Policy		NHS Worcestershire Acute Hospitals NHS Trust

POLICY ON THE CLINICAL AUDIT OF INVASIVE CERVICAL CANCER AND DISCLOSURE OF RESULTS

Department / Service:	Colposcopy / Gynaecology
Originator:	Reena Panchal
Accountable Director:	Alex Blackwell
Approved by:	Gynaecology Governance meeting
Date of Approval:	08/03/2024
Review Date: **This is the most current document and should be used until a revised version is in place**	08/03/2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Colposcopy / Gynaecology clinics / Ward
Target staff categories	Medical / Colposcopy staff

Policy Overview:
The policy provides clear guidelines on the process to be followed when a patient is diagnosed with Invasive cervical cancer with regards to the Invasive cervical cancer audit and the disclosure of these results to the patient.

Key amendments to this Document:

Date	Amendment	By:
Jan 2012	Addition of the duties and responsibilities of the Countywide Lead Colposcopy Nurse	J Underhill
October 2012	Expiry extended for 2 years following review	J Underhill
May 2013	Updated to reflect changes in National Policy	J Underhill
Nov 2013	Policy approved for republication	Paul Moran
October 2016	Documents extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2016	Further extension as per TMC 22nd July 2015	TMC
June 2017	Updated to reflect changes in names of organisations involved in the audit and to include updated standard paperwork	Joanne Underhill
March 2019	Revision & updated to reflect changes in NHSCSP terminology	Joanne Underhill
March 2021	Document extended for 6 months as per Trust agreement	

October 2022	Updated to reflect changes in National Policy	Joanne Underhill
January 2024	Updated to reflect changes in National Policy	Joanne Underhill

Contents:

Supporting Documents

Supporting Document 1 – Equality Impact Assessment Tool
Supporting Document 2 – Financial Risk Assessment

Appendices

1. Invasive Cervical Cancer Audit Forms September 2021
2. Invasive Cervical Cancer Audit Colposcopy Checklist September 2021
3. Patient Invitation for disclosure letter 2023
4. Patient Information Leaflet
5. Patient consent form
6. Letter 1
7. Letter 2

1. Introduction

The aim of the NHSCSP is the reduction in the incidence of and mortality from invasive cervical cancer.

For women and people with a cervix aged 25-64 who are screened in England every 3-5 years, it is estimated that cervical screening prevents 70% of cervical cancer deaths by the detection and treatment of pre-cancerous cervical abnormalities, which, if left untreated, may develop into invasive disease. If everyone attended screening regularly, 83% could be prevented.

In recent years the NHSCSP has been very successful in reducing the incidence of cervical cancer and increasing the fall in mortality compared to levels existing in 1986.

The purpose of the invasive cervical cancer audit is to support the continuous learning and development of health professionals involved in the programme, monitor the effectiveness of the cervical screening programme by comparing the screening histories of individuals who develop cervical cancer with those who do not and to identify areas of good practice and/or areas where improvements can be made to support evidence based policy and practice.

With respect to an individual, the audit of screening data may help to identify possible reasons for the occurrence of invasive disease (if they wish to receive this).

2. Scope of this document

A Trust policy in line with guidance provided by the NHS Cervical Screening Programme outlining how each invasive cervical cancer will be identified and audited is a requirement of the NHSCSP.

The invasive cervical cancer audit is a retrospective review of all aspects of the screening programme in full knowledge of the final cancer diagnosis, i.e., call and recall data, cytology and histology specimens and colposcopic assessments.

The review relates to episodes occurring in the 10 years prior to diagnosis of the cancer.

Aim of the Policy

1. To ensure that all women and people with a cervix diagnosed with cervical cancer will be given the option of being informed of the results of a review of all clinical material reported by the Laboratories (cytology and histology) and findings from assessments undertaken by the Colposcopy services within the Acute Trust or at Evesham Community Hospital.

2. To provide consistency of audit throughout the Trust by providing a framework for carrying out the audit.

3. To provide collation of the reviews of all cervical cancers on an annual basis.

Definitions

Abbreviations

NHSCSP	National Health Service Cervical Screening Programme
SQAS	Screening Quality Assurance Service
CSPL	Cervical Screening Provider Lead
WAHT	Worcestershire Acute Hospitals NHS Trust
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
RWT	Royal Wolverhampton Trust
BSCCP	British Society for Colposcopy and Cervical Pathology

3. Roles and Responsibilities

SQAS

- Linking audit data together to ensure a complete case history for each patient
- Supplying screening histories and available details of organizations involved in the patient's history to the diagnosing CSPL
- Liaising between regional SQAS teams (where necessary) to obtain HPV, cytology, histology and colposcopy data and to organize reviews, feeding back results of reviews to the diagnosing CSPL
- Administering and distributing reviews for SurePath cytology slides requested by laboratories who do not have members of the network within their host laboratory
- Monitoring progress and outcome of audits that have been notified to SQAS, including advising on additional reviews (should this be necessary)

CSPL

The CSPL is the audit lead and is responsible for coordinating the audit by organizing and collating the review results. This is regardless of whether the individual is treated at the diagnosing organization.

The CSPL must be supported by a sufficient level of designated administrative staff to ensure that the audit is completed to the timescales as described in the national guidance for audit and disclosure.

The CSPL should:

1. Have processes in place to capture all patients diagnosed with invasive cervical cancer within the trust regardless of where the diagnosis was made (non-colposcopy patients)

2. Log the cases and add them to the agenda of the colposcopy multidisciplinary team (MDT) meeting
3. Initiate the audit process, and contact the relevant parties (this may include one or more of cytology, histology and colposcopy departments)
4. Make contact with the relevant clinician at the treating organisation (if the individual is being treated at a different organisation to where their diagnosis was made)
5. Ensure the audit is completed and within the timescales recommended by the NHSCSP (within 6-12 months' maximum)
6. Notify SQAS at the earliest opportunity if there is a possible screening incident
7. Present the completed audit results at the colposcopy MDT, where a decision is made regarding the classification of the case, including whether duty of candour applies
8. Ensure agreement is made at the MDT regarding who will be the disclosing clinician
9. Inform the treating organisation of the results of the review
10. Create the summary report, incorporating the final case assessment, and send to the disclosing clinician
11. Send the completed audit to the Screening Quality Assurance Service (SQAS)
12. Ensure the disclosure offer letter and any reminder letters are sent to the patient
13. Ensure the treating organisation is informed that disclosure has been offered
14. Document the end of the disclosure process when advised by the disclosing clinician

Once completed the CSPL should:

1. Include any local outcomes and learning in their annual report - this report will be discussed at the local programme board following approval by the organisation, enabling outcomes and learning to be captured by the SQAS
2. Carry out an annual audit of offers of disclosure to individuals diagnosed with cervical cancer

Diagnosing clinician

- Notify the CSPL and the lead colposcopist of an invasive cervical cancer diagnosis
- Follow local protocols in line with national disclosure guidance

The diagnosing clinician must be a patient facing clinician, not a pathologist.

Countywide Lead Colposcopy Nurse

- Invites the patient for the results of the review if deemed appropriate and at the time specified by the responsible clinician/ MDT

- Arranges the appointment for the patient to discuss the audit outcome with the appropriate consultant if requested/required

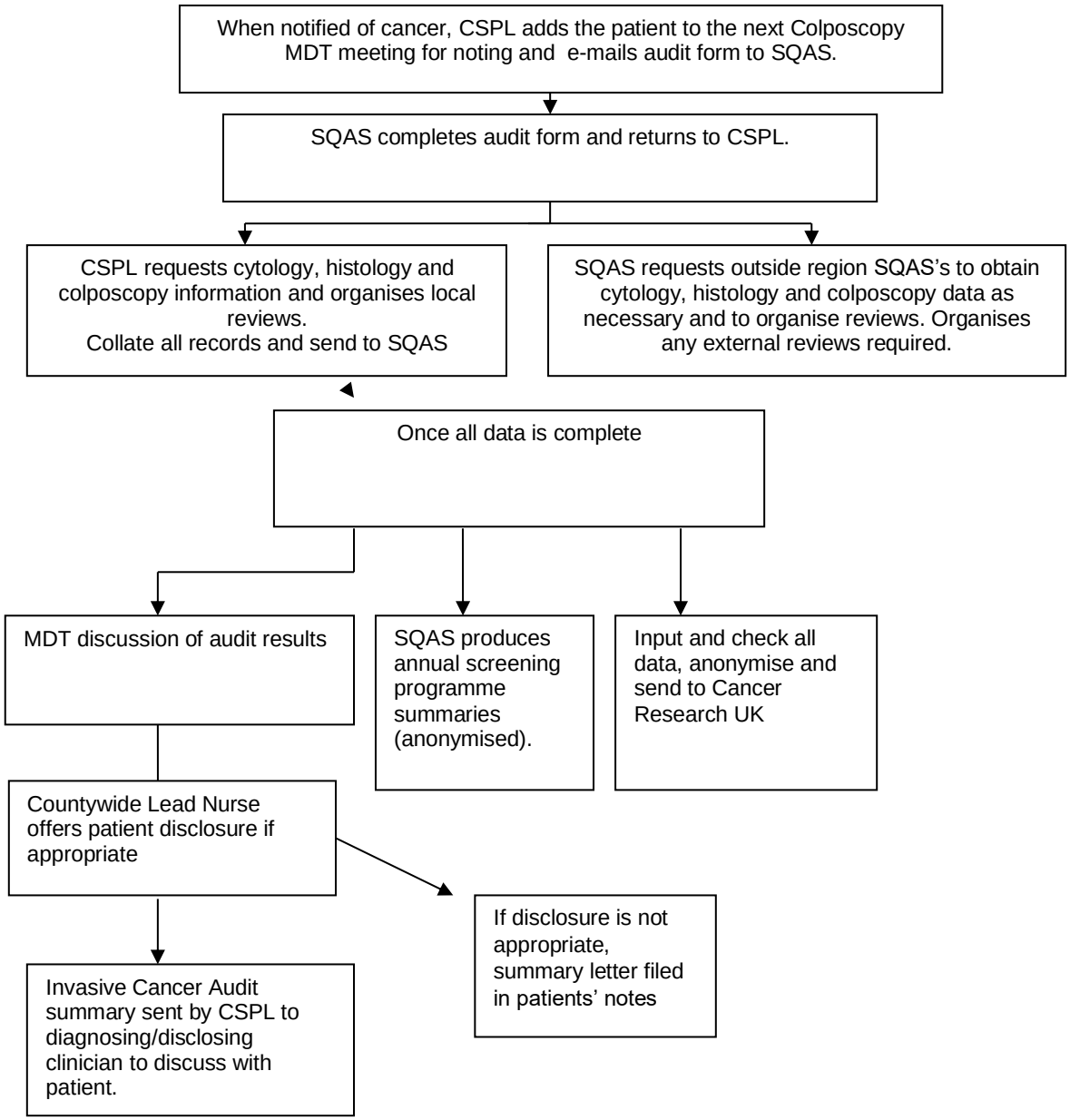
Lead consultant in cervical histology

- Coordinates the required cervical histology reviews
- Ensures that an appropriately experienced pathologist or consultant biomedical scientist who has not previously authorized the specimen report, where possible, undertakes the reviews (SQAS can provide support in identifying a location for a review to take place when this is not possible due to very small numbers of staff)
- Report the outcome of reviews in the required timeframe to the requesting CSPL

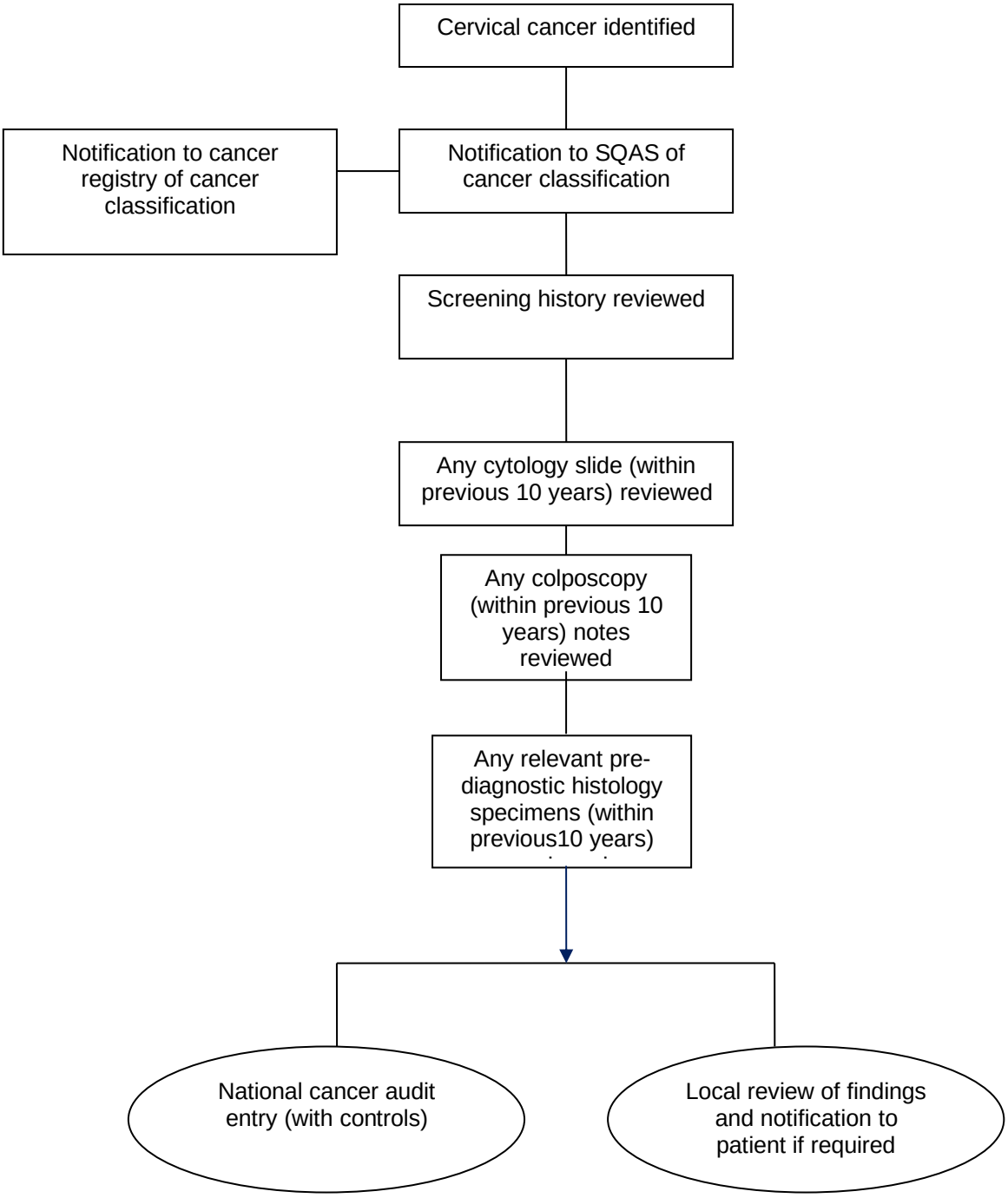
Lead colposcopist

- Coordinates the required colposcopy reviews
- Make sure colposcopy histories from all hospital sites within the trust are included
- Make sure the senior experienced colposcopist undertaking the review of colposcopic assessments and management was not involved in the patient's care
- Report the outcome of the review in the required timeframe to the requesting CSPL
- Nominate an appropriately trained clinician to offer disclosure to the individual (this could be a consultant gynaecological oncologist if most appropriate)
- Make sure all colposcopists involved in disclosure discussions have undertaken the required training (see link above)

Summary Flowchart – Overview of the audit process



Outline of audit sequence
(within previous 10 years)



4.1 Notification of cases

All histologically proven invasive tumours of the uterine cervix stage 1a1 or more / cases diagnosed via other methods such as imaging are included in the audit.

1) Colposcopists within the trust should inform the Lead Colposcopist/CSPL when an invasive cancer is diagnosed. The patient details should be added to both the Gynaecology Oncology and the Colposcopy Countywide MDT agendas. Appropriate proformas should be completed at both MDT's.

In order to ensure that no cases of invasive cancer are missed, two procedures have been put in place. On a monthly basis the CSPL will receive a printout from the Directorate Support Manager in Pathology at Worcestershire Royal Hospital of all cases of cervical disease which have been diagnosed on histology. From this, cases of invasive cervical cancer can be identified. Additionally, the CSPL will receive lists of patients discussed at the Gynaecology Oncology meetings from the MDT Co-ordinators / Medical Secretaries so that cervical cancer patients can be identified. Some cases may have presented clinically and histological confirmation may not have been performed in this Trust.

2) For all identified cases, the CSPL's secretary will initiate completion of the National Invasive Cervical Cancer Audit form (cover section, sections A & D). **Sections highlighted in yellow are the trust's responsibility to complete.** (see Appendix1) This is then forwarded via email (phe.cervixqamidsandeast@nhs.net) to SQAS who will issue a unique Study ID number and populate the sections in blue which includes the cervical screening histories of the patient, and identify which cervical screening tests requires review. The notification form is then returned to the CSPL's secretary so that the audit can begin.

4.2 Cytology Review

Review covers the 10 year period prior to diagnosis of the cancer.

Cervical cytology screening ceased in Worcestershire in April 2007, when the then Worcestershire Primary Care Trust (PCT) relocated the service to Gloucestershire NHS Foundation Trust (GHNHSFT). Cervical cytology screening transferred from Gloucester to the Royal Wolverhampton Trust (RWT) in 2019.

1) For all relevant slides independent review is required in the host laboratory by a Consultant pathologist or Consultant BMS who did not report on the original sample.

a) The CSPL's secretary sends a copy of the Invasive Cervical Cancer Audit Form (September 2021 version) to RWT via NHS net email (rwh-tr.colpmdt-westmids@nhs.net copying in angela.brown8@nhs.net and the CSPL) . The slides that require

review will have been identified. For slides that are held at GHNHSFT that require review an email should be sent to: andrew.usher1@nhs.net, and serena.turner@nhs.net detailing the patients name, NHS number, date of birth, audit ID number and the numbers of the slides for review. Instructions should be given to send the slides to:

Cytology Administrative Team (Audit Slides)
Cytology Department, A18
New Cross Hospital
Wolverhampton
WV10 0QP

RWT should be copied into this with the audit forms attached. For other out of area reviews SQAS should be contacted to obtain the details of the CSPL at the trust where the slides are held and then the above process followed.

b) The local review should be completed within 6-8 weeks of diagnosis.

It is not necessary to review any abnormal samples that were reported as moderate dyskaryosis or worse, provided that these were taken within **three months** of diagnosis and led to the immediate referral of the woman.

c) SQAS will notify the audit lead of slides which require submission for external review.

Notes

i) Where a patients screening history indicates that cytology has been reported by other Trusts within the West Midlands, SQAS will assist in arranging these reviews by RWT.

ii) Where cytology has been reported by Trusts in other regions, the Midlands and East of England SQAS will contact the SQAS in the other regions to request reviews.

iii) External reviews must take place at NHSCSP approved Cytology Training centres.

2) Following the review, all completed forms are returned to the Worcestershire Acute Hospitals CSPL for collation and submission to SQAS.

4.3 Histology Review

The Histology review should include slides from any gynaecological slides from the previous 10 years. There is no longer any need for the diagnosing histology to be reviewed or any samples taken after the diagnostic sample.

Only existing slides should be reviewed – it is not necessary to cut new sections.

A histopathologist who routinely reports on NHSCSP histological material should perform independent review of each case. The reviewer must not have reported the specimen originally and need not have access to the original report.

1. For each histological case on a patient the CSPL's secretary forwards the audit forms to the local Histopathology Lead to organise the review of any existing slides.

2. On completion of the review/s the forms should be returned to the CSPL's secretary.

Notes

i) SQAS no longer request reviews of the "diagnosing histology". They require reviews of previous Histology, e.g. punch biopsies, LLETZ, etc. It is, however, necessary for section D of the audit forms to be completed in order to ascertain details such as size and morphology of the tumour.

ii) An external review should only be performed where an abnormality is detected that was not formerly reported and/or where earlier detection would have led to the further clinical review or treatment in that clinical unit, rather than discharge of the patient back to the GP (This rule applies to non-cervical biopsies also.)

4.4 Review of gynaecological management – Colposcopic reviews

Implementation

The colposcopy review is likely to be a review of notes only. Review should be undertaken of any colposcopic assessments up to diagnosis for which records are available.

One BSCCP accredited colposcopist is required to review the colposcopy history.

1. A copy of the audit form is sent to the relevant colposcopist (this should be a clinician who was not involved in the patient's care) or Countywide Lead Nurse.

2. Section C1 should be completed with section C2 only to be completed for patients with colposcopy appointments that predate the index referral by up to 10 years. Section 2 does not need to be completed for any colposcopic examinations associated with the index referral cytology and

made within 18 weeks of the subsequent diagnosis of cervical cancer. It can be completed twice if the patient was referred to colposcopy more than once before the index referral test.

3. Once completed the forms should be returned to the CSPL for submission to SQAS.

4.5 Disclosure of audit results

Overview

- **The audit process should be completed within 6-12 months' maximum**

- It is the responsibility of the diagnosing Trust to ensure that all women/people with a cervix diagnosed with cervical cancer are informed about audit and disclosure. If, however, there are situations in which appropriate judgement considered that disclosure is inappropriate (e.g., the patient may be terminally ill and unlikely to cope with the information), then the reason for not offering the audit results should be documented in the patient's notes. The GP should be informed of this decision by the diagnosing Clinician.
- The diagnosing clinician should be responsible for deciding the appropriate occasion to discuss this for each individual patient at the initial MDT discussion. The initial consultation when the results of diagnosis are given is not an appropriate occasion to discuss audit and review unless the patient asks about their screening history. However, the patient should be informed that the review will take place. At this consultation an information leaflet and consent form should be included in the documentation given to the patient for them to refer to when appropriate for them. The patient can return the consent form at this point. However, they will be contacted again once the results of their review are ready and, if they prefer, can complete and return the consent form then, this is the responsibility of the Countywide Lead Nurse.
- In a very small number of cases, once the results of the review are known, duty of candour will apply. A discussion regarding whether or not duty of candour applies should take place at the Colposcopy MDT meeting once the results of the review of screening history are completed. The MDT should consider whether the review results are categorised as:

    1. satisfactory
    2. satisfactory with learning points
    3. unsatisfactory

- Cases identified as 'satisfactory' or 'satisfactory with learning points' are not classified as a duty of candour cases. See link below for guidance on determining classification. (https://www.gov.uk/government/publications/cervical-screening-disclosure-of-audit-results-toolkit/cervical-screening-review-and-classification-of-previous-screening-results) The findings must, however, be disclosed to the individual if they have asked for disclosure of their review results.

- Duty of candour applies to cases with an assessment of 'unsatisfactory'. For these cases please refer to the trusts policy on duty of candour. (http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2874)

- **However, if duty of candour applies but the patient has requested on their consent form that they do not wish to know the results of their review, this decision must be respected.**

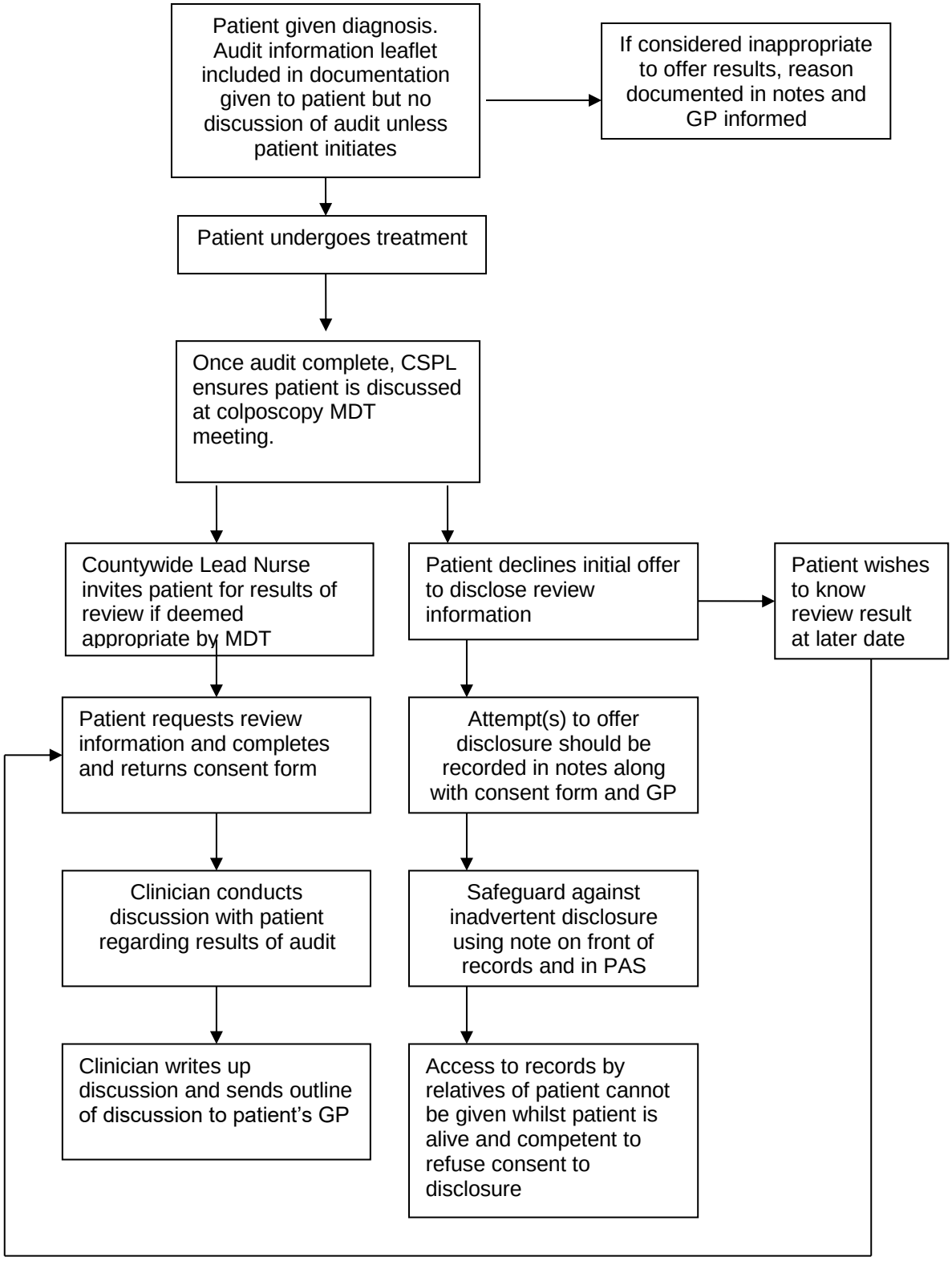
- If duty of candour applies but the patient has not returned their consent form, a second letter should be sent offering disclosure. If the patient still does not respond, the trusts policy on duty of candour should be followed.

- Once the case is complete the CSPL will then ensure that the case is discussed at the next available Colposcopy Multi-Disciplinary Team meeting (MDT). Minutes of the discussion should be made and a record of these placed in the patient notes.

- Following discussion of the review outcome results at MDT the CSPL will then produce a summary of the review and send it to the responsible clinician

- The Lead Colposcopist for the relevant site will then see the patient to discuss the outcome of the audit.

Disclosure of Audit Results Following Diagnosis of Cervical Cancer



Disclosure Offer Process

1. If the patient has not responded to the invite for disclosure within 3 months it should be considered whether duty of candour applies.

2. If **not** the failure to respond should be documented in the patient notes. The Countywide Lead Nurse should inform the CSPL, treating clinician and the patient's GP.

3. If duty of candour **does** apply a second offer letter should be sent. If no response is received within 3 months, assume the patient does not wish to know the results. This should be documented in the patient notes and inform the CSPL, treating clinician and the person's GP.

4. If the patient declines disclosure this should be documented in the patient notes and the CSPL, treating clinician and the patient's GP informed.

5. If the patient declines the offer for now, but requests a reminder in 6 months this should be logged and a reminder letter offer sent after 6 months.

If the patient does not respond to the reminder letter steps 1-4 should be followed

The patient should be informed that reviews of screening histories are carried out for all patients and that the patient can be given the results if they wish when they become available.

A consent form (Appendix 5) and information leaflet (if not already given) covering this process should be provided for the patient. If this occurs during a consultation, the patient may be happy to read and sign the form to indicate their preference about being provided with the results or not; or it may be preferable for the patient to take the form away for signing. This will give them more time for consideration. They should be instructed to return the form by post to the Countywide Lead Nurse

The consent form should be filed in the patient's notes and a copy forwarded to the CSPL.

4.6 Patients who wish to receive their results

If a patient accepts the offer of disclosure and the audit outcome is deemed satisfactory (no findings), letter 1 (appendix 6) can be sent. A copy should be sent to the CSPL, treating clinician and the patient's GP.

If the audit outcome is deemed satisfactory with learning points or unsatisfactory (duty of candour applies for this category) then letter 2 (appendix 7) should be sent to the patient along with an appropriate appointment with the Consultant colposcopist to discuss the audit outcome. The diagnosing clinician treating the patient should carry out the review in line with the Trust's protocols for giving bad

news.

- Once the audit results have been disclosed the discussion should be documented in the patient's notes. A summary of the discussion should be sent to the patient, their GP, their treating clinician and the CSPL.

4.7 Patients who do not wish to receive their review results

- These patients should be informed that they can change their minds at any time.

- If a patient subsequently wishes to be informed of the review results they should contact their consultant at the hospital to make the necessary arrangements. If the patient has been discharged when they make the subsequent decision, they should contact their GP.

- The GP should be informed by the clinician of the woman's decision not to receive the review results. He should be advised that if the woman does change her mind post-discharge he should notify the Trust so that the review results can be communicated by the diagnosing clinician.

If the GP wishes to know the report of the review, it must be re-iterated that the patient does not wish to receive the results of the review. If the patient does not wish to be informed of the review results:-

1) the offer and rejection of review information SHOULD be recorded in the patient's notes.

2) It is essential that staff dealing with the patient is made aware of her wish not to know.

3) A note should be made on the front of the medical records file which contains details of any discussion about the audit result.

4) A note should be made on the Patient Administration System (PAS) to alert those who may be involved in a subsequent request for disclosure by the patient

5 Ongoing Audit

The CSPL should undertake an annual audit to ensure that all women diagnosed with cervical cancer have been offered the results of their review where appropriate

6 Access to records by relatives of patients – living and deceased

Whilst the patient is alive and competent to refuse consent to disclosure of their medical record, an "interested" party (husband, partner, sibling or child) cannot be given access to medical information about the patient even if this may seem to be in the patient's best interests. (Disclosure of Audit Results in Cancer Screening. Advise on Best Practice. NHS Cancer Screening Services No. 3, Page 10).

Further advice relating to incompetent or deceased patients can be obtained from the above NHS document and the Access to Health Records Act 1990.

7. Plan for Implementation and Dissemination

The policy will be primarily disseminated to staff by placing it on the Trust's Intranet and alerting staff to it by means of e-mail and the Intranet's bulletin board. Key staff will be alerted by direct e-mail.

7.1 Training and awareness

Awareness of this policy will be raised through the dissemination process above. Limited training is necessary but assessment leads will be contacted and made aware of the policy's requirements.

8. Monitoring and compliance

The policy will be audited on an annual basis by the CSPL. This will be achieved by reviewing the patient's notes for evidence of discussion at MDT meetings, discussion with the patient and the presence of consent forms.

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

9. Policy Review

The policy will be reviewed on an annual basis by the CSPL with consultation with all accredited colposcopists.

10.References

References: Code:

Advice on best practice NHS Cancer Screening Series No 3	
Guidelines on the Audit of Invasive Cervical Cancers NHSSCP Publications No 28	
Audit of Invasive Cervical Cancers Regional Policy Publication No C09/01 West Midlands Cancer Intelligence Unit; West Midlands Breast and Cervical Screening Assurance Reference Centre	
Disclosure of Audit Results in Cancer Screening. Advice on Best Practice. NHS Cancer Screening Series No 3	
Guidance for Disclosure of Audit Results in Cancer Screening West Midlands Cancer Intelligence Unit Publication C07/09	
Protocol changes to the Audit of invasive Cervical cancers 2013	
Guidance: National Invasive Cervical Cancer Audit updated 29 September 2021	

11. Background

11.1 Consultation

Key individuals involved in external assessment and accreditation visits have been consulted during the development of this policy

11.1 Approval process

This Policy will be approved by the Trust Operational Committee. Checklist for approval can be found in Supporting Document 1.

11.2 Equality requirements

The content of the policy has no adverse impact on equality and diversity. A copy of the completed checklist form is found in Supporting Document 1.

11.3 Financial risk assessment

See supporting document 2

Supporting Document 1 – Equality Impact Assessment (EIA) Form

NHS 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	**Joanne Underhill**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Joanne Underhill	**Cervical Screening Provider Lead**	**Jo.underhill1@nhs.net**
Date assessment completed	**01/04/2021**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Policy on The Clinical Audit Of Invasive Cervical Cancer And Disclosure Of Results
What is the aim, purpose and/or intended outcomes of this Activity?	To monitor the effectiveness of the screening programme and to identify areas of good practice and/or areas where improvements can be made. Audit may provide educational feedback to all involved in the

	screening process. With respect to an individual, the audit of screening data may help to identify possible reasons for occurrence of invasive disease				
Who will be affected by the development & implementation of this activity?	❑ X ❑ ❑	Service User Patient Carers Visitors	❑ ❑ X ❑	Staff Communities Other: trusts involved in the cervical screening programme in Worcestershire_____	
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.	National Health Service Cervical Screening Programme Guidance of undertaking the invasive cervical cancer audit and disclosure of results				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	None – national requirement by all trusts				
Summary of relevant findings					

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		The content of the policy has no adverse impact on equality and diversity.
Disability		X		The content of the policy has no adverse impact on equality and diversity.
Gender Reassignment		X		The content of the policy has no adverse impact on equality and diversity.
Marriage & Civil Partnerships		X		The content of the policy has no adverse impact on equality and diversity.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		X		The content of the policy has no adverse impact on equality and diversity.
Race including Traveling Communities		X		The content of the policy has no adverse impact on equality and diversity.
Religion & Belief		X		The content of the policy has no adverse impact on equality and diversity.
Sex		X		The content of the policy has no adverse impact on equality and diversity.
Sexual Orientation		X		The content of the policy has no adverse impact on equality and diversity.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		The content of the policy has no adverse impact on equality and diversity.
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		The content of the policy has no adverse impact on equality and diversity.

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)	

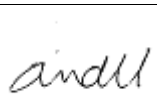
Section 5 - Please read and agree to the following Equality Statement

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	
Date signed	01/04/2021
Comments:	
Signature of person the Leader Person for this activity	
Date signed	01/04/2021
Comments:	

Supporting Document 2
Financial Risk 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.

Appendix 1 – Invasive Cervical Cancer Audit Forms September 2021

Copy of
Invasive_cervical_canc

Appendix 2 – Invasive Cervical Cancer Audit Colposcopy Checklist September 2021

Copy of
Invasive_cervical_canc

Appendix 3 – Patient Invitation letter 2023

Invasive review
invitation letter.doc

Appendix 4 – Patient Information leaflet

Reviewing your
cervical screening hist

Appendix 5 – Patient consent form

Updated consent
forms 2023.docx

Appendix 6 – Letter 1

Letter 1.doc

Appendix 7 – Letter 2

Letter 2.doc