Gloucestershire Cervical Screening Programme

Annual Report

April 2002-March 2003

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Acknowledgements

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Further copies of the report

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1. Introduction

The aim of this report is to provide information on the performance of Gloucestershire Cervical Screening Programme for the year April 2002-March 2003. The Gloucestershire Programme operates as part of the national screening programme. The aim of the NHS Cervical Screening Programme (NHSCSP) is to reduce deaths from cervical cancers and increase survival, by early detection of abnormal changes in tissue.

The programme is effective at detecting abnormalities requiring further investigation and treatment. It does this by detecting pre-cancerous changes in the cervix, enabling early treatment, which is aimed at preventing the development of invasive cervical cancer. All eligible women aged 20-64 years are invited for cervical cytology. In Gloucestershire this is every three or five years depending on age. The programme aims to achieve at least 80% coverage within the eligible population.

Although the overall uptake for the County is good, recent practice-based data indicates that there are considerable variations by GP practice.

The Gloucestershire programme needs to comply with national guidance and achieve agreed standards. A Quality Assurance Regional Centre (QARC) monitors these standards annually. The Gloucestershire programme achieves most national standards. Gloucestershire has one of the lowest rates of invasive cervical cancer in the country, and the cervical cancer mortality rates remain well below the national average.

2. Delivery of the Gloucestershire cervical screening programme

Delivery of the programme involves many health professionals from a range of health agencies. The following local providers have a major role in the delivery of the programme:

- Laboratory and clinical services (colposcopy) services - Gloucestershire Hospital NHS Trust
- Primary Care - all general medical practices in Gloucestershire participate in the programme. Practice nurses are the main smear takers.
- Genito-Urinary Medicine (GUM) -Cotswold & Vale PCT
- Family Planning -Cotswold & Vale PCT
- Family Health Services, Shared Services - patient data management, including call and recall, and the overall co-ordination of the programme.

Gloucestershire Cervical Screening Steering Group includes representatives of these services, as shown in the Appendix. The group provides professional advice on all aspects of the Programme and is responsible for it’s monitoring. Meetings are held quarterly.

2.1 Where smears are taken

The vast majority of women have their smears taken in primary care, either by a GP or a practice nurse. The relative proportions of smears taken in different settings remains unchanged. Approximately 45,300 smears were taken during the year, representing an increase from the previous year.

Table 1: Source of smear taking, Gloucestershire, 2002/03

Source:	GP	FP Clinics	GUM Clinics	NHS Hospital	Private	Total
Percentage of smears	92.5%	3%	1.1%	3%	0.4%	100%
Number of smears	41874	1363	510	1364	186	45297

Source: KC61

3. Cervical cancer epidemiological data

The NHSCSP reports important declines in both the incidence and mortality since the call and recall system was introduced in 1988. It estimates a 42% reduction in incidence between 1988-1997, and a saving of approximately 1300 lives a year nationally.

3.1 Incidence of cervical cancer

Although cervical cancer is the fifth most common cancer in women, it is still relatively rare. On average, 24 new cases are diagnosed in Gloucestershire each year, half of which occur in women aged 65 years and over. Cervical cancer in women under 20 is extremely rare. The most recent data available is up to the year 2002. Annual averages have been calculated from the three-year totals, to reduce the effects of yearly fluctuations in cases.

Table 2: Number of registrations for cervical cancer in Gloucestershire, 1993-2002

Age group	1993 - 1995	1994 - 1996	1995 - 1997	1996 - 1998	1997 - 1999	1998 - 2001	1999-2002
20-64	47	40	43	50	46	45	45
65+	30	28	24	28	26	24	22
Total	77	68	67	78	72	69	67
Yearly average	**26**	**23**	**22**	**26**	**24**	**23**	**22**

Source: South and West Cancer Intelligence Service

Standardisation takes account of the age structure of Gloucestershire women. It can be seen that the registration rate in Gloucestershire, at fewer than seven women per 100,000, remains below average for the South and West region.

Table 3: Age-standardised registration rates for cervical cancer, per 100,000 women, 1991-2001

Area	1991 - 1997 (95% CI)	1992 - 1998 (95% CI)	1993 - 1999 (95% CI)	1994 - 2000 (95% CI)	1995 - 2001 (95%CI)
Gloucester-shire	6.9 (5.8 – 8.0)	7.6 (6.4 – 6.8)	7.6 (6.4 – 6.8)	6.8 (5.7 - 7.9)	6.9 (5.8-8.0)
South& West	10.6 (10.2 – 11.0)	9.9 (9.2 – 10.0)	9.8 (9.4 – 10.2)	9.5 (9.0 - 9.9)	9.1 (8.8-9.5)

Source: South and West Cancer Intelligence Service

3.2 Mortality

On average, eight women a year die from cervical cancer in Gloucestershire. Gloucestershire has a lower standardised mortality ratio (SMR) for cervical cancer than average for the South and West. The age standardised rate for Gloucestershire has a wide confidence interval, reflecting the small number of deaths. Therefore, the true rate may be below average or similar to the regional and national average mortality rates.

Table 4: Number of deaths from cervical cancer in Gloucestershire, 1993-2002

Age	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
20-64	1	5	5	4	3	7	1	4	6	2
65+	7	6	8	8	5	9	3	4	3	4
All	8	11	13	12	8	16	4	8	9	6

Source: ONS VS3 tables and PHMF

Table 5: SMRs for cervical cancer (all ages) in Gloucestershire, 1997-2001

Area	1997-1999	1998-2000	1999-2001
Gloucestershire	72	74	53
South & West	98	99	88

Source: PHCDS/CHCI 2001

Table 6: Mortality from cervical cancer: age standardised rates per 100,000 women aged 15-64 years, 1997 – 2001

Area	1997 - 99 (95% CI)	'98 - 2000 (95% CI)'	'99 -2001 (95% CI)
Gloucester-shire	2.0 (0.8 – 3.2)	2.1 (0.9 - 3.4)	1.8(0.5- 3.1)
South & West	3.0 (2.6 – 3.5)	3.1(2.6 - 3.6)	2.6 (2.1- 3.2)
England & Wales	3.4 (3.2 – 3.5)	3.2 (3.1 - 3.4)	3.0 (2.8- 3.2)

Source: CHCI 2000. Data for 1999 & 2001 pooled (2yrs)

4. Eligible population and screening coverage

4.1 Eligible population

A total of 149,898 women in Gloucestershire are within the eligible age range for cervical screening of 20-64 years, comprising more than half of the female population. The call and recall system that supports the cervical screening programme currently operates for the resident, registered population of eligible women, derived from the Exeter database. These are women who live in Gloucestershire and who are registered with a GP either within or outside of the County.

4.2 Screening coverage of the population

The national programme requires that women be screened at least every 5 years. In Gloucestershire, women aged 20-34 years are invited for screening every 3

years, and those aged 35-64 years (which comprise 68% of the eligible screening population) are invited for screening every 5 years. Younger women are currently screened more often as they are more likely to have an abnormal smear result. Guidance from the NHSCSP discourages any smear-taking outside the call and recall programme, particularly from teenagers.

The Gloucestershire programme continues to exceed the national coverage target of 80%, as it has done for a number of years. Coverage is calculated as the proportion of eligible women screened in the past 5 years. Twenty-five is the starting age for inclusion in coverage calculations, although women are invited to attend screening from age twenty years.

Table 7: Coverage for Gloucestershire women aged 25-64, 1997-2003

1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	National Standard
86%	86.5%	85.65%	85.39%	84.2%	84%	>80%

Source KC 53

Women can be ceased (removed) from the screening programme for a number of reasons, most commonly following a total hysterectomy. Women can also be ceased at their request, by signing a disclaimer form. They can request to re-enter the programme at any time.

Changes within the NHS organisation resulted in the formation of the three PCTs in the county from the 1st April 2002. Screening coverage statistics for each Trust and general practice can now be collected. These screening coverage figures include out of county residents registered with the responsible GPs. All three PCTs have similarly high rates of coverage, which exceed the national target. However, coverage by general practice shows a wide variation. Six of the ten practices with coverage of less than 80% are in the West Gloucestershire PCT area. Efforts can now be directed at supporting these practices in achieving higher coverage.

Table 8: Cervical Screening Coverage Statistics by PCT 01.04.2002 – 31.03.2003

	C&T	C&V	WG	Gloucestershire total
Number of women in target group	42089	49114	58695	149898
Women ceased for clinical reasons	4169	4675	6120	14963
Target population to be screened	37920	44439	52575	134934
Number of women tested in the last 5 years	31882	37788	43564	113234
% Coverage	**84**	**85**	**83**	**84**

Source: Family Health Services

Table 9: Summary information of coverage by general practice in each PCT 01.04.2002 – 31.03.2003

	C&T	C&V	WG
Number of general practices	19	33	32
Range of coverage	76-89 %	70-90%	73-92%
Number of practices < 80% coverage	2	2	6

Source: Family Health Services

5. Laboratory performance and the results of smear tests

From 1st April 2002 the two Acute Trusts merged (East Gloucestershire NHS Trust and Gloucestershire Royal Hospital Trust), to form a Gloucestershire Hospitals Trust. There is now a single statement of compliance for the Gloucestershire laboratory. A Regional Quality Assurance Team (QAT) assesses laboratory performances.

Deleted:

The main findings of the QAT are included in this section. It should be noted that the national standards for laboratory performance are no longer fixed, but are set by the middle 90th percentile of the previous year's laboratory returns (KC61).

Section 1

QARC report objective	Lab perform-ance	QARC comments
1. To minimise the incidence of invasive cancer of the cervix.	√	The Gloucestershire programme is exceeding 80% coverage and the lab is auditing cervical cancers.
2. Sampling of the transformation zone for training.	√	The laboratories are actively involved in training smear takers. CGH records the smear taker; GRH will be implementing in the coming year.
3. All women receive their smear results in writing; 80% within 4 weeks, 100% within 6 weeks	√	This is a difficult target to monitor with results sent out by GPs. However, laboratory performance is at a level that will allow these parameters to be met.
4. All women with other than routine recall scheduled must have appropriate action taken.	√	There is a dual circuit fail safe system in place covering these women (the lab communicates with smear takers/GP and the Exeter system communicates with the GP).

Section 2

QARC report objective	Lab perform-ance	QARC comments
1. To ensure accuracy of smear reporting	*	See comment 2.1 below.
2. Primary screener workload	√	Not all primary screeners participate in internal QA. The QARC is content with this as all other standards in this area are met.
3. Checkers workload	√	All checkers exceed 750 smears per annum.
4. Pathologists & Advanc. Practitioner workload	*	See comment 2.4 below.
5. Monitoring the outcome of high grade smears	√	The laboratory met all criteria for this objective
6. Laboratory workload	√	The laboratory met all criteria for this objective
7. Reporting profiles	√	The laboratory met all criteria for this objective
8. EQA scheme participation	*	See comment 2.8 below
9. Training, qualifications and CPD	*	See comment 2.9 below

2.1 *All primary screeners should achieve 90% total sensitivity (accuracy) and 95% for high grade results*.
Not all screeners achieved these standards. The QARC has assessed the protocols in place for dealing with this issue and is content with the review process undertaken in the laboratory.

2.4 *All pathologists should screen 750 slides annually*.
Not all pathologists achieved this standard. A review of working practices was implemented part way through the year with the introduction of an Advanced Practitioner post. Two pathologists who were not achieving this standard ceased reporting cervical smears. This is acceptable to the QARC.

2.8 *Has External Quality Assurance scheme participation been satisfactory?*
Screening and reporting EQA performance has been satisfactory at all levels.. There was some evidence of poor performance in technical EQA (staining of smears) although this was not persistent. Remedial action has been taken.

2.9 *Do all screening staff hold the Certificate in Cervical Cytology and are all technical staff registered for CPD (continuing professional development)?*
The number of screening staff not holding the Certificate dropped from 2 to 1 in this period, this was due to someone approaching retirement (BMS1) for whom the certificate is not compulsory. All senior staff are registered for CPD but not all primary screeners.

Section 3

QARC report objective	Lab perform-ance	QARC comments
1. Screening backlog	*	See comment 3.1 below.
2. Staffing	√	The laboratory met all criteria for this objective
3. Accreditation	√	The continuing conditional accreditation of services at GRH due to problems with Histology laboratory space is an issue that will be addressed by future reconfiguration of service provision.

3.1 Screening backlog
The laboratory backlog on 1st April 2003 was in excess of the national guidance of 4 weeks, this may be attributable to residual increase in attendance as a result of the 'Coronation Street' storyline referred to in last year's report. This should disappear in the coming year.

Table 10: Laboratory screening backlogs

Date	Cheltenham	Gloucester
1.4.99	1 week	2 weeks
1.4.00	2 weeks	2 weeks
1.4.01	3 weeks	1 week
1.4.02	1 week	3 weeks
1.4.03	5 weeks	

Source: S&W QAT report

This indicator requires backlog to be assessed at a single day in the year, making it a cruder measure of performance than a yearly average backlog. However,

comparisons can be made with backlogs at the same date in previous years, which shows an increased backlog in the Gloucestershire laboratory.

Table 11: Comparison of smear results from women under 20, 2002-03

	No of smears examined		Low grade		High grade		Inadequate	
Age (yrs)	<20	20-64	<20	20-64	<20	20-64	<20	20-64
1998-99	927	38557	13.3%	5.3%	1.8%	1.6%	2.8%	10.3%
1999-00	646	36191	16.0%	6.3%	2.5%	1.7%	9.6%	9.2%
2000-01	539	40457	18.0%	6.8%	2.0%	1.6%	11%	10.0%
2001-02	463	41147	14.0%	6.7%	1.7%	1.6%	14.9%	9.9%
2002-03	405	41700	16.8%	5.5%	0.5%	1.4%	16.5%	10.8%

Source: KC 61

The downward trend in the numbers of smears from women aged under 20 in recent years, has been associated with an increase in the proportion of inadequate smears. However, a likely explanation for this is that increasingly smears are only being taken from teenagers with a symptom of some kind, such as discharge, which inevitably gives rise to a higher proportion of unsatisfactory smears. The best action to continue to combat this is to reinforce the message that a cervical smear is not a diagnostic test. If a woman is symptomatic, the correct management is a high vaginal swab if discharge is present, or more rarely, colposcopy in cases where the cervix looks abnormal.

Table 12: Results of smear test by Gloucestershire laboratories, 2002-03

Laboratory	**Smears examined**	**Low grade detection rate%** (borderline / mild dyskaryosis)	**High grade detection rate %** (moderate dyskaryosis or worse)	**Inadequate smear rate %**
Gloucester-Shire labs	45353	11.0%	1.6%	11%
National standard	>15000 smears/yr	6.1 – 12.6%	0.9 – 1.7%	6.1 – 12.6%

Source: KC 61

Table 13: Positive predictive value (PPV) for high grade smears

Laboratory	**1999-00**	**2000-01**	**2001-02**	**2002-03**
Cheltenham	74.3%	89.2%	86.7%	Both labs merged 77.6%
Gloucester	95.6%	72.3%	74.3%	
National standard	65 – 90%	68 – 87%	67 – 87%	65 - 88%

Source: KC 61

Positive predictive value is a measure of the outcome of cervical cytology. It compares the grading of smears with their subsequent histological/colposcopic outcome. The PPV is within acceptable standards for the year 2002-03.

Table 14: Accreditation

The two laboratories providing cytology screening services were re-inspected by Clinical Pathology Accreditation (CPA) during 2001-02. Both were awarded conditional status until the following are improved:

Cheltenham (Inspected in Nov 2001)
Three recommendations impact on the cervical screening programme:
Deficiency in staffing at Consultant level – 2 additional appointments are required
Insufficient ergonomic microscopes
Benching in cytology screening room are not ergonomic
A further two areas for improvement are off site storage of archive material.

Gloucester (Inspected in Feb 2002)
Deficiency in staffing at Consultant level – 1 additional appointment is required
Insufficient laboratory space in histology

To date all the issues at Cheltenham have been resolved with the exception of the second Consultant grade appointment, which is currently being advertised.

At Gloucester hospital the issue around laboratory space is difficult to solve without major service reconfiguration. This is currently under discussion, as is the appointment of a further member of Consultant staff. Merging of laboratory databases is still a major constraint to further progress in laboratory merger. Constraints are imposed by local IT strategy rather than departmental issues.

6. Colposcopy performance

The Colposcopy Service is an essential part of the cervical screening programme. It has the central role in the clinical management of premalignant disease of the cervix detected by abnormal cytology. The Gloucestershire Hospitals NHS Trust has run the service for the whole county since April 2002. Clinics are held in Gloucester, Cheltenham, Stroud, Cirencester and Bourton.

In January 2000 a direct referral system was introduced where the laboratories refer any patients with an abnormal smear directly to the colposcopy clinic. This substantially reduces the time between cytology reporting and clinic appointment.

The colposcopy examination assesses the severity of the lesion confirming this by biopsy and treats. Treatment is mostly by diathermy excision of the lesion usually under local anaesthetic and often at a single "see and treat" visit. The patient is then discharged back to the call-recall system. A laboratory based failsafe system checks the follow-up of all patients seen at the colposcopy clinic before return to the normal recall system.

Table 15: **%** of women referred to colposcopy within the recommended intervals

	90% of all Referrals to be offered an appt within 8 weeks of referral					**90% of all High Grade Smears to be offered an appt within 4 weeks of referral**				
	Apr-Jun 2002	**Jul-Aug 2002**	**Sep-Dec 2002**	**Jan-Mar 2003**	**April 2002-March 2003**	**April-Jun 2002**	**Jul-Aug 2002**	**Sep-Dec 2002**	**Jan-Mar 2003**	**April 2002-March 2003**
GRH	98 n=192	93 n=203	99 n=182	98 n=173	**97**	69 n=95	75 n=92	78 n=109	63 n=73	**72**
CGH	95 n=152	94 n=137	98 n=132	95 n=134	**96**	90 n=52	85 n=60	94 n=62	83 n=66	**88**
National average	**72**	**71**	**66**	**64**	**69**	**63**	**31**	**50**	**48**	**53**

The NHS Cervical Screening Programme (NHSCSP) and the British Society of Colposcopy and Cervical Pathology (BSCCP) set a target for 90% of women to be offered an appointment for colposcopy within a specified time following referral. The waiting time varies according to the grade of smear result, with high grade smears prioritised to a four week interval, whilst eight weeks is acceptable for lower grade results. The interval starts from the date of the smear report, for direct laboratory referrals, or from the date of a referral letter for other referrals, such as from GPs.

The average national result fell short of the 90% target throughout all of the year's quarters, with waiting times increasing as the year progressed. Performance was particularly below the standard for women with high grade smear results, with hospitals failing to offer women appointments within four weeks. Both Cheltenham and Gloucester complied with the 8 weeks standard for all smears throughout the year. Cheltenham marginally failed (88%) the four week standard for high grade smears. The Gloucester and Stroud clinics failed to comply with the four weeks standard for high grade smears but still performed better than the national average. There was however, a fifty percent increase in referrals to the Gloucester/Stroud clinics in 2001/2002 over previous years as a result of over reporting of low grade smears by the Gloucester laboratory. This has now been corrected and referrals have returned to previous levels with the expectation of now being able to comply with waiting times standards.

7. Work of the Gloucestershire Cervical Screening Steering Group

7.1 Programme of work

Gloucestershire Health Authority Board accepted an Action Plan in 1998, following the requirements of The Cancer Screening Quality Assurance and Management (Executive Letter (97) 67). The following is a summary of progress by the Gloucestershire Cervical Screening Steering Group in implementing the Action Plan:

Issue	Task	Update
Commissioning, Specification and funding for the programme.	Commissioning agreements in place.	Principles to support specification agreed. Work on the Service level agreements has begun.
Laboratory provision	To undertake option appraisal for laboratory provision	From 1st April '02 the two Trusts merged and there is a single statement of compliance for the Gloucestershire laboratory.
Colposcopy: - waiting time for assessments - other data/ information	- purchaser to monitor waiting times for colposcopy - agree minimum dataset for colposcopy	- Regular information received. - New national form issued in 2000. Both sites have submitted KC 65 as required
Failsafe arrangements	Review current policies - to agree a countywide policy.	Local failsafe policy developed and incorporated in revised Yellow Folders.
Training for smear takers	To have a countywide training policy.	Countywide training policy for smears takers in place. See paragraph 7.2 for activity

7.2 Training for smear takers

Gloucestershire has run programmes of teaching and assessing for smear takers for 13 years. This year the Steering Committee developed a policy for Training Smear Takers to inform PCTs and to facilitate adherence to NHSCSP guidelines on the training of smear takers.

Seventeen nurses successfully completed training in smear taking in 2002. Most of these nurses work in general practice, with some coming from family planning and colposcopy clinic backgrounds. The same programme is available for doctors, although to date there have been no applicants. An annual update is offered to all smear takers, although once again, only nurses have attended.

The current programme is approved by the NHS South West Regional Quality Assurance Team. The criteria to exceed the national recommendation for an 80% adequate smear rate is exceeded, by consistently demonstrating adequate smear rates of above 90% and above.

7.3 NHS Cancer Plan

The national NHS Cancer Plan was published in September 2000, shortly after the NHS Plan. The Cancer Plan sets out a comprehensive strategy to tackle cancer over a five year period by linking prevention, screening, diagnosis, treatment, care and research. The new Cancer Task Force leads national implementation.

The former South West Regional Office co-ordinates the local Cancer Network Plans. Gloucestershire is a member of the Three Counties Cancer Network. The following are the tasks and local action for cervical cancer screening programme:

Implementation of Cancer Plan by Gloucestershire Cervical Screening Programme

Cancer Plan	National time-scale	Local action
All women to receive national information leaflet on cervical screening	2001	**Current practice** Following publication of national leaflets, all GP practices and other clinics were supplied with free leaflets. **Future action** Ensure adequate stocks of leaflets are maintained and distributed. **Action by** Cervical Screening Steering Group (CSSG), GP practices and clinics.
National guidance on screening for women with learning disabilities (LD)	Published 20/11/00	**Current practice** the issue was raised at the Gloucestershire LD Moving Forward Group. Leaflets were made available to all GPs and others in contact with women with LD. **Future action** Maintain current practice **Action by** CSSG, General practices, other smear takers and LD services.
Pilot sites to trial new workforce arrangements	started 2001	**Current practice** Advanced BMS Practitioner in cervical cytology appointed and in post. Other staff changes revolve around Agenda for Change. **Future action** Implement Agenda for Change as appropriate **Action by** DOH/Local trusts

Pilot sites for liquid based cytology and Human Papilloma Virus	Results due Sept 2003	**Current practice** NICE guidance recommended implementing LBC. Await results of HPV pilot and national policy for implementation. **Future action** Plan for implementing LBC in the next five years. **Action by** NHSCSP/SHA/Laboratory
All women to receive their results in writing	2001	**Current practice** This is already a local policy. Members of the group undertook an audit of compliance. Satisfactory performance was found. **Future action** Maintain current practice. **Action by** CSSG, GP practices and other smear takers
Review screening coverage rates by PCTs. Where necessary draw up plans to increase the accessibility of screening among deprived & minority ethnic groups.	2002	**Current practice** Coverage rate exceeds national target, No targeted programme for women in disadvantaged groups at present. **Future action** Ongoing review of coverage by PCTs and general practices to identify where individual practices need targeting. **Action by** CSSG, PCTs
Maximum one month wait from diagnosis to treatment	2001	**Current practice** Compliant **Future action** Maintain current practice. **Action by**: CSSG, Gloucestershire Hospitals Trust, 3 Counties Cancer Network

8. A Forward Look

From April 2004 there are to be two major changes to the cervical screening programme following the issue of NICE Guidance and advice from the National Advisory Committee on Cervical Screening. Firstly, it has been recommended that there will be a conversion from the Pap smear to liquid base cytology (LBC) which will have the advantage of leading to fewer inadequate smears and to quicker turn round of results. NICE has given a five year frame for the rollout of LBC.

Secondly, evidence from Cancer Research UK recommends that women below 25 should no longer be invited for screening as it is likely to do more harm than good, women aged 25-50 should be screened every 3 years and women aged 51-64 should be screened 5 yearly. The changes will be introduced across Gloucestershire from 1st June 2004.

This is the first time screening coverage statistics have been collected by GP practice. This provides an opportunity to work closely with individual underperforming GP practices to enable them to improve their cervical screening uptake.

Further work needs to be undertaken by PCTs to enable women with a learning disability (LD) to be easily identified and offered cervical screening. There is a national guidance available (Good Practice in Breast and Cervical Screening For Women with Learning Disabilities). This will enable the equity of access to the screening service to be offered in an appropriate way to women with LD and their carers/responsible adult.

Appendix 1

Gloucestershire Cervical Screening Steering Group

Membership 2002/03

Cheltenham & Tewkesbury PCT

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

Cotswold and Vale PCT

Dr Pauline Allen	Consultant in Family Planning
Dr Gillian James	Head of Family Planning (until end of 2002)
Dr Z Sulaiman	Consultant in Genito-Urinary Medicine

Gloucestershire Hospital Trust

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

Family Health Services

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

SW Region

Margaret Stoddart	Cervical Cytology QAT member

General Practitioner, Gloucestershire LMC representative

Dr N Taylor

University of Gloucestershire

Adrienne Willcox	Senior Lecturer (Nursing)