Colposcopy Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

The aim of the NHS Cervical Screening Programme (NHS CSP) is to reduce the incidence of and mortality from cervical cancer through a systematic, quality assured population-based screening programme for people aged 24.5 to 64 who have a cervix. The screening programme is designed to reduce the incidence and mortality from cervical cancer by detecting disease early, before the development of symptoms.

Since the introduction of the NHS CSP, the programme has helped to halve the number of cervical cancer cases, research published in 2004 (https://www.researchgate.net/publication/8447687_Peto_J_Gilham_C_Fletcher_O_Mattews_FEThe_cervical_cancer_epidemic_that_screening_has_prevented_in_UK_Lancet_364_249-256) and 2016 (https://pubmed.ncbi.nlm.nih.gov/27632376/) estimates thousands of lives have been saved in England each year.

The programme is continuously monitored to ensure adherence to the programme standards.

Primary HPV Screening

Primary HPV screening has been shown to be more sensitive than cytology in the detection of pre-invasive cervical disease. This improved sensitivity allows a decreased incidence of squamous carcinoma and adenocarcinoma compared to cytology alone. HPV primary screening has a high negative predictive value and could allow longer screening intervals, however, due to the lower specificity cytology triage is performed in hr HPV positive samples as to not inundate the colposcopy clinics.

National primary HPV screening was implemented in December 2019.

This guideline is for use by the following staff groups: **Lead Clinician(s)**	
Miss Rina Panchal Mrs Joanne Underhill	Lead Colposcopist Cervical Screening Provider Lead
Approved by *Gynaecology Clinical Governance Committee* on:	10th May 2024
Approved by Medicines Safety Committee on: *Where medicines included in guideline*	N/A
Review Date: This is the most current document and should be used until a revised version is in place	10th May 2027

Key amendments to this guideline

Date	Amendment	Approved by:

CONTENTS

INTRODUCTION TO THE COLPOSCOPY SERVICE AT WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Geographical site of service and opening times

The Colposcopy Clinics are situated within 3 hospitals – the Worcester Royal Hospital (WRH), Alexandra Hospital (AGH) and Kidderminster Hospital (KTC).

Opening Hours

The colposcopy clinics are open from Monday to Friday 9.00 am to 5.00 pm.

Contact Details:

Colposcopy Service
Worcestershire Acute Hospital NHS Trust
Alexandra Hospital
Woodrow Drive
Redditch
B98 7UB
Telephone:
Email address: wah-tr.colposcopyadminteam@nhs.net

Colposcopy Service Personnel

Role	Name
Lead Colposcopist	Miss R Panchal
Cervical Screening Provider Lead	Mrs J Underhill
Consultant Colposcopists	Miss R Panchal Miss M Van Seters Miss J Lee Mr Mohamed Yosef Shehata Mr J Twigg Mr Sam Agwu
Lead Colposcopy Nurse	Mrs J Underhill
Colposcopy Clinical Nurse specialists	Mrs J Underhill Mrs J Brassington Mrs E Lynott
Clinic Co-ordinators	Mrs S Newton Mrs A Phillips Mrs Carrie Pottinger
Colposcopy Support Secretary	Mrs Amanda Furey

CLINICS

Worcester Royal Hospital (WRH)

The Colposcopy department incorporates a sectioned area which is manned by a clinic clerk, a waiting room with toilet facilities, a single clinical room and changing area and close toilet facilities. There is a nearby recovery room

The clinical room is self-contained unit separate from the main corridor. The accommodation consists of:

- One clinic room which is used for the management of new patients and follow up patients.
- It has an inbuilt changing cubicle separated by curtains with toilet facilities nearby.
- A recovery area with reclining chair for patients who faint or need to rest after treatment is near the Colposcopy clinic, separated by a single corridor.
- Refreshments are available for those patients who require rest after treatment

Colposcopy Clinic Sessions

DAY	TIME	COLPOSCOPIST
Monday	0850-1230	Mr Mohamed Yosef Shehata
	1330-1700	Mrs J Brassington
Tuesday	0850-1230	Mrs J Brassington
	1330-1700	Miss M Van Seters, Mrs J Brassington week 5
Wednesday	0850-1230	Mrs J Brassington
Thursday	1330-1700	Mr Mohamed Yosef Shehata. Monthly clinic 1st of each month

Kidderminster Treatment Centre (KTC)

The Colposcopy department incorporates a sectioned area which is manned by a clinic clerk, a waiting room with toilet facilities, and a single clinical area with a nearby recovery room and changing rooms with toilet facilities.

The clinical area is self-contained unit separate from the main corridor. The accommodation consists of:

- One clinic room which is used for the management of new patients and follow up patients.
- It has an inbuilt changing cubicle with toilet facilities
- A recovery area with couch for patients who faint or need to rest after treatment is opposite the Colposcopy clinic, separated by a single corridor

- Refreshments are available for those patients who require rest after treatment

Colposcopy Clinic Sessions

DAY	TIME	COLPOSCOPIST
Tuesday	1330-1730	
Wednesday	0845-1230	Miss Joanne Lee
Friday	0900-1230	Mr Sam Agwu

Alexandra Hospital

The Colposcopy department is based within the Women's Health Unit (WHU), which is manned by a clinic receptionist, has a waiting room with refreshment and toilet facilities. It has a clinical area which incorporates a recovery room.

The WHU is a self-contained unit. The accommodation consists of:

- A clinic rooms which is used for the management of new patients and follow up patients.
- One clinic room which is used as a patient recovery room.
- Refreshments are available for all patients.

Colposcopy Clinic Sessions

DAY	TIME	COLPOSCOPIST
Tuesday	0900-1230	Mrs J Underhill
	1330-1700	Mrs J Underhill
Wednesday	0900-1230	Miss R Panchal
	1330-1700	Mrs J Underhill
Thursday	0900-1230	Mrs J Underhill
	1330-1700	Mr J Twigg (week 2&4); Mrs E Lynott (week 1 &3); Mrs J Underhill (week 5)
Friday	0900-1230	Mrs J Underhill (week 2&4)

REFERRAL TO THE COLPOSCOPY CLINIC

New referrals come from several sources:

- Direct referral from the Cytology laboratory (See appendix 1)
- General practitioners
- Genitourinary Medicine clinics
- Family Planning clinics
- Other hospital Consultants within the trust
- Other gynaecological clinics / wards

The majority of colposcopy referrals are by direct referral from the laboratory. The remaining referrals are usually made by letter from the sources mentioned above or via the ICE referral form if internal referrals. Referrals other than the direct referral from the Cytology laboratory are triaged by the Lead Colposcopist or Lead Nurse Colposcopist to assess if appropriate for Colposcopy Clinic.

To assist with appropriate clinic scheduling referrals are usually channelled through the Colposcopy Co-ordinators to ensure appropriate utilisation of available slots in the various clinics. Generic referral allows appropriate triage of patients according to clinical priority, within the set National Quality Assurance Standard Guidelines

Women should be referred for Colposcopy in the following circumstances:

1. Following a HPV positive cervical screening sample with inadequate cytology result on 2 occasions (3-month interval between samples).
2. Following three cervical screening samples that have been HPV positive annually for 2 years with negative cytology.
3. Following any cervical screening sample that is HPV positive and has any cytological abnormality.
4. Following two cervical screening samples where the HPV result is unavailable (3-month interval between samples).
5. Women with an abnormal cervix or suspicious symptoms with features suspicious of cancer. Sample-takers must visualise a woman's cervix when taking a cervical screening sample. If they notice abnormalities suggesting possible malignancy, the woman should be referred for gynaecological examination. These women must be seen within two weeks of referral. Women presenting with symptoms of cervical cancer (e.g. postcoital bleeding, persistent vaginal discharge that cannot be explained by infection or other causes) must be referred for examination by a Consultant Gynaecologist who may then refer these women on for symptomatic colposcopic examination outside the NHSCSP if cancer is suspected.

Waiting Times

Cancer waiting times: national policy

Referral times to colposcopy are governed by Improving Outcomes: A strategy for cancer and the 18-week pathway. Screening results that require referral to colposcopy and the pathway are given in the table below.

The patients referred as a two week wait who do not have cancer on examination at the first visit revert to the 18-week pathway for the remainder of their care.

Faster diagnosis standard

The new Faster Diagnosis Standard ensures that all patients referred as a suspected cancer are confirmed or excluded to have cancer within 28 days of referral. This was introduced in April 2020.

Prioritisation of referrals

Appointments are prioritised as follows:

Reason for referral	Waiting Time Target (% target)
Clinical appearances suggestive of cervical cancer	2 weeks (93%)
Postcoital bleeding lasting more than 6 weeks in women >35 years with abnormal looking cervix	2 weeks (93%)
Postcoital bleeding lasting more than 6 weeks in women <35 years where infection and contraceptive methods have been eliminated as the cause	6 weeks (99%)
Query invasive carcinoma on screening test	2 weeks (93%)
Glandular abnormalities	2 weeks (93%)
High risk HPV positive, Borderline nuclear changes in squamous cells	6 weeks (99%)
High risk HPV positive, Borderline nuclear changes in glandular cells	2 weeks (93%)
High risk HPV positive, low grade dyskaryosis	6 weeks (99%)
High risk HPV positive, negative cytology 3 consecutive samples (0,12&24 months)	6 weeks (99%)
High risk HPV positive, inadequate cytology on 2 occasions	6 weeks (99%)
Request for routine cytology	6 weeks (99%)
Referral for out of area follow-up	6 weeks (99%)
High risk HPV positive, negative cytology on Test of Cure	6 weeks (99%)

- Referrals to Colposcopy with a Clinically Suspicious cervix and/or suspicious symptoms suggestive of cervical cancer should be directed through the Two Week Wait Office and then through the Colposcopy booking office.
- All referral letters are stamped with the date on receipt within the hospital.
- Letters are screened by the colposcopy clinic co-ordinator and will be prioritised by a Colposcopist.
- The Colposcopy co-ordinator enters an appointment on PAS system within 72 hours of receiving the referral and the patient is sent a Colposcopy information pack containing the following:
    - *An appointment within the appropriate time scale*
    - *Colposcopy patient information leaflet*
    - *Parking and public transport details*

- The Lead Colposcopist or Lead Nurse should be informed if any referrals the cannot be seen within the above guidelines in order that additional appointment slots can be created.
- If there is a possibility of the patient not receiving a Colposcopy pack because of limited time, i.e. in the case of 2 week wait referrals the clinic clerk makes the appointment by telephone or an appointment is allocated and sent in the post to the patient, the colposcopy leaflet would be given to the patient at the time of the clinic visit in this instance.

Hr HPV results

Inadequate samples

Consecutive inadequate samples

- If the hr HPV test result is unavailable or cytology is inadequate at any screening test in the pathway, the sample must be repeated in no less than 3 months.
- Those who have an inadequate cytology at the 24-month repeat do not need to have a repeat test in 3 months but are to be referred to colposcopy.
- If there are 2 consecutive inadequate cytology or unavailable HPV results, in any combination are to be referred to colposcopy.
- Those who are referred to colposcopy as stated above (2 consecutive HPV unavailable or inadequate cytology) who have an adequate and normal colposcopic examination should have follow-up with a repeat test in the community in 12 months.
- If HPV testing at 12 months is negative, return individuals back to routine recall.
- If colposcopic examination is inadequate a repeat screening test and colposcopy should take place in 12 months. If colposcopy is normal then discharge to routine recall, and if abnormal manage as per national protocols.

Hr HPV Negative results

- If results are hr HPV negative, then discharge to age related routine recall unless on:
    - Test of cure pathway
    - Untreated CIN1 pathway
    - Follow-up for incompletely excised CGIN/SMILE/cervical cancer
    - Follow-up for borderline changes in endocervical cells

Hr HPV positive and negative cytology

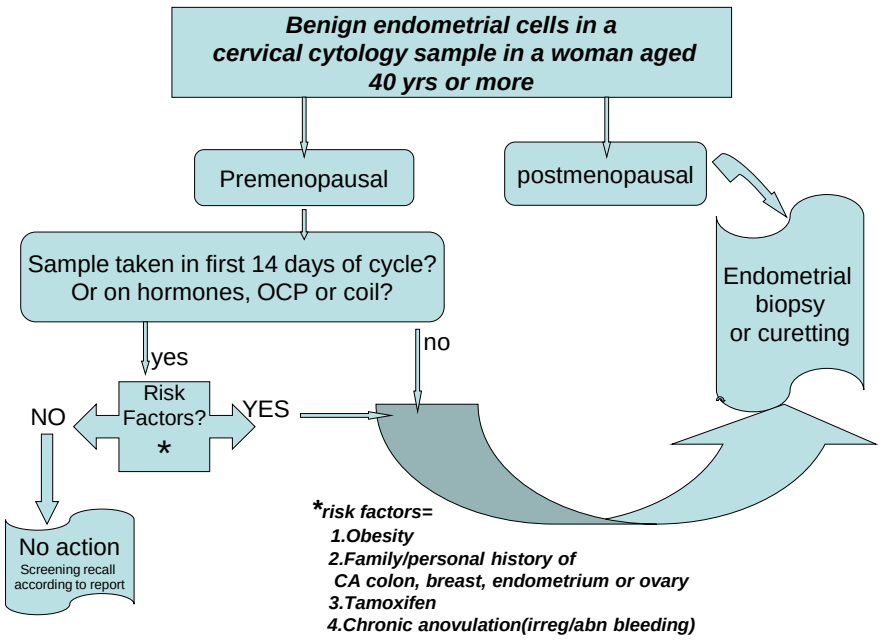
- Those who are hr HPV positive with negative cytology as part of routine screening should have HPV test repeated at 12 months.
- At 12 months if HPV negative return to routine recall. If HPV positive with negative cytology, repeat HPV test in a further 12 months.
- At 24 months if HPV negative return to routine recall. If HPV positive with negative cytology refer to colposcopy.

Hr HPV positive results and abnormal cytology

- All individuals with HPV positive result and abnormal cytology are to be referred for colposcopy.

Benign endometrial cells in cervical samples

- Benign endometrial cells are only reported in samples that are hr HPV positive in those aged 45 and over.
- The significance of benign endometrial cells with cervical samples varies with medication, age, clinical history and phase of menstrual cycle.
- If there is any history of abnormal vaginal bleeding refer to the gynaecology clinic.



Cervical screening samples suggestive of endometrial cells in a postmenopausal woman should be referred via the PMB Pathway. Women with normal endometrial cells age less than 40 years old do not need referral to colposcopy or gynaecology. In women aged 40 or more but premenopausal an endometrial sample should be undertaken, preferably a pipelle sample.

Abnormal cervix

- A two week wait suspected cancer referral should be made for all patients with clinical appearance of cervical cancer.

Individuals with symptoms

Management of individuals with symptoms

- Individuals presenting with symptoms (e.g. Postcoital bleeding (PCB) or persistent vaginal discharge not explained by infection or other causes) are not indications for screening.
- The majority of patients with PCB are not as a result of cervical malignancy, in the younger population contraceptive or infective causes are more likely.
- If hormonal or infective causes are excluded in general practice, referral for examination by a gynaecologist is advised (gynaecology clinic).
- At the time of cervical sampling contact bleeding may occur, this is NOT an indication for referral to colposcopy in the absence of other symptoms.
- If cancer is suspected gynaecologists may refer to colposcopy for those with symptoms.

GUIDELINES FOR COLPOSCOPIC ASSESSMENT & DIAGNOSTIC STANDARDS IN CLINIC

The Colposcopist introduces him/herself and other Colposcopy staff to the patient. Full discussions regarding the reasons for referral to the clinic are discussed and explanation of the proposed assessment and treatment and possible procedures are given to the patient with adequate time for patient to ask questions. Written consent is obtained and put in the notes if any treatment is envisaged. The patient is guided to the changing area before being positioned on the Colposcopy couch.

The Colposcopist initially inspects the vulva before inserting a lubricated speculum of appropriate size into the vagina to allow adequate visualisation of the cervix. The vagina is assessed for any significant abnormality. The cervix and vagina are assessed with the colposcope prior to applying any solutions. If cervical/vaginal screening samples are required, these are taken using the appropriate sampling device.

A full explanation is given to the patient throughout. Any excess mucus may be removed with normal saline. Following this 5% acetic acid is applied to the cervix. Appropriate magnification is achieved. The cervix is visualised in its entirety, taking note of the squamocolumnar junction and size of the transformation zone, the size and shape of any lesion(s) (if present), density of acetowhite staining, presence of punctuation or mosaicism and involvement of the endocervical canal. The green filter can be used to enhance the vascular features if necessary. Lugol's iodine may be applied at this stage to demarcate the treatment zone prior to an excision. All the above features should be recorded on the Colposcopy database.

If biopsies are required of the transformation zone, explanation is given to the patient prior to biopsy and generally more than one biopsy is recommended, and on occasions multiple biopsies may be required. Monsel's solution (ferric subsulphate) or silver nitrate are applied to the biopsy sites where necessary.

Having completed the assessment, the speculum is withdrawn. The patient is guided to the changing area and given advice regarding sanitary protection as necessary and allowed to change in privacy.

Following this, the findings and further management is discussed in detail with the patient, explaining in particular how results will be communicated to the patient and her GP. Appropriate literature relevant to interventions are given to the patient prior to departure. Once again the patient is allowed adequate time to ask questions.

Before leaving the department, the patient is offered time to recover if necessary.

Details of the colposcopic assessment are recorded directly onto the colposcopy database by the clinician.

Accuracy of colposcopic diagnosis

Colposcopic examination allows diagnosis or CIN, and to differentiate between low- and high-grade lesions. The accuracy is dependent on disease prevalence in the population being screened. The highest prevalence is found in those with high grade cytology results, and lowest in those referred with persistent HPV and negative cytology.

The recommended positive predictive value (PPV) should be a minimum 75% for a colposcopic impression of a high-grade lesion (CIN2 or worse) in individual referred with high grade cytology, and at least 35% for all other referrals.

Invasive disease

Invasive disease must not be overlooked. An excisional form of biopsy is recommended when:

a) When most the ectocervix is replaced with high grade abnormality.
b) Low grade colposcopic change is associated with a severely dyskaryotic cervical screening sample or worse.
c) When a lesion extends into the endocervical canal, sufficient endocervical tissue should be excised to remove the lesion.
d) When cytology is suggestive of invasive disease or? glandular neoplasia.

In the above punch biopsies are not considered reliably informative. There is a small risk of inadvertent destruction of an invasive or glandular lesion.
There may be valid reasons for delaying excision (pregnancy). Reasons for not performing a biopsy must be documented.

Colposcopically directed punch biopsies

Unless an excisional treatment is planned, a cervical biopsy should be taken when cytology is high grade, and when an atypical/abnormal transformation zone is seen.

In individuals with hr HPV and either negative or low-grade cytology changes (mild dyskaryosis or less), and colposcopic examination is either negative or low grade a cervical biopsy is not necessarily required but can be taken.

When biopsies are taken (directed or excisional) ≥90% should be suitable for histological interpretation.

When a directed biopsy is inadequate, it should be repeated if there is a residual lesion on colposcopic examination (≥95%)

Excisional or punch biopsy is not generally recommended in certain conditions including pregnancy, patients with bleeding disorders or patients on anti-coagulant therapy. Clinicians should refer to the trusts policy for advice on management.

CLINICAL MANAGEMENT GUIDELINES

Treatment of CIN

All individuals having a treatment should have a colposcopic assessment and treated in properly equipped and staffed clinics. All treatments must be recorded in the colposcopy database and patient notes.

- All patients with high-grade cytology (moderate/severe dyskaryosis/glandular changes) are potential candidates for 'See and Treat' management (under local anaesthetic), if colposcopically appropriate and if the patient is in agreement. The patient is appropriately counselled regarding the referral abnormality and consent is sought for treatment prior to the patient being positioned on the Colposcopy couch. The management regime at Worcestershire Acute Hospitals Trust, at present, is excision using loop diathermy.

- The proportion of individuals who have see and treat at first visit with evidence of CIN2/3 or CGIN must be ≥90%.

- See and treat should not be offered at first visit when referred with hrHPV positive and cytology negative/borderline/low grade dyskaryosis.

- ≥90% of patients should be offered an appointment for treatment for high grade CIN within 4 weeks of receiving a diagnostic biopsy result. All individuals with high grade CIN must be treated within 8 weeks, the exception to this are those who are pregnant and those that are on the conservative CIN2 management pathway.

- At least 80% of excisional treatments should have the specimen removed as a single sample.

- **All** women must have histological diagnosis established by taking a biopsy prior to ablative or destructive therapy when an atypical transformation zone is present.

- Glandular abnormalities require an excisional treatment. Incomplete excision at the endocervical/deep lateral margin requires a further excisional procedure to rule out occult invasive disease. **All** cases of CGIN/SMILE **must** be discussed at MDT.

- Care should be taken not to overlook invasive disease. An excisional form of biopsy is recommended, as punch biopsies are not considered to be reliably informative and the colposcopist should be aware of the small risk of inappropriate or inadvertent destruction of invasive or glandular lesions.
- Patients who do not wish to opt for or who are not suitable for outpatient treatment are offered treatment under general anaesthesia as a day case unless existing co-morbidities necessitates an overnight stay. The same follow up procedures and patient information will apply.

- The proportion of treatments as an outpatient with local anaesthesia should be at least 85%, with an achievable target of 90%.

- For routine non-urgent co-existing gynaecological conditions, the patient should be advised to contact her GP for appropriate management in primary care or referral to gynaecology outpatients by GP if appropriate.

Depth of excision

The aim of excisional treatment is to remove all the abnormal epithelium, and the depth of excision will depend on the type of transformation zone (TZ). These depths differ when there is glandular disease (see later).

- **Type 1 TZ**
  Aim to remove tissue to a depth of more than 7mm in ≥95% cases. In individuals of reproductive age, the aim would be to excise a depth of <10mm.
- **Type 2 TZ**
  Aim to remove tissue to a depth of 10-15mm in ≥95% cases, depending on the position of the SCJ within the endocervical junction.
- **Type 3 TZ**
  Aim to remove tissue to a depth of 15-25mm in ≥95% cases, depending on the position of the SCJ within the endocervical junction.

Repeat Excision

- **High grade CIN extending to margins**
  High grade CIN extending to the deep lateral and/or endocervical margins or uncertain margin status result in a high incidence of recurrence. Routine repeat excision is **NOT** justified if:
    - The individual is under 50 years of age
    - There is no glandular or invasive disease

- **Individuals over the age of 50**
  Those over the age of 50 years who have incomplete excision of CIN3 at the deep lateral and/or endocervical margins, and where satisfactory screening samples and colposcopy cannot be guaranteed, they must have/be offered a repeat excision performed to try to obtain clear margins.

Local excision of microinvasive squamous cell carcinoma stage 1a1

Micro-invasive squamous cell carcinoma FIGO stage 1a1 can be managed by local excisional treatment if:

- The deep lateral and endocervical excision margins are free of invasive disease and CIN. Re-excision is not required when **ONLY** the ectocervical margin is positive for CIN.
- The histology has been reviewed at the MDT meetings (colposcopy and gynaecology).

- When the invasive disease is completely excised but the CIN extends to the endocervical and deep lateral margins, a repeat excision should be performed to confirm complete excision of CIN and exclude the presence of further invasive disease.

Follow up after treatment for cervical intraepithelial neoplasia (CIN) and early-stage cervical cancer

Treated Individuals'

Individuals who have had treatment for CIN are at risk of developing cervical cancer and must have follow up 6 months' post treatment (this should be in primary care); this is irrespective of completeness of excision margins. Treated individuals are 2-5 times more likely to develop cervical cancer in comparison to the general population, therefore, patient compliance is encouraged.

Exceptions to follow up in primary care are:

- Those with difficult access to the cervix or difficulty in obtaining CSS e.g. cervical stenosis.
- Following discussion and agreement at colposcopy multidisciplinary team (MDT) meeting.
- Microinvasive disease that has been completely excised. These individuals require a CSS at 6 and 12 months and then annual CSS for the following 9 years in the colposcopy clinic at least before returning to routine recall.

The proportion of histological treatment failures should not exceed 5% within 12 months of treatment.

Duration and frequency of follow up following CIN treatment

Individuals who have had treatment for CIN1, 2 or 3 should be invited 6 months after treatment for test of cure (TOC) cervical sample in the community.

Cervical screening sample (CSS) should be taken 6 months following a treatment and no later than 8 months.
After this 6-month sample:

- If hr HPV negative, then individuals are recalled for a repeat CSS in 3 years, regardless of age. If the 3-year test is negative the individual can return to age related routine recall.
- All individuals with hr HPV positive will be referred to colposcopy regardless of the cytology result.
- If at the TOC hr HPV result is unavailable, then a repeat test at 3 months is recommended.
- Individuals who reach 65 years of age must be invited for follow up tests and further investigations if required until completion of all follow up protocols.

Follow up for early-stage cervical carcinoma

Stage 1a1

Follow up is recommended for all individuals with a remaining cervix.

A TOC CSS sample should be taken at 6- and 12-months following treatment, and then annual sampling for the following 9 years in the colposcopy clinic at least, before returning to routine recall.

Stage 1a2/1b1

If stage 1a2/1b1 disease is treated by simple or radical trachelectomy, follow up is determined by the Gynaecological Oncology Team/MDT.

If treated with total hysterectomy for early-stage cervical cancer, follow up will be in accordance with local cancer network guidelines. The individual is ceased from the CSP.

Individuals who are treated with chemoradiotherapy are followed up in accordance with local cancer network guidelines and ceased from cervical screening.

Invasive cervical cancer audit

The purpose of the invasive cervical cancer audit is to monitor the effectiveness and performance of the cervical screening programme, to identify areas of good practice, to identify areas where improvements may be made. The audit aims to understand why cervical cancers may occur despite the existence of the CSP.

The audit offers an opportunity to review the original results and management of each case of cervical cancer and if appropriate management was undertaken.
Taking part in the cervical cancer audit is an essential part of the cervical screening programme and quality assurance.

It is the role of the Lead Colposcopist and CSPL to ensure the colposcopic aspects of the audit are fulfilled. Those individuals who develop cervical cancer and taken part in the CSP must be offered the opportunity to receive the completed review of their screening history and opportunity to discuss this further.

This is carried out according to the principles for disclosure outlined in the Guidance on applying Duty of Candour and disclosing audit results.

Untreated Individuals

Individuals referred with high grade dyskaryosis (moderate/severe)

Those referred with high grade cytology are at significant risk of CIN2-3, even if colposcopy is normal.

Biopsy should be undertaken in ≥95% in those with high grade cytology. If colposcopic examination is normal or low-grade CIN, these cases are for MDT discussion.
If there is no treatment, close surveillance is advised with colposcopy and cervical samples 6 monthly.

If at follow up there is persistent high-grade cytology, CIN2 or 3 on biopsy, an excisional treatment is recommended (≥90%).

All unexplained high grade dyskaryosis should be discussed at MDT.

Individuals referred with low grade cytology

Those referred with low grade cytology or less and have adequate and normal colposcopic examination are at low risk of developing cervical cancer and can be returned to community based 3-year recall.

Those referred with low grade cytology or less and have low grade colposcopic opinion and/or biopsy proven CIN1 should have a further screening sample at 12 months in the community.

Individuals with persistent hr HPV and unsatisfactory colposcopy (TZ3)

Following the introduction of primary HPV screening an increasing number of individuals are being seen with persistent hr HPV with either negative cytology (x3) or low-grade cytology (excluding borderline in endocervical cells) where the transformation zone is not visible (TZ3/unsatisfactory colposcopic examination).

The NHSCSP guidance suggests that those with hr HPV positive and cytology that is low grade or negative (excluding borderline changes in endocervical cells) should be seen for repeat colposcopy in 12 months. If this repeat colposcopic examination is still unsatisfactory, to consider LLETZ after discussion with patient.

Individuals with a TZ3 and persistent hr HPV with low grade or negative cytology should have the findings and the need for 12 month follow up as per NHSCSP guidance explained to them.

Consideration should be given to administration of vaginal oestrogens for those that have atrophic changes and to discuss with individual using progestogen only contraception with TZ3 to consider altering this with advice from their GP.

At the 12-month appointment a cervical screening sample and colposcopy should be performed. If colposcopic examination remains unsatisfactory, the pros and cons of follow-up versus LLETZ procedure should be discussed with the patient and patient preference should be documented.

Individuals with persistent hr HPV with unsatisfactory colposcopic examination with a history of high-grade CIN in the previous 10 years or a history of CGIN are to have a case review at the Colposcopy MDT meeting.

Conservative Management of CIN2

Management of high-grade CIN in the form of excision is not without risk, in particular adverse obstetric outcomes like pre-term labour in women of reproductive age.

This has resulted in debates nationally and internationally if selective cases of CIN 2 can be managed without excisional treatment as a significant proportion of cases may regress spontaneously.

NHSCSP guidance does not differentiate between CIN 2 and 3 and recommends treatment for high grade disease (CIN 2 & 3).

Guidance:
All cases of CIN2 considered for conservative management **must** be discussed at colposcopy MDT. A consensus should be reached by the team that it is reasonable to consider conservative management.

The choice of treatment or non-treatment should be discussed with the patient and the patient's wishes are to be considered after careful evaluation of the case.

Factors to consider (this is not a comprehensive list but for guidance only):

Each patient should be considered on an individual basis.

- Age, degree of abnormality and parity will probably be the three key determinants.
- Future fertility wishes.
- HIV status, immuno-suppression, smoking status and the size of the lesion should also be taken into account.

Individuals can be offered conservative management of CIN2 if:

- Colposcopic examination is adequate and CIN3/invasive lesion has been excluded.
- The CIN2 lesion occupies no more than 2 quadrants of the cervix.
- CIN2 has been diagnosed on biopsy and reviewed at MDT to exclude an overcall or undercall.
- Individuals agree to regular 6 monthly colposcopy, cervical screening samples +/- biopsies if indicated.
- Individuals understand the time for CIN2 resolution can be at least 24 months.

Follow up of patients with CIN2 managed conservatively

All patients with CIN 2 who have been managed conservatively **must** remain under the care of colposcopy until such a time that a definitive treatment has taken place or there is evidence of regression of disease on colposcopic examination and cytology.

Treatment should be offered if the CIN2 has not resolved within 24 months.

Those persistently positive for hr HPV and/or cytological changes at 24 months are to be reviewed at MDT.

If at the 6 monthly follow up the cervical screening sample +/-biopsy are improving, and colposcopic examination is adequate and impression is not high grade, then continue 6 month follow up.

If at 6 monthly follow up the cervical screening sample +/- cervical biopsy show persistent CIN2, high grade cervical screening results and/or high grade colposcopic opinion, cases are to be reviewed at MDT.

If at any stage cervical screening sample returns to HPV negative, review at MDT to confirm discharge from pathway.

MANAGEMENT OF GLANDULAR ABNORMALITIES

Borderline changes in endocervical cells samples

Individuals with hr HPV positive test and borderline changes in endocervical cells should be referred to colposcopy as two week wait referrals and ≥93% should be seen within 2 weeks. They should be primarily investigated with Colposcopy and appropriate assessment +/- LLETZ. Discussion at colposcopy MDT should occur once results are available.

If colposcopic assessment is negative, discussion at the Colposcopy MDT meeting is required. They are likely to be followed up at 6 months with screening or in the colposcopy clinic. Only discharge to 3-year recall if downgraded to negative at MDT.

? Glandular neoplasia (non-cervical)

These patients require referral to PMB/gynaecology as two week wait referrals, at least 93% should be seen within 2 weeks.

? Glandular neoplasia of endocervical type

All cervical screening samples suggestive of glandular neoplasia of endocervical type require colposcopic assessment to exclude significant cervical neoplasia (100%). At least 93% should be seen within 2 weeks The extent of the investigation will depend on the written descriptive report of the cervical screening sample. **All** cases must be discussed at colposcopy MDT.

All other cervical screening samples suggestive of glandular cervical intraepithelial neoplasia should be seen in Colposcopy with appropriate excisional biopsy undertaken. Punch biopsy is of **no** value in the assessment of suspected CGIN.

Management of cervical glandular intraepithelial neoplasia (CGIN)

Individuals with suspected CGIN or early invasive cervical adenocarcinoma, the excision should be tailored to each individual and TZ type.

- **Type 1/2 TZ**
  A cylindrical shaped cervical excision including the whole TZ with a depth of more than 10mm of endocervix above the SCJ.
- **Type 3 TZ**
  A cylindrical shaped cervical excision including any visible TZ with a depth of 20-25mm of endocervix above the SCJ.

Management of confirmed CGIN

- All biopsy specimens graded as CGIN or SMILE should be discussed at the colposcopy Multidisciplinary Team Meeting and appropriate treatment options will be discussed depending on the grade of the lesion and the extent of the abnormality.
- Excisional treatment is recommended for CGIN.

Management of incompletely excised CGIN

Individuals with incomplete excision of CGIN should be offered a further excisional treatment in order to exclude invasion and obtain negative excision margins.

Individuals who decline a repeat excision or if a repeat excision is not possible should be followed up in colposcopy at 6 & 12 months and then annually for 9 years with primary hr HPV testing.

All cases should be discussed at MDT.

Hysterectomy for cervical glandular neoplasia

Simple hysterectomy maybe considered if:

- Fertility is not required
- there are positive margins after an adequate excisional procedure
- treatment by excision is followed by further high-grade cytological abnormality
- the patient is unwilling to undergo conservative management/follow up
- adequate screening follow up has not been possible, for example because of cervical stenosis
- there are other clinical indications for the procedure
- invasive disease has been confidently excluded

Follow-up for treated CGIN

Those who have had excisional treatment for CGIN are high risk of recurrence.

All follow-ups are in the colposcopy clinic.

When taking a cervical screening sample, endocervical cells should be sampled using an endocervical brush after routine ectocervical sampling.

Cytology is not required in hr HPV negative women to confirm the presence of endocervical cells.

If further cytological abnormalities occur during the outlined follow up further discussion at the multidisciplinary meeting is advisable.

Women treated for CGIN with incomplete excision margins will be followed up with hr HPV testing at 6 and 12 months and then annual hr HPV testing for a further 9 years. Follow up will be in the Colposcopy Clinic.

When the CGIN has been completely excised either at the first excision or subsequent re-excision, they are followed up with cervical screening at 6- and 18-months' post treatment in the colposcopy clinic. All samples will initially be tested for hr HPV and those women testing negative and with normal colposcopy will be recalled for the second follow up test in a further 12 months (18 months' post-treatment). At the second follow up test, women testing hr HPV negative with normal colposcopy will be recalled for further testing in 36 months, when they will restart the screening protocol for primary hr HPV testing.

Women testing hr HPV positive at the first follow up test will have cytology performed. The cytology samples from these hr HPV positive women must contain endocervical cells to be considered adequate for cytology (unless they contain abnormal cells).

Women testing hr HPV positive at the second follow up test will have cytology performed. Women with negative cytology and normal colposcopic examination will continue to be called at 12 monthly intervals for hr HPV testing and managed according to these protocols for CGIN follow up.

Women with abnormal cytology at either of the 2 follow up tests (6 or 18 months) and where colposcopy is found to be normal or repeat excision is not appropriate, 10 years follow up should be completed with annual hr HPV testing. It is recommended that these cases should be discussed at colposcopy MDT.

All women with a hr HPV positive result will enter the CGIN post treatment follow up pathway again if they have further re-excision with complete excision margins.

If the margins of an initial conservative excision are not free, a further attempt at conservative excision in order to exclude invasion and obtain negative margins should be undertaken.

All CGIN cases **must** be discussed at the Colposcopy MDT meeting.

Stratified mucin producing intraepithelial lesion of the cervix (SMILE)

SMILE is a histological diagnosis usually found in conjunction with CIN and CGIN, it can occur without CIN/CGIN.

The cytological appearance is not well understood.

Individuals diagnosed with SMILE are managed as per the guidance for CGIN.

MULTIDISCIPLINARY TEAM MEETINGS

The colposcopy MDT meetings are held twice monthly between the colposcopy teams on Teams. The meeting is chaired by the Lead Colposcopist or the Cervical Screening Provider Lead. The colposcopists are required to attend 50% of the meetings annually. A pathologist and cytopathologist are present at the meetings.

Colposcopy MDT referral criteria:

- Smear and histology discrepancy
- Smear and Colposcopy discrepancy Histology/Cytology review
- All HGCGIN/cervical cancers
- TOC with high grade abnormalities
- Difficult management cases
- Conservative management of CIN2 (initiation, discharge, persistent/progression of cytology or histology)
- Persistent hr HPV with negative/low grade cytology and TZ3 with a history of high-grade CIN in previous 10 years or CGIN

Colposcopy in Pregnancy

An individual who has been called for routine screening and are pregnant, the screening should be deferred.

An individual referred with an abnormal screening test should have colposcopy in the late first or early second trimester, unless there is a contraindication. Colposcopic examination is safe in pregnancy and women should not be discouraged to attend the colposcopy clinic.

If the previous colposcopy examination was abnormal and the individual becomes pregnant, then colposcopy should still go ahead as planned.

Those pregnant individuals who require colposcopy or screening sample after treatment or follow up of untreated CIN1, their assessment may be delayed until 3 months postnatal.
An individual who meets the criteria for Colposcopy still requires Colposcopy if she is pregnant. The primary aim is to exclude invasive disease and to defer biopsy or treatment until the individual has delivered. Those seen in early pregnancy may require further assessment at the colposcopists' discretion. If the patient does not wish to be seen, a letter should be sent to the referring GP informing them of this and requesting re-referral after delivery.

If high grade CIN is suspected, repeat Colposcopy at the end of the second trimester and thereafter 3 months following delivery for appropriate treatment if necessary. Biopsy or treatment is usually reserved for those with high grade colposcopy and concerns about cancer.

If invasive disease is suspected clinically or colposcopically, a biopsy adequate to make the diagnosis is essential. Biopsies undertaken in pregnancy are associated with an increased risk of haemorrhage and the patient needs to be counselled appropriately. Management of such cases should be discussed at a Colposcopy and Gynaecology Multidisciplinary Team Meeting.

Colposcopy follow up after pregnancy

Follow up arrangements for postnatal assessment should be made for those referred with an abnormal screening test or suspicious looking cervix who have had an abnormal colposcopy. If the patient is unsure whether to proceed with the pregnancy, a letter should be sent to the GP asking them to inform the Colposcopy department when a decision is made either to continue with the pregnancy or following termination.

Colposcopy evaluation of pregnant individuals

Colposcopic assessment of a pregnant individual should be in a medical colposcopy clinic.

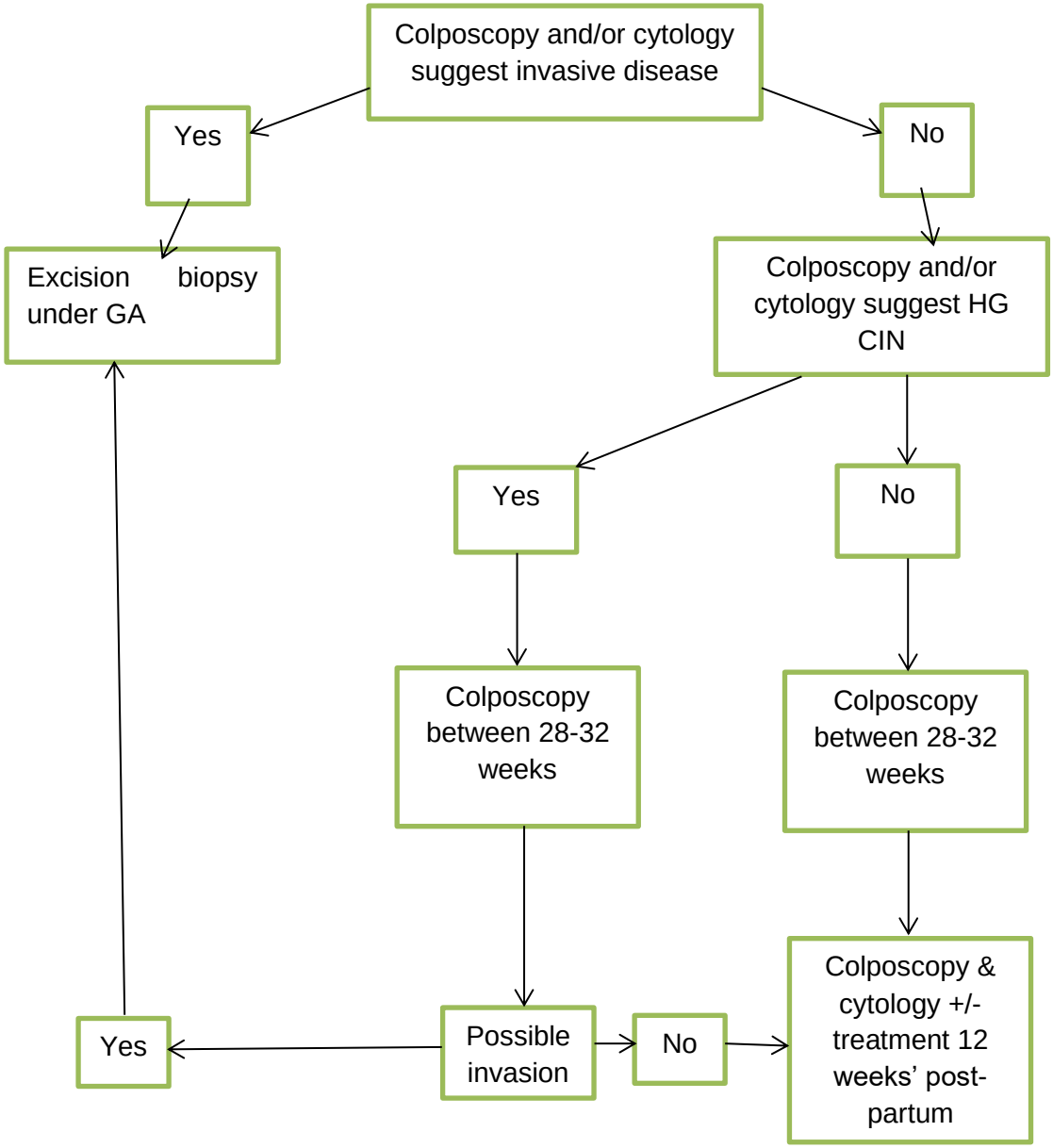
If CIN1 or less is suspected – manage as per screening algorithm.

If CIN2/3 suspected – repeat colposcopy at the end of the second trimester, if the pregnancy has advanced beyond this gestation then repeat 3 months following delivery.

If invasive disease is suspected clinically or colposcopically, a biopsy adequate to make the diagnosis is essential. Excisional treatments are safe in the first and second trimester of pregnancy.

All excisions are associated with a risk of haemorrhage and such biopsies should be taken where appropriate facilities to deal with a haemorrhage are available. A punch biopsy suggestive of CIN only cannot reliably exclude invasive disease.

Management of abnormal cervical samples in pregnancy



Contraceptive Use

Individuals with abnormal cervical screening results

An abnormal screening sample should not influence the choice of contraception.

Individuals with an intrauterine system (IUS)

Give individuals with an IUS clear information on the management policy whether the IUS will be removed or not. They will need to know and should be informed if they are to use an alternative method of contraception. It is not necessary to remove an IUS to perform local treatment.

Use of condoms

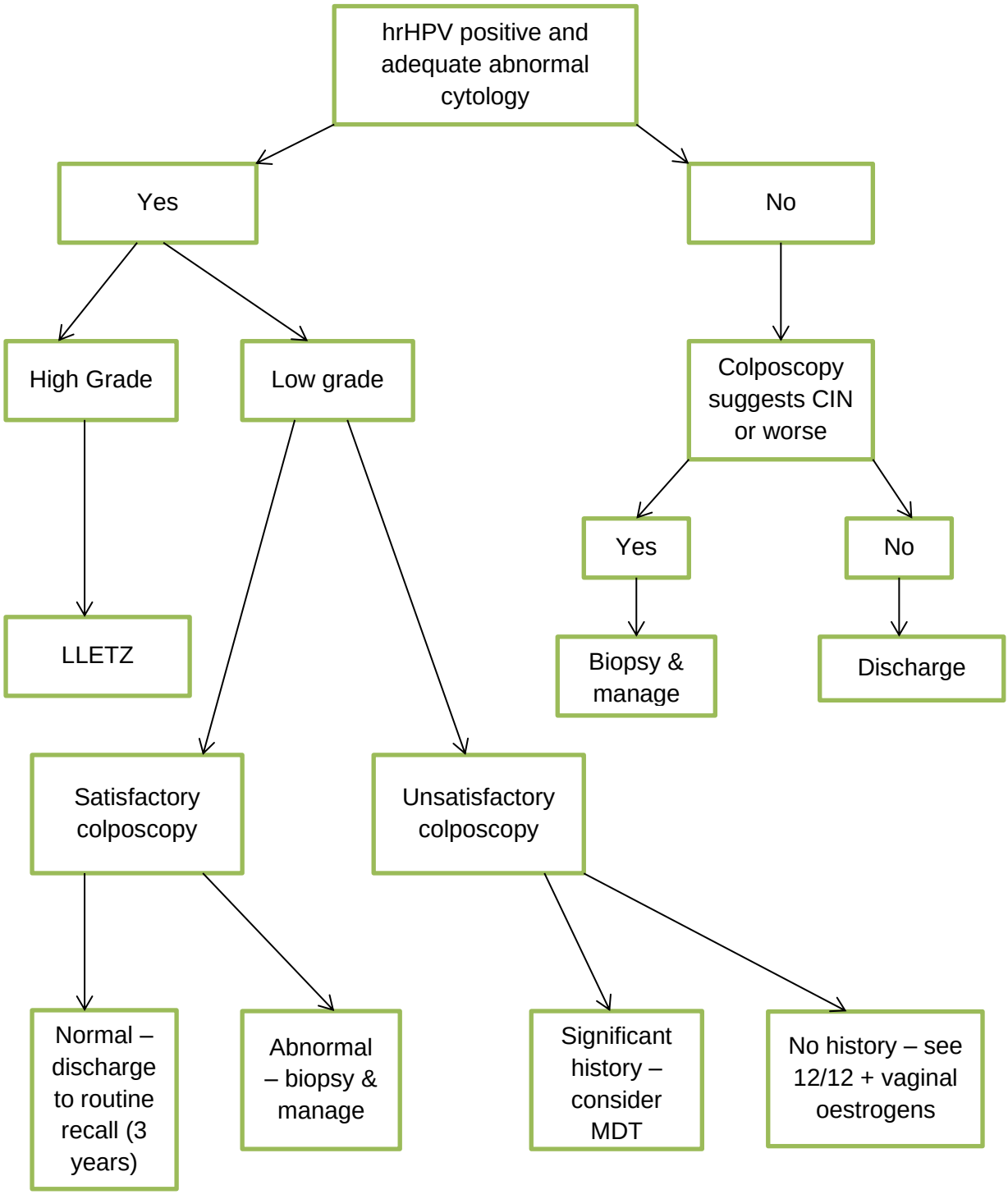
Condoms may promote hr HPV clearance and CIN regression in conservative management, this depends on their consistent use for at least 3 months.

Menopause

The incidence of hr HPV positivity and abnormal cytology is low in postmenopausal individuals with previous normal screening. The use of systemic HRT is not known to alter the risk of cervical disease. Colposcopic examination and adequacy can be improved with the use of topical oestrogens.

In adequately screened individuals, postmenopausal bleeding (PMB) is not an indication to take a cervical screening sample. Part of investing PMB should be direct visual inspection of the cervix, a cervical screening sample is not an appropriate test to investigate PMB.

Management of abnormal Cervical Screening in Postmenopausal Women



Hysterectomy

Individuals having hysterectomy for reasons other than cervical disease

All patients in the cervical screening age range (25 to 64 years old) undergoing hysterectomy for other gynaecological reasons that would be best managed by hysterectomy (not cervical cancer) should have a negative screening test within the routine recall screening interval. If not, a cervical sample should be taken as part of their preoperative investigations.

Individuals being considered for hysterectomy

All patients being considered for hysterectomy who have an abnormal cervical screening sample or symptoms suggestive of cervical cancer should have a diagnostic colposcopy and biopsy if needed.

Hysterectomy as a treatment for histologically proven CIN

Hysterectomy is a recognised treatment for histologically proven CIN if there are co-existing conditions treated by hysterectomy:

- Where the anticipated morbidity would be less than a LLETZ in a woman who has completed her family.
- Where multiple local excisions have been performed, the cervical sample and or Colposcopy are still suggestive of high-grade disease (but not invasion) and the woman's family is complete.
- After the diagnosis of a stage Ia2 lesions in a woman who has completed her family (to be discussed at gynaecology MDT).
- Incompletely excised stage Ia1 lesions in women who have completed their families (to be discussed at gynaecology MDT).

Hysterectomy as a treatment for persistent abnormal endocervical cytology

Hysterectomy is an acceptable treatment in cases where abnormal endocervical cytology persists despite a previous excision biopsy of adequate size. This is provided that all measures to exclude occult invasion have been made.

Mapping vaginal abnormalities

Patients with CIN should have any vaginal abnormality mapped by colposcopy/Lugol's iodine at the time of surgery to ensure any co-existing VAIN is seen and excised at time of hysterectomy.

The histology of the hysterectomy should be correlated with the prior cervical screening result.

Follow up after hysterectomy

Vault sampling is not part of the routine screening programme. Individuals who have had a hysterectomy with CIN present are potentially at risk of developing vaginal intraepithelial neoplasia (VaIN) and invasive vaginal disease. There is no clear evidence that colposcopy increases the detection of disease on follow up.

The recommended post hysterectomy follow up within the screening age group (25 to 64 years old) is:

- Individuals on routine recall and with no CIN in the hysterectomy specimen, no further vaginal vault sample is required.

- Individuals **NOT** on routine recall (these are usually patients under the care of colposcopy clinic with different screening recall) and with no CIN in the hysterectomy specimen should have a vaginal vault screening sample at six months following their surgery.

- Individuals who undergo hysterectomy and have completely excised CIN should have vaginal vault sample at 6 months following their hysterectomy; if they have a negative hr HPV result, they can be discharged.

- Individuals who undergo hysterectomy and have completely excised CIN and are hr HPV positive cytology negative at 6 months, should be referred to colposcopy; if there is no evidence of VaIN at colposcopy the individual can be discharged.
  Individuals who undergo hysterectomy and have incompletely excised CIN (or uncertain excision), primary hr HPV screening follow up should be:

    - CIN1 - vault sample at 6, 12 and 24 months
    - CIN2/3 - vault samples at 6 and 12 months followed by 9 annual vault samples
    - Follow up for incompletely excised CIN continues to 65 years or until 10 years after surgery (whichever is later)

- Vault samples can be taken in the GOPD, using the same cervical screening sample form and labelling process.

- The clinician is responsible for the failsafe mechanism for this small group of individuals.

- Individuals who undergo subtotal hysterectomy still have their cervix in situ, and so must remain within the cervical screening programme.

**Routine recall = Those women who are in the NHSCSP call/recall system between the age of 25 and 64 years old. Individuals are recalled every 3 years until they turn 50, after which the recall interval changes to every 5 years. Automatic recall stops when the next cervical screening test due date is on or after their 65th birthday.*

SCREENING AND MANAGEMENT OF IMMUNOSUPPRESSED INDIVIDUALS

Immunosuppressed individuals are those that are on immune suppressing medication, transplant recipients of any organ and all other forms of immunosuppression.

Individuals who are HIV positive

All individuals should have a cervical screening sample performed at diagnosis performed by or in conjunction with the medical team managing the HIV infection.

Annual screening should be performed with an initial Colposcopy if resources permit.
The management of these individuals will follow the protocols as per the national guidelines.
The age range for screening remains the same.

Despite the higher cervical treatment failure rate, high grade CIN should be managed according to national guidelines. Low grade lesions less severe than CIN2 should generally not be treated as these are likely representation of persistent hr HPV infection and respond poorly to treatment and may clear spontaneously. Regular cervical cytology will detect any progression.

Individuals who are HIV positive may cease cervical screening at age 65 if they fulfil the general criteria for ceasing.

Individuals with renal failure requiring dialysis (or any other disease with a high chance of requiring organ transplantation)

A Cervical screening sample must be performed at or shortly after renal failure diagnosis if not up to date with screening. If there is an abnormal screening test individuals should be referred to colposcopy in line with the current pathway. All individuals eligible for cervical screening and about to have organ transplantation should have had a cervical screening test within the previous 12 months. Coexisting CIN should be managed according to the national guidelines.

Individuals taking maintenance immunosuppression medication post transplantation

Individuals with no history of CIN can be screened in accordance with national guidelines for the non-immunosuppressed population. Referral to Colposcopy should occur for any abnormal cytology result as per the current pathway. Women with a history of CIN should have follow up as for the immunocompetent population.

There should be good education of organ transplant recipients and their carers about the importance of participating in the CSP. Immunosuppressant drugs increase the risk of contracting hr HPV (drugs following organ transplant, autoimmune and neurological disorders). They do not have an impact on the rate of progression through hr HPV, CIN to cervical cancer.

Other Individuals who are immunosuppressed

There is no indication for increased surveillance for individuals receiving:

- Cytotoxic chemotherapy for non-genital cancers

- Oestrogen antagonist e.g. tamoxifen
- Alemtuzumab
- Cytotoxic drugs for rheumatological disorders or biological agents for other disorders
- Receiving long term steroids

These individuals should have regular cervical screening samples in accordance with national guidelines.

Individuals with multifocal disease

These individuals must be managed in units with demonstrable skill and expertise. Patients with multifocal disease of the genital tract should be assessed by symptom enquiry, cervical screening (within the CSP), colposcopy, vulvoscopy and biopsy where indicated at least six monthly. There must be a balance between increased risk of CIN and additional psychological and physical trauma of assessment and treatment.

Individual exposed to diethylstilboestrol (DES)

Daughters of individuals exposed to DES are at increased risk of clear cell carcinoma of the cervix and vagina but not other forms of cervical cancer. There is estimated to be no more than 1 case per year in England and Wales.

Routine call and recall is appropriate.

Individuals who are DES daughters are followed up in the medical colposcopy clinic annually for colposcopy/vaginoscopy.

Granddaughters of those exposed to DES ae not at an increased risk of cervical or vaginal cancer.

Induction Protocols for New Colposcopists to the Trust

All BSCCP Accredited colposcopist's commencing practice in WAHT are required to fulfil the following:

- Provide the trust with a copy of their current BSCCP accreditation certificate.
- Attend WAHT induction programme for medical or nursing staff.
- The trust will ensure that the colposcopist is provided with all the relevant paperwork e.g. local guidelines, policies and procedures and orientation regarding clinic setup and equipment.
- BSCCP colposcopy trainees will be directly supervised in accordance with the BSCCP training curriculum. When indirect supervision is in place, an accredited colposcopist will be in the clinical area whilst the clinic is in progress.
- Locum colposcopists (if used) will be required to undertake at least two clinics with a permanent, accredited colposcopist within the trust. Written confirmation (in email or formal hard copy letter) from the supervising colposcopist should be provided to the Lead Colposcopist and Lead Colposcopy Nurse that this has taken place and that the clinician has demonstrated adequate knowledge of local and national guidelines before independent clinics are undertaken.
- All accredited colposcopists working in the trust will be subject to audit regarding individual performance data on a quarterly basis by the lead nurse. Any areas that fall below standard will be addressed on an individual basis by the Lead Colposcopist.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Whole document	Performance of service against all KPI's and national standards	Production of mandatory performance data for NHSE Clinical Audit	Quarterly and annually as per KC65 and Individual Colposcopist Annual Performance data	Lead Colposcopist Lead Nurse Colposcopist CSPL	NHSE (SQAS) Gynaecology divisional team Trust board	4 times per year and adhoc if required

References

https://www.researchgate.net/publication/8447687
Peto_J_Gilham_C_Fletcher_O_Mattews_FEThe_cervical_cancer_epidemic_that_screening_has_prevented_in_UK_Lancet_364_249-256)

2016 (https://pubmed.ncbi.nlm.nih.gov/27632376/)

Cervical screening: programme and colposcopy management
Guidelines for commissioners, screening providers and programme managers for NHS cervical screening. From: **NHS England** Published 3 May 2010 Last updated 5 January 2023

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Mr Jeremy Twigg, Consultant Gynae Oncologist/Colposcopist
Miss Joanne Lee, Consultant Gynaecologist/Colposcopist
Mr Samson Agwu, Consultant Gynaecologist/Colposcopist
Ms Manon van Seters, Consultant Gynaecologist/Colposcopist
Mr Mohammed Yosef Shehata, Consultant Gynaecologist/Colposcopist
Mrs Julie Brassington, Nurse Colposcopist
Mrs Joanne Underhill, Nurse Colposcopist/Cervical Screening Provider Lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Gynaecology Clinical Governance Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Miss Rina Panchal**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Joanne Underhill	**Lead Nurse Colposcopist/ CSPL**	**Jo.underhill1@nhs.net**
Date assessment completed	**10/06/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Colposcopy Clinical Guidelines**			
What is the aim, purpose and/or intended outcomes of this Activity?	To ensure the colposcopy service and it's user receive equitable care when using the service delivered within the national guidelines.			
Who will be affected by the development & implementation of this activity?	x x x x	Service User Patient Carers Visitors	x ❑ ❑ ❑	Staff Communities Other _____

Is this:	x Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	All national guidance relating to the cervical screening programme
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation with accredited colposcopists within the trust to ensure national guidelines and local policy are agreed upon.
Summary of relevant findings	National guidelines followed. Local policy with persistent HR HPV & TZ3 in the absence of full national guidance.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Joanne Underhill
Date signed	10/06/2024
Comments:	
Signature of person the Leader Person for this activity	Rina Panchal
Date signed	10/06/2024
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.