Invasive Cervical Cancer Disclosure Audit Procedure (previously CP64)

1.0 Procedure Statement (Purpose / Objectives of the Procedure)

The purpose of this policy is to provide a clear and consistent process by which all newly diagnosed cases of invasive cervical cancer are audited and also to ensure that the results of the audit are offered to the individual women concerned in line with NHSCSP guidelines.

2.0 Accountabilities

Covered in section 2.0 of this document to include the accountabilities of:

- Cervical Screening Provider Lead (CSPL)
- Audit Lead (Cytology Lead Consultant Biomedical Scientist)
- Histopathology & Cytology Lead Consultant Pathologist
- Cytology Consultant Biomedical Scientist
- Lead Colposcopist (Consultant Gynaecologist)
- Consultant Gynaecologist/Oncologist
- Screening Quality Assurance Service Midlands and East (SQAS)

3.0 Procedure/Guidelines Detail / Actions

Followed as per requirements

4.0 Equipment Required

- PC with access to Winpath/patient records

5.0 Training

The Cervical Screening Provider Lead must attend one-off CSPL training, which is provided by the North Of England Pathology and Screening Education Centre (NEPSEC)

6.0 Financial Risk Assessment

1	Does the implementation of this document require any additional Capital resources	No
2	Does the implementation of this document require additional revenue resources	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 programs or allocated training times for staff.	No
	Other comments	

7.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

8.0 Maintenance

The Cervical Screening Provider Lead will ensure that this document is kept up to date.

9.0 Communication and Training

Training of Cervical Screening Provider Lead has been completed.

10.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Evaluation
At a minimum needs to reflect monitoring that demonstrates compliance with the document guidelines	Cervical Screening Provider Lead	Review triggered by release of updated NHS E/I Guidance	Not on a regular basis – but perhaps every 2-3 years	All staff involved in Audit process, though this will be initiated and led by the Cervical Screening Provider Lead

11.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

Reference:

PHE Guidance: National invasive cervical cancer audit, updated 29 September 2021
https://www.gov.uk/government/publications/cervical-screening-auditing-procedures/national-invasive-cervical-cancer-audit

Part A - Document Control

Procedure/ Guidelines number and version	**Title of Procedure/Guidelines** Invasive Cervical Cancer Disclosure Audit Procedure (previously CP64) V3.0	**Status:** Final		**Author: Cervical Screening Programme Lead** **For Trust-wide Procedures and Guidelines Chief Officer Sponsor: Chief Medical Officer**
Version / Amendment History	Version	Date	Author	Reason
	V1.0	April 2014	Dr A Bhatnagar	Revised Trust Version
	V1.1	June 2017	Mr R Cooper	Revised Policy WMCIU references updated to SQAS. References section updated. Consultation group members updated Definitions section updated
	V2.0	Nov 2018	Mr R Cooper	Added process flow chart Names removed – roles identified by title Abbreviations updated References updated 'Slide review' definition added CLINICAL PRACTICE PROCEDURE Section 2 Accountabilities updated following recommendations from SQAS visit Section 1, 3 – Duty of Candour details added
	V2.1	Feb. 2021	Cervical Screening Programme Lead	Extension approved

	V2.2	January 2022	Cervical Screening Programme Lead	Extension approved
	V3.0	May 2022	Cervical Screening Programme Lead	Review Title updated CSPL contact updated References updated

Intended Recipients: Clinical staff in Gynaecology (Colposcopy) and Cytology (Pathology)	
Consultation Group / Role Titles and Date: December 2021 Cervical Screening Programme Lead (CSPL) Colposcopy Clinical Lead Lead Pathologist for cervical screening Colposcopy Nurse (1) Colposcopy Nurse (2) Consultant Biomedical Scientist (laboratory Audit/Quality Lead) Consultant Biomedical Scientist Colposcopy Administrator CSPL Administrative Support	
Name and date of group where reviewed	Trust Policy Group – May 2022
Name and date of final approval committee(if trust-wide document)/ Directorate or other locally approved committee (if local document)	Trust Management Committee – May 2022
Date of Procedure/Guidelines issue	June 2022
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	May 2025, every 3 years

Training and Dissemination: Training requirements will be updated and reviewed at annual CSPL appraisals.
Publishing Requirements: Can this document be published on the Trust's public page: **Yes** If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.
To be read in conjunction with: State the name / s of any other relevant policies / procedures.
Initial Equality Impact Assessment: Done (OP73) **Full Equality Impact assessment [as required]: N/A** **If you require this documentation in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114**

Contact for Review	Mrs H Diamond (Acting CSPL), Ext 85858
Monitoring arrangements	• By CSPL, annually as per NHSCSP guidelines via audits and case reviews. • Incident reporting as per trust OP10 Version 17.1 – Protocol 2. April 2021 • Presented at the quarterly cervical screening business meetings. • Exception report to Quality oversight Group (annually).

Document summary/key issues covered.

To ensure that all women diagnosed as having cervical cancer will be given the option of being informed of the result of the review on all clinical material reported by or related to Royal Wolverhampton NHS Trust Cytology, Histopathology and Colposcopy Services during the preceding 10 years from diagnosis, via the process where feedback is given to patients where requested..

• To provide safe mechanisms for the audit process

• In addition, to collate this information with all other reviews of cervical smears, histology specimens and Colposcopic findings from all other cervical cancers and to provide an annual audit of results.

• To provide all data in an anonymised form to the Midlands and East Screening Quality Assurance Service (SQAS) who will co-ordinate history reviews, for collation of review results and dissemination to the NHSCSP.

• To perform annual audit of the compliance with this Clinical Procedure, by means of annual cervical cancer audit, Colposcopy MDT's and quarterly cervical screening business meetings.

Key words for intranet searching purposes	

(Part B) **Ratification Assurance Statement**

Name of document: Invasive Cervical Cancer Disclosure Audit Procedure (previously CP64)

Name of author: Hilary Diamond **Job Title: CSPL (acting)**

I, Hilary Diamond the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.

- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.

- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).

- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.

- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.

- I will send the document and signed ratification checklist to the Policy Management Officer for publication at my earliest opportunity following ratification.

- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: 

Date: 22/03/2022

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to:
The Policy Management Officer

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Procedure/Guidelines number and version	**Title of Procedure/Guidelines**	
Reviewing Group		**Date reviewed:**
Implementation lead: Print name and contact details		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form		
Development of Forms, leaflets etc.; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed		
Procedure/Guidelines communication; Consider 1. Key communication messages from the policy / procedure, who to and how?		
Financial cost implementation Consider Business case development		
Other specific issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		