Disclosure to patients of cervical cancer invasive review results

University Hospitals of Leicester NHS
NHS Trust

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Contents

1. Introduction and who the guideline applies to:

The introduction of the National Health Service cervical screening programme in 1988 has led to a substantial reduction in the number of cervical cancers diagnosed in the UK. Women aged between 25-64 years who are registered with a GP are sent an invitation to attend for screening either at 3 yearly (25-50 years) or at 5 yearly (50-64 years) intervals. Cervical screening enables pre-cancerous changes to be detected, which can be treated thereby preventing a cancer developing. Adherence to screening schedules has consistently been shown to be significantly associated with reducing the risk of developing a cervical cancer. Cervical screening changed to HPV Primary Screening in December 2019, with all screening samples that are HPV positive having cytology review.

These cytology slides will be reviewed as part of an audit. Samples that are only HPV tested (HPV negative result and not put onto a slide) are not reviewed as they are not kept. However, they are subject to an HPV process review. HPV test results and cytology screening history can be obtained from the national call and recall system which holds an individual's invitation and screening history. Demographic details such as name and date of birth are required to search on the call and recall system.

Since the screening programme has been shown to prevent the majority of cervical cancers, any cancers that do develop require investigation in order to identify why it has occurred. The investigation is a national requirement and involves a review of the woman's previous screening behaviour, cytological and colposcopic history. As a result of the audit a screening classification is assigned to each of the cases, as set by the NHSCSP (National invasive cervical cancer audit - GOV.UK (www.gov.uk)) [1].

Scope:

This guideline covers phase 1 of the audit process undertaken when a person is diagnosed with cervical cancer.
Phase 1 (the cancer audit process) terminates with the disclosing clinician sending a letter to the individual, offering them the chance to receive information arising from the audit.
Phase 2 (the disclosure offer process) [2] covers the 4 possible outcomes of this offer. It should be completed within 6 months of the offer letter being sent.
The following flowchart (Appendix B) illustrates the cancer audit process [3] (Cancer audit process - GOV.UK (www.gov.uk))

2. Who should be offered the results of a screening history review?

Individuals diagnosed with cervical cancer while resident in England should be included in the audit irrespective of whether they are registered with a GP or not.

Recurrent cervical cancers and metastasis to the cervix should be excluded from audits. SQAS will follow up these cases to work out if there are any potential quality issues. A recurrent cervical cancer will involve an individual who has remained in the NHS CSP after their initial treatment (very early stage cervical cancer).

Occasionally patients may have been diagnosed or treated in a UK country other than England, although some parts of their screening history are held in England. Similarly, the screening history needed for a case diagnosed in England may be held in another part of the UK.
In these cases, arrangements need to be agreed on a case by case basis. Advice should be sought from the English national cervical screening SQAS team, who will co-ordinate requests for information.

Sometimes an individual will be diagnosed privately or be in the process of being treated privately. A cervical screening history review must take place provided:

- they have been screened or treated within the NHS CSP in the previous 10 years
- the NHS is aware of their cervical cancer diagnosis

The CSPL of the diagnosing organisation should take responsibility for co-ordinating the audit. This is most likely to be via the gynaecological oncology MDT.

3. What should be included in the review

A review of all records connected to an individual's cervical screening history from the past 10 years should be undertaken as part of invasive cervical cancer audits. This includes cervical screening tests and any medical investigations related to cervical screening.

Review is not possible if individuals have no previous screening history or their most recent history is more than 10 years before they were diagnosed. Old cytology samples will have been destroyed in these cases.

Audits do not currently involve the review of primary care records or a detailed review of call and recall processes. These are being assessed for inclusion in future.

Cervical screening changed to HPV Primary screening in December 2019. All screening samples that are HPV positive are put onto a slide to be checked under a microscope for abnormal cells (cytology).

These cytology slides will be reviewed as part of an audit. Samples that are only HPV tested (HPV negative result and not put onto a slide) are not reviewed as they are not kept. However, they are subject to an HPV process review.
HPV test results and cytology screening history can be obtained from the national call and recall system which holds an individual's invitation and screening history. Demographic details such as name and date of birth are required to search on the call and recall system.

The screening history obtained from the search should identify:

- the full history of screening invitations, including invitations not acted upon
- results
- laboratories involved in reporting the screening test
- the source of samples
- colposcopy records

All local colposcopy clinics should be contacted for relevant records. The record should include:

- the dates of all appointments
- whether the patient attended
- what was done
- colposcopic impression and treatment
- a record of histology results to produce a complete picture of the patient history and create a slide review

There is no longer a requirement to arrange for external reviews of cytology, histology samples, or colposcopy cases for routine audit purposes. However, SQAS may request that additional reviews are completed outside of the audit process. This might be:

- where there are potential concerns about quality of care
- to investigate unusual themes arising from the audit results

HPV process review

HPV samples cannot be retained in the same way as cytology and histology samples. Therefore there is no sample to go back and review. An administrative process review should be carried out instead. This should be completed for all HPV negative and HPV unreliable tests in the last 10 years. It should include:

- testing platform name
- original result
- valid run data from either the Roche archive viewer or downloaded run data stored on laboratory IT systems (where available)
- external quality assessment reports

At the moment, only 2 HPV testing platforms are in use within the English CSP. Equivalent information will be required if other platforms are used in the future.

Cytology slide review

For audit purposes, review of slides is a different activity to that of routine reporting of screening tests for patient management purposes. Case review takes place in the full knowledge of the original result. This helps to identify any information which could help explain how a cervical cancer may have developed. There is no requirement to review slides taken more than 10 years prior to diagnosis, even where these are still available on file. This also goes for any abnormal samples that were reported as high grade or worse (including borderline changes in endocervical cells since February 2020). This is provided these were taken within 3 months of diagnosis and led to the immediate referral of the individual.

Review all slides relating to cases which SQAS has informed the diagnosing CSPL/audit lead about (other than those excluded). The review (known as a 'local review' in previous guidance) must be undertaken in the hub laboratory by a consultant pathologist or consultant biomedical scientist (BMS) who routinely reports on cervical cytology on behalf of the NHS. They must satisfy current NHS CSP criteria for reporting. The person carrying out the review must also not have reported on the slide previously. Access to the original report is essential. Refer to the SurePath guidance when carrying out reviews of cytology slides prepared using SurePath liquid-based cytology (LBC) technology. Make a note on the forms/ICCA database if cytology slides are not available for review. Reviews undertaken by other laboratories apart from the diagnosing hospital must be returned to the diagnosing CSPL within a month of receipt.

Audit reviews should use accepted NHS CSP terminology including cytology reporting codes and the revised terminology for abnormal cervical cytology from the British Society of Cervical Cytology (BSCC).

Colposcopy management review

Do not routinely review any colposcopic examination associated with the index referral cytology and made within 18 weeks of the subsequent diagnosis of cervical cancer. Review any colposcopic examinations that predate the index referral by up to 10 years. This is because these examinations (and the associated management of the individual) may have impacted on the development of cervical cancer.

The capacity to record a digital image of the colposcopic findings and/or use of adjunctive (additional) technology has become standard practice in some clinics. For the purpose of the

review, images and the findings from adjunctive technology should be included. However, the opinion of the colposcopist, rather than the adjunctive technology, is taken. The findings of the technology should be noted on the audit form. The reviewer must check whether the colposcopic management of the woman reflected the relevant NHS CSP guidelines in place for England at the time. The invasive cervical cancer audit colposcopy review process spreadsheet [4] is provided to support this process. Retain the colposcopy review process spreadsheet locally in the patient record and do not send to SQAS.

Histological slide review

Audits of cervical cancers will include a full review of all relevant histological material. This includes cervical biopsies and cervical excisions (for example, treatment specimens including those taken under general anaesthetic). The screening history of the individual will help indicate when an individual was referred for colposcopy and therefore when histology specimens were likely to have been taken. All relevant histology samples taken over the 10 years before diagnosis must be reviewed, with the exception of the diagnostic sample and any samples taken after the diagnostic sample. Best practice is for the reviewer not to have reported the specimen originally. The reviewer must have access to the original report.

The review prepared for the gynaecological cancer MDT meeting as part of the NHS CSP audit of invasive cervical cancers may be used – providing the above criteria is met. Only existing slides should be reviewed. There is no need to cut new sections. The review should also include a macroscopic examination of any blocks if there is any suggestion that all pieces have not been cut into or where there is a clear discrepancy found in the review.

4. How should reviews be classified

Categorise all elements of the screening history reviewed for the invasive cervical cancer audit as:

- satisfactory
- satisfactory with learning
- unsatisfactory

This is as described in the review and classification of previous screening results in the cytology slide review process. Classifications should be included in the invasive cervical cancer audit form and uploaded to the ICCA database.

A screening incident assessment form should be submitted to SQAS for review if a case review is classified as unsatisfactory. For audit purposes, there is no need for more than one person to review each slide or case if the first review is ‘satisfactory’. However, if the review is ‘satisfactory with learning points’ or ‘unsatisfactory’ then:

- at least 2 members of appropriately qualified staff should review the case
- a consensus opinion should be reached

5. When to discuss the audit and disclosure process

The timing of informing patients about the audit and disclosure process will be dependent on the individual patient circumstances and wishes. If not discussed before, patients will be

given an information leaflet on the disclosure process (**Appendix C**) by the Clinical Nurse Specialists in their end of treatment appointment. Or if not seen by Clinical Nurse Specialists will be sent an invitation letter (**Appendix F**).

Patient details will be added to the Remote Monitoring System in order for the timing of the review, offer of discussion and disclosure process can be monitored and audited. The Clinical Support Worker will be responsible for monitoring for overdue reviews and liaising with the Disclosure lead clinician.

If the woman wishes to be informed of the results consent form should be completed **(Appendix D**) and the Remote Monitoring System updated to document the patient's decision.

6. Actions depending on patient's wishes

1) No response to offer letter

If no response received in 3 months – does duty of candour apply?
No: Document this in the patient notes and inform the cervical screening provider lead (CSPL), treating clinician and the person's GP.
Yes: Send a second offer letter (Letter C). If no response is received within 3 months, assume the person does not wish to know the results. Document non-response in the patient notes and inform the CSPL, treating clinician and the person's GP.

2) Offer declined

Document this in the patient notes and inform the CSPL, treating clinician and the person's GP.

3) Offer declined for now, but reminder requested in 6 months

Log the reminder offer letter request, and inform the CSPL. Send a reminder offer letter after 6 months. There are 3 potential outcomes from sending an offer reminder letter.

No response to reminder: If no response received in 3 months – does duty of candour apply?

No: Document non-response in the patient notes and inform the CSPL, treating clinician and the person's GP.

Yes: Send a second offer letter. If no response is received within 3 months, assume the person does not wish to know the results. Document non-response in the patient notes and inform the CSPL, treating clinician and the person's GP.

Reminder offer declined: Document this in the patient notes and inform the CSPL, treating clinician and the person's GP.

4) Offer accepted

Are there are findings from the audit?

No: Send 'no findings' Letter A to the individual, copying in the CSPL, treating clinician and the person's GP. (See the section on 'being open and transparent' in the guidance on disclosure of cervical screening history review results and applying duty of candour.)

Yes
The clinician:

- sends 'findings' Letter B to the individual (see the section on 'being open and transparent' in the guidance on disclosure of cervical screening history review results and applying duty of candour)
- makes an appointment with the individual to discuss the findings, and informs the CSPL
- discloses audit results at the appointment, and documents the discussion in the individual's notes
- sends a summary of the discussion to the individual, their GP, their treating clinician and the CSPL

7. What should be discussed at a disclosure meeting?

The disclosure consultation should be performed by a clinician with experience in the cervical screening and disclosure process with the support of a Clinical Nurse Specialist. Appropriate time duration should be allocated and scheduled for a disclosure appointment.

It is important to establish the woman's understanding as to why she wishes to know the outcome of the review and ask how much information she wishes to know should be ascertained. If the review has identified under reporting in a cytology/histology result or under treatment in colposcopy then the results should be disclosed in a sensitive manner, discussing all the relevant reports and the implications. The woman should be invited to voice her comments and concerns before moving on to provide reassurance.

The patient should be helped to understand the reason for any missed abnormality or potential under treatment. The effectiveness and limitations of the screening programme should be described. This can be reinforced by the written information leaflet (**Appendix C**).

Apologies and explanations, as opposed to liability, should be encouraged. At the time of disclosure consultation, the woman should not be assured of a right to compensation but rather of the right to have the issue investigated further should they wish.

If the woman says they she wishes to complain or seek compensation she should be given the details as to how to proceed by being given the contact details for PILS.

Following the consultation, details should be documented in the woman's medical notes and a letter outlining the contents of the discussion should be sent to the woman and GP.

8. When does duty of candour apply?

When a patient has come to either moderate or serious harm in a screening programme a review (audit) should be carried out to understand why this has occurred. If the audit reveals

something has gone wrong in the screening process, then this should be treated as a notifiable safety incident and duty of candour regulations will apply.

A DATIX will be completed for each cases of moderate or serious harm, which will be reviewed along with the Invasive audit summary review and clinic letter.

The letter to the patient, and GP, from the disclosure appointment will include the sentence:

“I would like to take this opportunity on behalf of the Trust, to express my sincere apologies that this event has occurred and to assure you that the Trust aims to provide a quality service to all our patients. The invasive cervical cancer audit process has undertaken a full investigation into your previous interactions with the cervical screening programme in an effort to understand exactly what happened and to find out whether there is something that we could do differently in future to stop this happening to anyone else.”

Documentation in the patient’s medical notes will include:

“As per Duty of Candour, I have discussed this incident with the patient and explained what happened, what are the likely consequences of the audit findings. I have apologised to the patient and told them that they will be kept informed of any actions taken as a result of this incident. All questions were answered and we offered the patient and family our full support.”

9. Contacting the families of patients who have died

In some circumstances of outcome of the review process will not be complete until after the patient has died. In this case a disclosure should be offered to the patient’s next of kin. The support of the Gynaecology Specialist Nurses will be essential in this process and close working with the Risk management team.

10. Completion of documentation

The relevant forms (**Appendix E**) should be completed and returned to the QA.

All cervical cancers will be added to the Remote Monitoring System in order to record the Invasive Review audit. Alerts will be built in for 6 monthly reminders

11. Education and Training

None

12. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
All women diagnosed with cervical cancer are offered results of their screening review	Completion of Cervical cancer audit/disclosure record sheet	Consultant		Local audit committee
Results are disseminated to individuals in line with national guidance for audit and disclosure	Completion of Cervical cancer audit/disclosure record sheet	Consultant		Local audit committee

13. Supporting References

1. National invasive cervical cancer audit - GOV.UK (www.gov.uk)

2. Disclosure offer process - GOV.UK (www.gov.uk)

3. Cancer audit process - GOV.UK (www.gov.uk)

4. Invasive_cervical_cancer_audit_colposcopy_review_checklist.xlsx (live.com)

14. Key Words

Colposcopy, Cytology slides, HPV

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Development and approval record for this document			
Author / Lead Officer:	Esther Moss Author: EL Moss Written: June 2014	**Job Title:** Consultant Gynaecological Oncologist and Colposcopist	
Reviewed by:	All member of the colposcopy multi-disciplinary team meeting		
Approved by:	Gynaecology Governance Group	**Date Approved:**	

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
28/8/2019	V2	Dr. V.Shesha	Duty of Candour
15/05/2023	V3	Miss E. Moss	Rewrite to incorporate new national disclosure guidelines

APPENDIX A: Roles and responsibilities:

Diagnosing organisation responsibilities

The diagnosing organisation is responsible for:

- making sure health professionals have sufficient time and support to carry out audit activities (the greater the number and complexity of cases diagnosed each year will increase the amount of time needed)
- retaining the primary patient record of each audit case according to local data retention policies

Roles within organisations

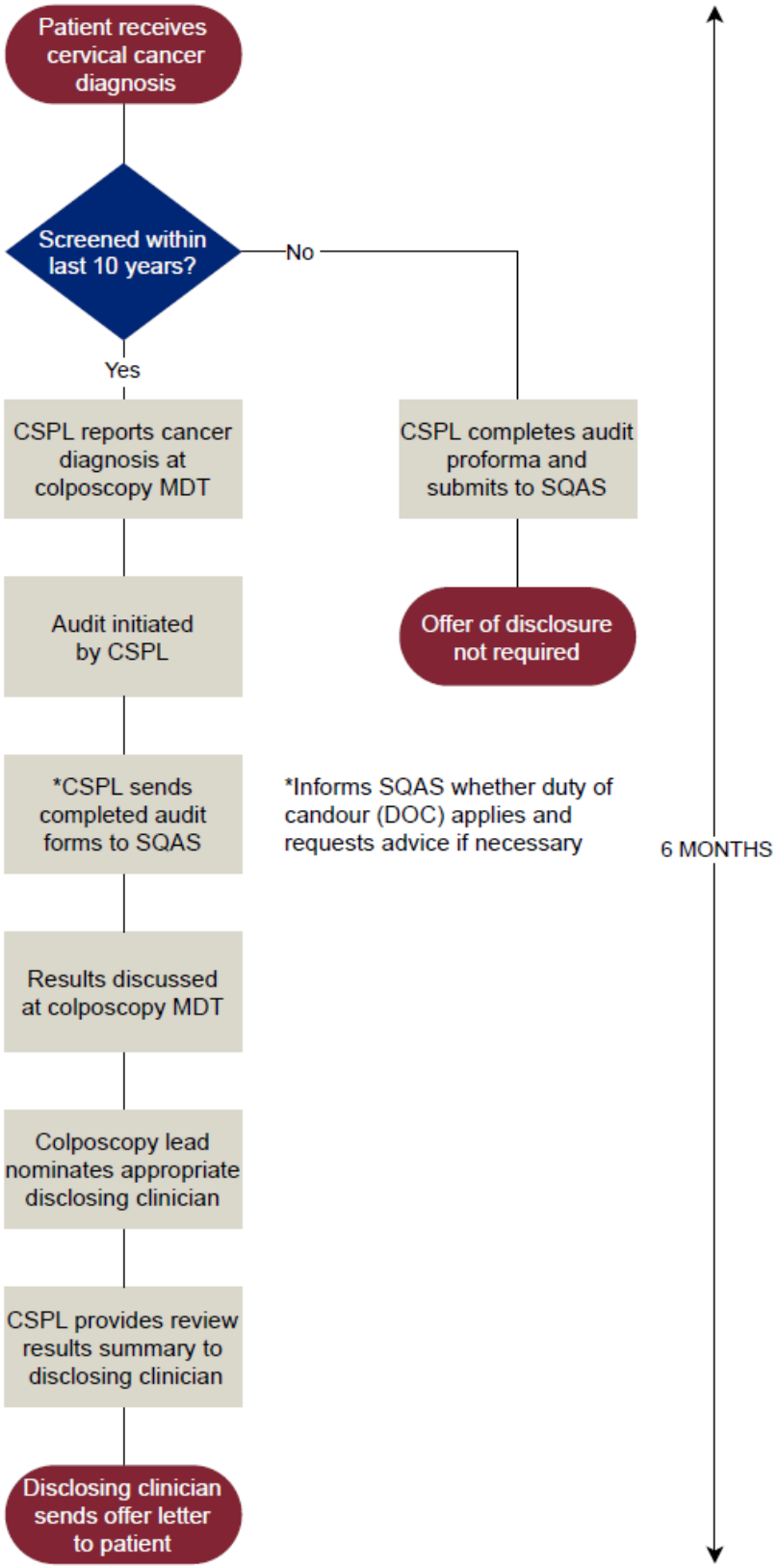
There are a number of important roles in the NHS CSP audit process.

Some roles may be carried out by the same individual, for example, the cervical screening provider lead (CSPL) and lead colposcopist may be the same person. Delegating is acceptable (for example, by the CSPL to a designated audit lead) but responsibility still sits with the individuals as described below.

Audit reviews must be carried out by individuals who:

- are qualified to work in the NHS CSP
- meet the training requirements and standards for the programme, as defined in national screening programme guidance

Appendix B: Disclosure pathway



Cervical screening: Reviewing your cervical screening history

We know that this is a difficult time for you. Naturally you will be concerned about your treatment and future health. You may also be wondering why you have developed cervical cancer, especially if you have had cervical screening tests (often known as smear tests) in the past.
We review the cervical screening history of everyone diagnosed with cervical cancer to see that any cervical screening tests and investigations have been carried out in line with NHS Cervical Screening Programme standards. Reviews are an essential part of every high-quality screening programme and are a routine part of the cervical screening process. Information we gather from individual cases helps to improve the programme and learn more about how cancers develop and how they are diagnosed.
Whilst regular cervical screening is the best way to reduce the risk of developing cervical cancer by detecting abnormal cells on the cervix early on, like all screening tests it is not perfect. Abnormal cells can be missed, even in the best performing screening programmes which meet all the quality standards.
If you would like to know the results of your cervical screening history review, please fill in your response form and return it to us. The review is likely to take at least 6 months to complete. We will contact you when your results are available and arrange a convenient time for you to come and discuss them with your hospital doctor.

The cervical screening history review

We review all records connected to your cervical screening history from the past 10 years. This includes your invitation letters, cervical screening tests, result letters and any medical investigations related to cervical screening. A group of professionals will look again at your previous tests and your medical notes related to cervical screening.
Cervical screening has recently changed to human papillomavirus (HPV) primary screening. All screening samples that are HPV positive (contain HPV) are put onto a slide to be checked under a microscope for abnormal cells (cytology). These cytology slides will be reviewed. We are not able to review samples that are only HPV tested (not put onto a slide), as they are not kept.
In most cases, a review will show that the correct procedures have been followed, and appropriate care was received. Occasionally, a review may find that one or more steps in the process have not worked as well as they should. This can highlight where we could make improvements to the screening programme.

Cancer detection

Screening history reviews usually find that a cervical cancer has been found at the earliest possible stage. Although cervical screening prevents most cervical cancers (about 7 out of 10)[1], it cannot prevent all of them. The review process aims to highlight any areas which could be improved in the future. Some examples of issues that can be found are described below.

Identifying abnormal cells

Screening cannot always identify abnormal cells on a cytology slide because:
• sometimes abnormal cells do not look much different from normal cells
• there may be very few abnormal cells on the slide
• the person ‘reading’ the slide may not identify the abnormal cells (this happens occasionally, no matter how experienced the reader is)

Colposcopy

Colposcopy (a visual examination of the cervix) cannot always identify abnormal areas of the cervix because:
• the abnormal area might not be visible during the examination

• the abnormal area might not be sampled in a biopsy (a small tissue sample)
• the abnormal cells might be hidden higher up inside the cervix
• some types of abnormality are very difficult to identify at a colposcopy

How we use your information

We routinely collect and review screening information as part of an ongoing audit process. This is carried out confidentially. Your information (without your name) helps us make improvements and discover more about how cancers develop and how to better diagnose and treat them. The audit is done whether or not you want to know the results of the review.

Why we offer cervical screening

Cervical screening reduces the risk of developing cervical cancer by treating abnormal cells before they can develop into cancer.

Next steps in your cervical screening history review

Please fill in the review results response form and return it to us. When the review is complete, we will contact you to let you know. If you wish to know the results, we will arrange for your hospital doctor to meet with you to discuss them in detail.
We understand this is a difficult time and it is completely up to you to decide whether you want to know the results of your review.
If you decide you do not want to know your results now, you can change your mind at any time and contact your hospital doctor or GP. They will arrange for you to receive your results.
Please note that unless you give us permission, we cannot give your review results to your relatives.

1 Landy, R and others (2016) Impact of cervical screening on cervical cancer mortality: estimation using stage-specific results from a nested case–control study. British Journal of Cancer 115, 1140-1146

More information

Public Health England (PHE) created this leaflet on behalf of the NHS.

The NHS screening programmes use personal information from your NHS records to invite you for screening at the right time. Public Health England also uses your information to ensure you receive high quality care and to improve the screening programmes. Find out more about how your information is used and protected, and your options at: www.gov.uk/phe/screening-data
Find out how to opt out of screening at: www.gov.uk/phe/screening-opt-out

APPENDIX D: Review results response form

Review results response form (Please read together with the 'Reviewing your cervical screening history' leaflet) NHS Cervical Screening Programme Reviewing your cervical screening history

We review the screening history of everyone diagnosed with cervical cancer to make sure that cervical screening tests and investigations meet national standards. We will be reviewing your cervical screening history including any tests you have had in the last 10 years. The review is likely to take at least 6 months to complete. Once this review is finished, we will offer you the results and an opportunity to discuss the findings if you wish. Cervical screening is not a test for cancer. It aims to detect abnormal cells in the cervix which can develop into cancer if left untreated. Even in the best performing screening programmes, where all quality standards are met, not every cancer can be prevented. Some people can go on to develop cervical cancer despite previous screening tests being reported as negative, or despite having been previously treated for abnormal cells. Reviewing the screening histories of all people diagnosed with a cervical cancer may help identify ways to improve screening in the future. The review of your previous screening tests may occasionally involve sending samples to be looked at by a team at a different hospital. This is done in a confidential manner so that your personal details cannot be identified. We will write to you when your review is available, and you can choose if you want to know the outcome. If you do not wish to have this information straight away, you can change your mind at any time. You just need to let your consultant or GP know so they can make the arrangements. Please tick one of the boxes below and return this form to your doctor to let them know whether you want to know the outcome of your review.

☐ I want to know the results of my cervical screening history review.

☐ I do not want to know the results of my cervical screening history review now, but would like you to remind me of this offer in 6 months' time.

☐ I do not want to know the results of my cervical screening history review. I understand that I can change my mind at any time.

Name…… Signature…… Date …….

Appendix E: Cervical cancer audit/disclosure record sheet

CERVICAL CANCER AUDIT / DISCLOSURE RECORD SHEET

(To be uploaded to Cito and a copy sent to CSPL when complete – along with Response form if received).

PATIENTS NAME: _____ **DOB:** _____ **HOSPITAL NUMBER:** _____
NHS NUMBER: _____

HISTOLOGY:

- ☐ Squamous Carcinoma
- ☐ Endocervical Adenocarcinoma
- ☐ Other type *Please Specify: _____

PRESENTATION:

- ☐ Screening
- ☐ Symptomatic

STAGE: _____

TREATMENT: _____

1. Patient aware of cervical cancer diagnosis
The following information should be been given/sent to the patient once their diagnosis has been discussed with them

- ☐ Letter 1 **(if sending in post)**
- ☐ 'Review Results Response' form
- ☐ 'Reviewing your cervical screening history' leaflet

Name: _____ Signature: _____ Date: _____

2. Results response form:
Has the 'Review Results Response Form' been returned within 3 months? YES / NO
If yes, would the patient like to be informed of the outcome? YES / NO

3. MDT action agreed:

- ☐ Satisfactory – **Letter A** to be sent to patient.
- ☐ Satisfactory with learning outcomes – **Letter B** to be sent to patient and appointment made to discuss findings.
- ☐ Unsatisfactory – **Letter B** to be sent to the patient and appointment made re: D.O.C.
- ☐ Patient does not wish to be informed of the results.

Name: _____ Signature: _____ Date: _____

If no response form received within 3 months:

- ☐ If satisfactory or satisfactory with learning outcomes – No action required.
- ☐ If unsatisfactory – **Letter C** to be sent to patient.

Name: _____ Signature: _____ Date: _____

4. Summary of Disclosure given – to be completed by Consultant Gynaecologist:
Patient and GP written to, confirming what was discussed in disclosure interview.

Name: _____ Signature: _____ Date: _____

Appendix F: Invitation letter

Invitation letter

Dear <Name>

For all patients diagnosed with a cervical cancer, we review the cervical screening history from over the last 10 years, to ensure that cervical screening tests and investigations meet national standards. We have included the following written information for you to have a read of:

- Reviewing your cervical screening history' patient information leaflet
- Review results response form

We advise that you read the enclosed information and then please complete the review response form as soon as possible. This can either be handed in to your doctor or nurse specialist at your next hospital appointment, or sent in the post to:

Gynaecology Oncology Clinical Nurse Specialist Team
Leicester General Hospital
Gwendolen Road
Leicester
LE5 4PW

If we do not receive a response form within 3 months, we will take it that you do not wish to be informed of the results of your cervical screening history review. If you have any questions or wish to discuss this further, please contact your nurse specialist team.

Yours sincerely

Appendix G: Patient letters

Letter A

Dear <Name>

Thank you for returning your form indicating that you would like to receive the results of your cervical screening history review.

Your review did not identify any problems with your care and this requires no further action.

If you would like to discuss this further, either by telephone or in person, please contact our nurse specialist team to arrange this.

Yours sincerely

Letter B

Dear <Name>

Thank you for returning your form indicating that you would like to receive the results of your cervical screening history review.

We would like to invite you to a meeting to discuss the findings and have included an appointment within this letter.

Please feel free to bring a partner, a family member or friend with you to the appointment if you would like.

If you have any questions or would like to discuss this further please do not hesitate to contact your nurse specialist team.

Yours sincerely

Letter C

Dear <Name>

We have previously written to you explaining that for all patients diagnosed with a cervical cancer, we review the cervical screening history from over the last 10 years, to ensure that cervical screening tests and investigations meet national standards. Included within our last letter were some written information and a review results response form for you to complete

and send back to us. However, our records show that we have not yet received your response.

We would like to take this opportunity to provide you with the following information again for you to have a read of:

- Reviewing your cervical screening history' patient information leaflet
- Review results response form

We advise that you read the enclosed information and kindly request that you please complete the review response form as soon as possible and hand it back to us. This can be given to your doctor or nurse specialist at your next hospital appointment, or sent in the post to:

Gynaecology Oncology Clinical Nurse Specialist Team
Leicester General Hospital
Gwendolen Road
Leicester
LE5 4PW

If we do not receive a response form within 3 months, we will take it that you do not wish to be informed of the results of your cervical screening history review. If you have any questions or wish to discuss this further, please contact your nurse specialist team.

Yours sincerely