988</td>
<td>National Co-ordinating Network (NCN) established to take forward the implementation of the national cervical screening programme</td>
<td>NCN included representatives from the UK Departments of Health, research, women's organisations, professional associations and Royal Colleges and Health Authorities</td>
</tr>
<tr>
<td>1988</td>
<td>Scottish Health Board Co-ordinators Group established</td>
<td>Designated CPHM's from each Health Board with responsibility for ensuring the delivery of an effective cervical screening programme for their population</td>
</tr>
<tr>
<td>1989/90</td>
<td>Call-recall systems (OCCURS and CCS) and national Community Health Index introduced across Scotland</td>
<td>One Board had used OCCURS since the early 1980s, 2 others adopted this system in 1987. 11 Boards implemented the CCS system and 1 developed a local system</td>
</tr>
<tr>
<td>1990</td>
<td>GP Target Payments Scheme introduced GP based system screening module introduced</td>
<td>Most smears are taken in GP practices. Limited training available</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Comment</td>
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<tr>
<td>1992/93</td>
<td>Provision of health services moved onto a contractual basis between Health Boards and newly established NHS Trusts</td>
<td>Trusts took over responsibility for providing cytology reporting services.</td>
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<tr>
<td></td>
<td>SODoH Management Executive (ME) was formed and first NHSiS Chief Executive was appointed</td>
<td>(ISD(D)1 series established in 1968)</td>
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<tr>
<td></td>
<td>ISD had responsibility for collecting and analysing laboratory workload statistics</td>
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<tr>
<td>1992</td>
<td>CRAG audit carried out into the effectiveness of the cervical screening programme in Scotland</td>
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<tr>
<td></td>
<td>Proficiency Testing introduced in Scotland</td>
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<tr>
<td></td>
<td>Audit Commission reviewed English Programme</td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>Inquiry into Cervical Cytopathology at Inverclyde Royal Hospital</td>
<td>The Minister of State for Scotland ordered an inquiry into the circumstances that led to a review of 20,000 cervical smear tests. The recommendations made by the Inquiry Team were to have far-reaching effects for the UK NHSCSP</td>
</tr>
<tr>
<td>1994</td>
<td>Population based data collection introduced ISD(D)4 series</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>Report of Working Party on Internal Quality Control for Cervical Cytopathology Laboratories</td>
<td>This report was issued in response to the Inverclyde Report with the following remit: ‘To determine the most appropriate methodology for internal quality control in all laboratories carrying out cervical cytopathology and produce recommendations for its implementation’</td>
</tr>
<tr>
<td></td>
<td>Guidance to Health Boards on Purchasing of Cervical Screening Issued</td>
<td></td>
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<tr>
<td></td>
<td>ABC Document Issued</td>
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<tr>
<td></td>
<td>RCPath, BSCC, NHSCSP Working Party Report</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Comment</td>
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<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1995 contd</td>
<td>National Co-ordinating Team for breast screening extended to include cervical screening in England</td>
<td></td>
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<tr>
<td></td>
<td>National Co-ordinating Unit for breast screening extended to include cervical screening in Scotland. (NHS MEL(3)96)</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>Report on Review of the QA Arrangements in place in the SCSP</td>
<td>Several recommendations made. Guidance to be revised and Information for women to be developed</td>
</tr>
<tr>
<td></td>
<td>National Audit of the screening history of women with invasive cancer introduced</td>
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<tr>
<td></td>
<td>SCSP National Advisory Group established</td>
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<tr>
<td>1999</td>
<td>Revised guidance issued</td>
<td>SCSP QA Director appointed</td>
</tr>
<tr>
<td></td>
<td>Model information leaflets for women issued</td>
<td></td>
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<tr>
<td></td>
<td>Quality Improvement Review of SCSP Call-Recall arrangements commissioned</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Quality Improvement Review of Call-Recall reported</td>
<td>Working Group on SCSP Call-Recall Arrangements established</td>
</tr>
</tbody>
</table>

**Key:**
- **SHHD:** Scottish Home & Health Department
- **DoH:** Scottish Office Department of Health
- **CCS:** Cervical Cytology System
- **SCSP:** Scottish Cervical Screening Programme
- **ISD:** Information & Statistics Division of CSA
- **CSA:** NHSiS Common Services Agency
- **CCU:** Central Co-ordinating Unit
- **OCCURS:** On-line Cervical Cytology Update and Recall system
Appendix III: Process Flow Chart Developed During Quality Improvement Review

**ROUTINE CALL-RECALL**

1. **Screening cycle start**
2. **Candidates become due for invitation**
3. **CRS** select names from CHI using rules
4. **CRS** sort names into GP lists
5. **GP** check list for relevance
6. **GP** advise CRS of transfer within/from HB
7. **GP** advise CRS of required postponement
8. **CRS or GP** invite for screening
9. **Smear Taker** make appointment for candidate
10. **Lab** report outcome

- **early recall recommended**
- **referral recommended**

11. **Smear Taker** take smear
12. **Lab** report outcome
13. **Routine 3 year recall**

14. **Smear Taker** invite for early recall
15. **Smear Taker or Lab** make colposcopy appointment
16. **Colposcopy Clinic** assess candidate and treat if necessary
17. **Colposcopy Clinic** advise smear taker of non-attendance

18. **Candidate miss colposcopy episode after >= 2 reminders**

19. **No automated route back into system. Dependent on smear taker action**

**NON-Routine CALL-RECALL (abnormal) RECALL**

1. **Smear Taker** plan to remind for early recall
2. **Smear Taker** or lab make colposcopy appointment
3. **Colposcopy Clinic** assess candidate and treat if necessary
4. **Colposcopy Clinic** advise smear taker of early recall

5. **Candidate miss early recall**
6. **Colposcopy Clinic** plan to reappoint

7. **Candidate miss colposcopy episode after >= 2 reminders**

**LEGEND:**
- The arc symbol represents alternative options
- **Process**
## Appendix IV: Call Recall Business Requirements Specification: Definition of Call-Recall Criteria

<table>
<thead>
<tr>
<th>Process</th>
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<th>Responsible Organisation</th>
<th>Proposed Changes</th>
<th>Proposed Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Selection</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Age range not standard</td>
<td>• Age 20-60 (up to 61st birthday)</td>
<td>Health Board for ensuring age range is well defined</td>
<td>• Standardise age range and age at first screen</td>
<td>• Age 20-60: first call in 21st year, cut off 61st birthday minus 1 day (normal only)</td>
</tr>
<tr>
<td></td>
<td>• Inclusion relies on batch update from CHI</td>
<td></td>
<td>PSD responsible for date of birth changes and for registering and removing patients</td>
<td>• Remove necessity for download (batch update to Cytology) i.e. automatic inclusion</td>
<td>• Immediate electronic update from CHI</td>
</tr>
<tr>
<td></td>
<td>• Date of birth changes not automatically transferred from CHI to Cytology</td>
<td></td>
<td>PCT responsible for ensuring GPs call women within eligible age range</td>
<td>• Clarify accountability / responsibility for: - ensuring selection - provision of selection</td>
<td>• Three yearly for routine recall</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frequency of screening to be agreed i.e. three or five yearly?</td>
<td></td>
<td></td>
<td>The programme will facilitate review of age range/ frequency of screening should LBC/new technology be introduced at a later stage</td>
</tr>
<tr>
<td></td>
<td>• Women not registered will not be called - long stay institutions, armed forces and students can present problems</td>
<td></td>
<td></td>
<td>• NHSCR to inform CHI of re-registration of women marked as untraceable. (requires more discussion)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Twice yearly failsafe sweeps</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Selection on long stay institution code - a named person responsible to ensure eligible women are screened (requires more discussion)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Armed forces - women may register with local GP or army doctor. If registered with GP include in call recall, if not RAMC responsibility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Students either remain with their own GP or reregister with the Student Health Centre - ? procedures when students leave studies - collaboration with further education re change of address etc. (requires more discussion)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Enable women to be called to various treatment centres e.g. family planning, well woman, GUM (requires more discussion), colposcopy etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Women flagged as untraceable will be monitored</td>
<td></td>
</tr>
</tbody>
</table>
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<th>Proposed Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Selection</td>
<td></td>
<td>Time taken to register/remove patients on CHI</td>
<td></td>
<td></td>
<td>PSD responsible for updating CHI (introduce targets)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accountability for monitoring transfers/moves away is unclear—particularly for non-routine smears</td>
<td></td>
<td></td>
<td>Co-ordination of CS services to be a Health Board responsibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Managerial responsibility lies with the PCT</td>
</tr>
</tbody>
</table>
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<th>Proposed Criteria</th>
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</thead>
<tbody>
<tr>
<td>2. Invite/Remind</td>
<td>• Confirmed as eligible:  - must have cervix  - be living</td>
<td>• Variable definitions of eligibility  • Unknown eligibility e.g. late clinical updates for hysterectomy, death etc.  • Post hysterectomy:  § CIN 1-3  § Invasive carcinoma  § High risk women  • Time lapse between death and CHI update  • Age range is interpreted differently by GPs, smear takers and women  • ‘Unclean’ data i.e. historical reasons used to cease women</td>
<td>Smear Taker/ G P PCT/ PSD</td>
<td>• Ensure eligibility is accurate by improving access to previous test data/ medical records</td>
<td>• PSD responsible for transfer of medical records (introduce targets)</td>
</tr>
<tr>
<td></td>
<td>❑ Age range 20-60 inclusive (no upper age limit for non-routine)  ❖ Due smear according to previous smear/ screening status</td>
<td>❑ Ensure “age rules” are understood by all parties</td>
<td></td>
<td></td>
<td>❑ Women on non-routine recall should be retained on call recall for vault smears as advised by the laboratory. This should also apply where a squamo-columnar junction has been put in place  ❑ Women with a sub-total hysterectomy should remain on call recall  ❑ Immediate electronic update of deaths and hysterectomies from CHI/ G P/ Hospital based systems</td>
</tr>
</tbody>
</table>
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<th>Proposed Criteria</th>
</tr>
</thead>
</table>
| 2. Invite/Remind | • Variable practice for postponement from call recall for a specific time period | • Women can be excluded permanently, guidance on “ceased” criteria required | Smear Taker/ G P/ Call Recall | • Define postponement criteria | • Establish the following **postponement criteria:**  
  - Pregnancy – automatic reinstatement 12 months after date of selection  
  - Pregnant women with a non-routine recall should not be postponed  
  - Co-morbidity (illness) – Automatic reinstatement 12 months after date of selection  
  - No woman on non-routine follow up should have two sequential postponements without an intervening smear or colposcopy attendance  
  - Establish “cease” criteria as follows:  
    - Death  
    - No cervix  
    - Outwith upper age range (routine recall)  
  - Identify women who are not to be sent a routine letter (NRLS)  
    - Women who wish to ‘opt out’ (focus required where smear result is no-neg? face to face counselling)  
    - Women with severe physical handicap/ condition  
    - Women with learning difficulties who cannot consent  
    - Women who are terminally ill  
    - Women who are not sexually active  
  - As a failsafe, women in this group, not indicated as reassessed will be automatically reinstated |
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</tr>
</thead>
<tbody>
<tr>
<td>2. Invite/Remind</td>
<td></td>
<td>- No national ‘disclaimer’ policy for ‘opt out’ women</td>
<td></td>
<td>- National disclaimer policy required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Women attached to the wrong GP practice</td>
<td></td>
<td>- Improve CHI updates – time taken and accuracy – automatic update for movement</td>
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<tr>
<td></td>
<td></td>
<td>- Undelivered mail</td>
<td></td>
<td>- Raise women’s awareness and also that of the smear taker</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Number of reminders and frequency – variation between Health Boards</td>
<td></td>
<td>- Standardise reminder procedure</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Invitations/ reminders sent out should be logged on the central system irrespective of where they have been distributed from</td>
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<td></td>
<td><strong>Proposed reminder policy:</strong></td>
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<td></td>
<td></td>
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<td></td>
<td><strong>ROUTINE</strong></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- <strong>one</strong> invitation (call) in writing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- <strong>one</strong> reminder, in writing, at three months from first invite</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- <strong>second</strong> reminder at six months from first invite Wording of letter should advise failure to attend will result in postponement of 3 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- <strong>return to routine recall</strong> at nine months from date of first invitation, if no response</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- next call date thirty six months from date of first invitation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- (non attenders will be considered as defaulters)</td>
<td></td>
</tr>
</tbody>
</table>

- Introduce ‘opt out’ information leaflet for both women and health professionals explaining the review process and include advice on action to be taken to initiate reinstatement

- Women who ‘opt out’ following an abnormal smear should be reassessed more frequently (MDDUS/CLO advice required)

- Introduce CHI quality checks (in line with national initiatives)

- Regular campaigns to encourage women to notify address changes (High workload) (social inclusion agenda - targeting)

- Proposed reminder policy:
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</tr>
</thead>
<tbody>
<tr>
<td>2. Invite/Remind</td>
<td></td>
<td>• Practices who organise their own call recall and do not return amended lists (approx. 50% in Scotland)</td>
<td></td>
<td>♦ A national definition of defaulter is required. Advice will be given on reasonable attempts to persuade a woman to attend</td>
<td>♦ A woman will default when she fails to attend three consecutive invitations from the call recall screening module.</td>
</tr>
</tbody>
</table>

**NON-Routine (early/abnormal/immediate)**
- one invitation (call) in writing
- first reminder, in writing, at two months from first invite
- second reminder, in writing, at four months issued by call recall staff to facilitate monitoring (NAG to be requested to commission research into most appropriate means of notification eg Recorded delivery)
- advise practices to make personal contact with woman and try to screen opportunistically
- next invitation one year from date of first invite. Wording of letter should advise failure to attend will result in postponement of 2 years
- next invitation three years from date of first invite

• All those involved in providing call-recall should work together, using the Scottish call-recall system, to provide an effective, national cervical screening programme.
• Electronic update of the national system from GP based systems
• Validation of information at all levels
<table>
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</thead>
<tbody>
<tr>
<td>Invite/Remind</td>
<td></td>
<td>- If the GP has set a limit on the number of women to be called the current system creates queues</td>
<td></td>
<td>- Remove maximum numbers set by practice</td>
<td>- All women eligible each month will be listed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality of invite/reminder lists and sort order (call priority of output)</td>
<td></td>
<td>- More meaningful, standardised output e.g. last test result, invitation/reminder letters (GP acceptable format)</td>
<td>- Flexibility remains on the number actually called but women will still be listed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No home correspondence</td>
<td></td>
<td>- Protocol for GUM clinics required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Women who attend GUM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Prioritised ‘call lists’** based on the outcome of previous smear/call
  - non-routine DNA
  - abnormal and borderlines
  - repeats (inadequate)
  - follow up after treatment
  - review cases
  - reminders
  - routines
- Invitation CHI address
- Results
- Anonymised envelope where possible (requires more discussion)
- Protocol for GUM clinics
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</tr>
</thead>
</table>
| 3. Notification of Results | • Screening carried out  
• Smear reported  
• Lab sends result to:  
  - smear taker  
  - call recall office  
• Smear taker/lab/call recall office inform women of results - not always confirmed in writing | • Variation between Health Boards  
- Inability to cope with volume of results  
- Distribution of output time consuming  
- Inadequate equipment  
- Not possible to monitor whether results are issued/received | Lab/Smear Taker/PCT | • Standardise rules for notification of results  
- Principle is that all women will receive confirmation of result in writing | • Use standard (evaluated) wording  
- Lab to inform smear taker of result (electronically)  
- Lab to inform call recall office of result (electronically) – electronic copy of result to GP if not the smear taker and woman consents  
- Phase I - issue normal results centrally  
- Non-routine result/recall - : initially personal contact (clarify meaning of personal contact) from practice followed by written confirmation from practice  
- Phase II - smear taker database to update call recall office when non-routine result/recall is issued to woman. |
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<th>Issues</th>
<th>Responsible Organisation</th>
<th>Proposed Changes</th>
<th>Proposed Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up Non-Negatives/Non-Routine Recall</td>
<td>• Non negative smear</td>
<td>• Varying systems and rules • Separate from routine recall • Retrospective and reactive</td>
<td>Lab / Call recall staff</td>
<td>• Include follow up of non routine smears in call recall</td>
<td>• Validation for contradictory result and advice e.g. first negative result following a severe dyskaryotic smear indicating routine recall</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Include on prioritised ‘call list’ (activate pre overdue)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Computerise Colposcopy – initiate download to call recall and smear taker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Ensure women previously referred and discharged from Colposcopy are returned to call recall</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Standard protocol for recording colposcopy attendance/diagnosis/treatment – Colposcopy Quality Group <em>(requires more discussion)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Flag set electronically to indicate women’s status on Colposcopy – non attenders high priority</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Notify GP women who fail two consecutive Colposcopy appointments. These patients should be notified outwith ‘call lists’ to facilitate identification of patients who require more focus/ <em>counselling</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Regular awareness campaigns/ advertising</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Exclusion of patients who have been referred</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Non attendees</td>
</tr>
</tbody>
</table>

---

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Appendix V: Process Flow Chart Developed by SCSP Call-Recall Working Group to Define the Business Processes involved in Cervical Screening Call-Recall

Cervical Cytology Call-Recall

**TRIGGERS**
- Routine recall from (5), and (3)/(4) after reminders exhausted
- Postponements from (2)
- Routine reminders from (3)/(4)
- Early recall reminders from (3)/(4)
- Treatment episode end/Early recall from (6) and (8)
- Restored from (10)

1. Select women, based on a) eligibility b) action of appropriate trigger
2. Refine basic selection
   - a) postponement
   - b) transfer between HBs
   - c) ceased
3. Invite for screening
4. Make appointment
5. Report result
6. Make colposcopy appointment
7. Assess and treat if required
8. Refer back to smear taker
9. Select 'ceased' women
10. Review status of each woman

Defer on grounds of:
- a) postponement
- b) transfer between HBs
- c) ceased

Note: Routine and early recall process identical although number of reminders and delay periods could be different

Note: With no appointment data, reminder triggers can be generated only by absence of results data after specified delay periods

Note: can anything be achieved here in terms of treatment or administration tracking?
Appendix VI: Information Requirements for Call/Recall in Cervical Cytology

Table 1. Information Required to Monitor the Performance of the Programme

<table>
<thead>
<tr>
<th>Item</th>
<th>Justification</th>
<th>Data User(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Numbers of females invited - first invitation recall for smear</td>
<td>Defines the scope of the programme and denominator population on which to calculate uptake.</td>
<td>CRO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Board</td>
</tr>
<tr>
<td>• Numbers of females smeared - in the last 3 ½ years - in the last 5 years by total population by eligible population Also by 1st Invitation 1st Reminder 2nd Reminder</td>
<td>Quantifies the uptake of the programme, is the basis for GP target payments Provides an indication of the effectiveness of reminders.</td>
<td>CSBS/ QARC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PSD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HB</td>
</tr>
<tr>
<td>• Number of ineligible females</td>
<td>Assists monitoring of criteria on target population</td>
<td>HB</td>
</tr>
<tr>
<td>• Number of defaulters by time of last smear: - more than 3 years - more than 5 years Also by number of previous smears</td>
<td>Describes characteristics of the women who do not respond to the programme in terms of their screening history</td>
<td>HB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Health education)</td>
</tr>
<tr>
<td>• Number of females never smeared</td>
<td>One aspect of coverage</td>
<td>HB/ CCU</td>
</tr>
<tr>
<td>• Number of “opt out” females - by number of previous smears</td>
<td>Defines resistance to the programme</td>
<td>HB/ CCU</td>
</tr>
<tr>
<td>• Time elapsing between two routine smears</td>
<td>Monitors stability of process / problems developing</td>
<td>HB</td>
</tr>
</tbody>
</table>
Appendix VI: Information Requirements for Call/Recall in Cervical Cytology

Table 2. Information for Medicolegal Use

<table>
<thead>
<tr>
<th>Audit trail for each woman not attending for smear</th>
<th>Number and type of invitations issued (routine or early recall), Reply(ies) from women/smear taker, Record of opt out after full discussion, Other actions eg. transfers</th>
<th>CRO HB CCU</th>
<th>Adhoc use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit trail for each female not attending colposcopy and/or for treatment/follow-up</td>
<td></td>
<td>Colp (HB)</td>
<td>Adhoc</td>
</tr>
</tbody>
</table>

Table 3. Information for Epidemiology Use

<table>
<thead>
<tr>
<th>Cytology results</th>
<th>HB CCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histology results</td>
<td>HB CCU</td>
</tr>
<tr>
<td>Colposcopy findings and treatment</td>
<td>HB CCU</td>
</tr>
<tr>
<td>Invasive cancer audit data</td>
<td>HB CCU</td>
</tr>
</tbody>
</table>
Appendix VI: Information Requirements for Call/Recall in Cervical Cytology

**Table 4. Information for quality assurance use**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Responsible Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytology results - comparison across laboratories</td>
<td>Each of these elements (cytology, histology and colposcopy) monitors these areas within its own discipline but “central” monitoring is variable.</td>
<td>CCU HB AT</td>
</tr>
<tr>
<td>Histology results - comparison across laboratories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histology/cytology correlation</td>
<td>Monitors the accuracy of both the histology and cytology results</td>
<td>CCU HB Lab’s AT</td>
</tr>
<tr>
<td>Invasive cancer audit</td>
<td>Retrospective review</td>
<td>CCU HB AT</td>
</tr>
<tr>
<td>Colposcopy reporting times</td>
<td>To monitor the achievement of timely processing of results</td>
<td>A/A</td>
</tr>
<tr>
<td>Colposcopy attendance/ non-attendance investigation and treatment details</td>
<td>Comparison between clinics and with national standards to monitor variability and success of standardisation guidelines</td>
<td>CCU HB Colp’s AT</td>
</tr>
<tr>
<td>Colposcopy waiting times and other clinic standards</td>
<td>To monitor variability and success in informing standards</td>
<td>CCU HB Colp’s AT</td>
</tr>
</tbody>
</table>

**Table 5. Information for administration use**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Responsible Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration data</td>
<td></td>
<td>PSD CRO</td>
</tr>
<tr>
<td>Transfer data - to Health Board from Health Board between practices</td>
<td></td>
<td>PSD CRO</td>
</tr>
</tbody>
</table>

**Glossary of Abbreviations**

AT  Acute Trust  
CCU  Central Co-ordination Unit  
Colp  Colposcopy Clinic  
CRO  Call Recall Office  
CSBS  Clinical Standards Board for Scotland  
GP  General Practitioner  
HB  Health Board  
PSD  Practitioner Services Division
Appendix VII: Indicative Costs for Implementation of Recommendations

The remit of the Working Group was to develop a full business specification for a national call-recall system and this has been achieved in association with those running existing systems and those who are likely to be using the national system in future. This remit did not extend to identifying the optimal IT solution that could provide a system meeting this specification and if the recommendations of the working group are accepted, a Project Board will be established to take this forward and present options. The costs given in this Appendix for the development of a national system are indicative of the likely development costs, and advice has been sought from those providing the existing service in developing these costs.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Overheads</td>
<td>£ 20,000</td>
</tr>
<tr>
<td>Development and implementation of single system with interfaces to CHI, labs and G P systems</td>
<td>£250,000</td>
</tr>
<tr>
<td>Training</td>
<td>£ 50,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£ 320,000</strong></td>
</tr>
</tbody>
</table>

Notes:

1. Does not cover hardware or future running/development costs

2. At present, the total costs of supporting and developing the existing call-recall systems is £1,255,150. These costs will be transferred in the future to cover the running costs of a single national system and may also allow for some investment in supporting interfaces which are not currently in place. There may also be some reduction in running and operational costs and it should be possible to share technical platforms with other CHI based systems as these are (re)developed.