Worcestershire Acute Hospitals NHS Trust

Standard Operating Procedures

COLPOSCOPY NURSING (OPERATIONAL GUIDELINES)

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Approved by:	**Gynaecology Clinical Governance Committee**
Approved by Medicines Safety Committee: *Where medicines are included in document*	**N/A**
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Date of Review: This is the most current document and is to be used until a revised version is available	**10th May 2027**

Aim and scope of Standard Operating Procedure

Colposcopy philosophy of care

- It is the aim of the colposcopy department to provide high quality patient care.
- We are committed to providing a service, which upholds personal dignity, respects difference and is always sensitive to individual needs.
- We aim to provide excellence in practice by providing holistic care to all people referred to the service within a friendly, relaxed environment.

Target Staff Categories

All Nursing staff in Colposcopy Services WAHT

Key Amendments to this Standard Operating Procedure (SOP)

Date	Amendment	Approved by:
10/05/2024	Annual review – document control transferred to Key Documents for centralised management. New version 1 created.	Gynaecology Clinical Governance Committee

Contents

1. Introduction to the Colposcopy departments

Trust wide Lead Colposcopist – Ms R Panchal
Deputy Lead Colposcopist – Ms J Underhill
Lead Nurse Colposcopist – Ms J Underhill
Deputy Lead Nurse Colposcopist – Mrs J Brassington
Cervical Screening Provider Lead – Ms J Underhill

1.1. The Alexandra Hospital

Geographical site of the service and opening times

The Colposcopy department is situated in the Worcestershire Women's Health Unit on the first floor of the Alexandra Hospital. The Worcestershire Women's Health Unit is open Monday – Friday from 0830-1800. The Colposcopy clinics take place all day Tuesday, Wednesday, Thursday, and alternate Friday mornings. There is an answer machine for out of hours use.

Service Provision

As one of the three Colposcopy clinics run across Worcestershire Acute Hospitals NHS trust on average 1850 patients are seen per year. Referrals are received via direct referral from the laboratory at the Royal Wolverhampton Trust, Primary care, all sites within the trust and other areas such as GUM clinics.

The clinicians working within the Colposcopy service are:

Miss R Panchal - Consultant Gynaecologist / Obstetrician/ Lead Colposcopist

Mr J Twigg – Consultant Gynaecology Oncologist/Colposcopist

Sister Jo Underhill - Nurse Colposcopist

Sister Emily Lynott – Nurse Colposcopist/Hysteroscopist

Nursing and Clerical Staff

The clinic is supported by Trained Nurses, Health Care Assistants, and a receptionist.

Colposcopy Clinic Co-ordinator	Angela Philips
Countywide Support Secretary	Amanda Furey

Six Colposcopy sessions are provided each week seeing 8 patients per session, plus 2 x clinics on the 2nd and 4th Friday morning of the month also seeing 8 patients.

Each session includes a mixture of patient's i.e. new referrals, follow up patients and patients returning for treatment.

Clinic Session Management- Copy of Schedule

DAY	TIME	COLPOSCOPIST
TUESDAY	0900-1230	Sister J Underhill
TUESDAY	1330-1700	Sister J Underhill
WEDNESDAY	0900-1230	Miss R Panchal
	1330-1700	Sister J Underhill
THURSDAY	0900-1230	Sister J Underhill
	1330-1700	Mr J Twigg (weeks 2 & 4) Sister E Lynott (weeks 1 & 3) Sister J Underhill (week 5)
FRIDAY	0900-1230	Sister J Underhill (weeks 2 &4)

Clinical Accommodation

The accommodation consists of:

- A reception area
- A waiting area with refreshments provided on request.
- A clinical room which is used for the management of new patients and follow up patients including treatments with a separate changing area & toilet.
- A separate recovery room with a couch and reclining chair

Clerical Accommodation

The Countywide Colposcopy administration team and nurse colposcopists are housed on the ground floor of the building at the back of the general outpatient's department.

1.2. Kidderminster Treatment Centre

Geographical site of the service and opening times

The Colposcopy department is situated in the Gynaecology department on level 2 of the Treatment Centre. The Colposcopy Clinic is open Tuesday 1330-1700, Wednesday from 0800-1300 and Fridays from 0800-1300.

Service Provision

Kidderminster Treatment Centre colposcopy department sees approximately 800 patients per year. Referrals are received via direct referral from the laboratory at the Royal Wolverhampton Trust, Primary care, all sites within the trust and other areas such as GUM clinics.

The clinicians working within the Colposcopy service are:

Miss J Lee - Consultant Gynaecologist / Site Lead Colposcopist

Mr S Agwu - Locum Consultant in Colposcopy

Nursing and Clerical Staff

The clinic is supported by Trained Nurses, Health Care Assistants, and a receptionist.

Colposcopy Clinic Co-ordinator Sara Newton

Countywide Support Secretary Amanda Furey

Three Colposcopy sessions are provided each week seeing 8 patients per session. Each session includes a mixture of patient's i.e. new referrals, follow up patients and patients returning for treatment.

Clinic Session Management- Copy of Schedule

DAY	TIME	COLPOSCOPIST
TUESDAY	1330-1700	Vacant nurse led session
WEDNESDAY	0800-1300	Miss J Lee
FRIDAY	0900-1300	Mr S Agwu

Clinical Accommodation

The accommodation consists of:

- The colposcopy department incorporates a reception area (within Ante natal clinic) which is manned by a clinic clerk. A waiting room with toilet facilities is close by.

Clinic Accommodation

- The clinic room is a self-contained clinical room separate from the main corridor with a separate changing area and toilet.
- A recovery area with couch for patients who feel faint or need to rest after treatment is near the colposcopy clinic separated by a single corridor.
- Refreshments are available for those patients who rest after treatment or upon request.

1.3. Worcestershire Royal Hospital

Geographical site of the service and opening times

The Colposcopy department is situated in Clover Suite on the ground floor of Worcestershire Royal Hospital. The Colposcopy Clinic is open Monday - Wednesday from 0830-1700 and a Thursday afternoon once per month. There an answer machine for out of hours use.

Service Provision

Worcestershire Royal Hospital colposcopy department sees on average 1370 patients per year. Referrals are received via direct referral from the laboratory at the Royal Wolverhampton Trust, Primary care, all sites within the trust and other areas such as GUM clinics.

The clinicians working within the Colposcopy service are:

Ms M van Seters – Consultant Gynaecologist & Site Lead Colposcopist

Mr M Y Shehata – Consultant Gynaecologist & Colposcopist

Sister J Brassington –Nurse Colposcopist

Nursing and Clerical Staff

The clinic is supported by Trained Nurses, Health Care Assistants, and a receptionist.

Colposcopy Clinic Co-ordinator Carrie Pottinger

Countywide Support Secretary Amanda Furey

On average 5 Colposcopy sessions are provided each week 8 patients per session. Each session includes a mixture of patient's i.e. new referrals, follow up patients and patients returning for treatment.

Clinic Session Management- Copy of Schedule

DAY	TIME	COLPOSCOPIST
MONDAY AM	0830-1230	Mr M Y Shehata
MONDAY PM	1330-1700	Sister J Brassington
TUESDAY AM	0830-1230	Sister J Brassington
TUESDAY PM	1330-1700	Ms van Seters Sister J Brassington (week 5)
WEDNESDAY AM	0830-1230	Sister J Brassington
THURSDAY PM	1330-1700	Mr M Y Shehata (week1 only)

Clinical Accommodation

The accommodation consists of:

- The colposcopy department incorporates a reception area which is manned by a clinic clerk. A waiting room with toilet facilities is close by.

Clinic Accommodation

- The clinic room is a self-contained clinical room separate from the main corridor.

The accommodation consists of

- One clinic room which is used for the management of new and follow up of clinic patients with an inbuilt changing cubicle separated by curtains with toilet facilities nearby.

- A recovery area with reclining chair and couch for patients who feel faint or need to rest after treatment is near the colposcopy clinic separated by a single corridor.

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

2. SOP scope

All members of staff involved with the Colposcopy service. This document provides clear guidelines on the processes to be followed when a patient is referred to the Colposcopy service at Worcestershire Acute Hospitals NHS Trust and outlines the roles and responsibilities of the individuals involved in delivering the service.

3. Indemnity statement

The Trust will assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise. **This includes for assisting nurses new to the colposcopy service completing a competency checklist. A copy of this will be held by the Lead Colposcopy Nurse for the service. (see appendix1)**

- Have been fully authorised by their line manager and their Directorate to undertake the activity.

- Fully comply with the terms of any relevant Trust policies at all times

- Only depart from any relevant Trust guidelines providing that such departure be confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician, it is fully appropriate and justifiable. Such decisions are to be fully recorded in the patient notes.

4. Staffing – brief summary of responsibilities

Colposcopy Clinic Co-ordinator / Support Secretary

- Download Direct Referral 'daily' spread sheet from laboratories and distributes to all other sites and maintains weekly spread sheet ensuring that all referrals are actioned.
- Receive and input patient referral letters and send out appointment letters and information leaflets to all patients.
- Make patient appointments as appropriate and send out confirmation letters.
- Reschedule appointments/clinics on the instruction of the relevant Colposcopist.
- Prepare patient notes prior to clinic appointments if required.
- Type all correspondence to referring doctors and patients.
- Enter patient details and episodes on to database using agreed proforma.
- Ensure patients episode notes are sent to Xerox for scanning in a timely manner.

Nursing Associate / Healthcare Assistant

- To ensure they are familiar with appropriate Health and Safety regulations and clinic protocols.
- To ensure that appropriate facilities and equipment are available and ready for use in each clinic.
- To assist the Colposcopist and support the patient throughout the examination.
- Send equipment to CSSD when clinic is completed and ensure area is clean and tidy.
- Attend multidisciplinary team meetings as time allows.

Registered Clinic Nurse

- To ensure they are familiar with appropriate Health and Safety regulations and clinic protocols.
- To ensure that appropriate facilities and equipment are available and ready for use in each clinic.
- To assist the Colposcopist and support the patient throughout the examination.
- Provide counselling and advice to patients after treatment.
- Ensure all cervical screening samples and histology specimens are correctly prepared and labelled ready for transportation to the laboratory.

- Maintain adequate stock levels and equipment.
- Attend multidisciplinary team meetings as time allows.

Accredited Nurse Colposcopist

- Conduct colposcopic examination and treatments.
- Answer patient queries should they arise.
- Ensure that clinic protocols are up-to-date and in line with BSCCP, NHSCSP and hospital guidelines.
- Allocate patient appointments with Clinical Lead Colposcopist to ensure that women are seen within times laid down by the NHS Cervical Screening Programme.
- Ensure that all clinics are properly staffed and that the staff are working within the framework of good practice.
- Ensure all results are accounted for following the failsafe-policy.
- Attend at least 50% of all Multi-Disciplinary Team Meetings.
- Liaise with the Cervical Screening Provider Lead.
- Collect audit data to produce reports for KC65, Screening Quality Assurance Service (SQAS) and BSCCP and for internal audits within the Trust.
- Manage their own caseload of patients within national guidelines and protocols seeking advice from consultant colleagues as when needed with difficult management cases. Provide cover for other colposcopist colleagues in their absence.

Gynaecologists/Colposcopist

- Carry out colposcopic examination and treatments.
- Provide support for the nurse colposcopists and a source of reference for difficult cases.
- Collect audit data to produce reports for KC65, SQAS and BSCCP and for internal audits within the Trust.

- Liaise with the Cervical Screening Provider Lead.
- Attend at least 50% of all Multi-Disciplinary Team Meetings.
- Manage their own caseload of patients within national guidelines and protocols.

Clinic Receptionist

- To act as a first point of contact for patients, other members of the public and other healthcare professionals in the department
- To input data as required into the Patient administration system.
- To provide support to the department in relation to administrative and clerical duties such as altering patients' appointments

5. Sickness and absence Procedure

- Please refer to the Trusts' Sickness, Absence, Health and Well-being Policy on the trusts intranet. Ref: Human Resources Policy Manual. March 2024.

6. Clinical Procedures

6.1. Clinical procedures - daily pre and post-clinic working instructions

Pre-clinic

- Before every colposcopy clinic session, it is essential that all equipment is checked and in sound working order in the interest of Health and Safety and patient comfort. See section 6.4.

Post-clinic

- The clinical treatment room should be thoroughly cleaned at the end of each session, including the couch, trolley, and surfaces.
- Any necessary re-stocking of clinical equipment and stationery should be conducted to ensure that everything is in place for the next clinic session.
- All specimens should be checked and signed off according to unit policy (please see section on management of histology and cytology samples).
- All sterile supplies (HSDU) equipment for sterilisation must be left in the appropriate place for collection. (if used)
- The computer monitor should be re-set for the next clinic session or switched off if it is the end of the clinic day.
- All equipment should be checked ready for the next session or switched off/unplugged if it is the end of the clinic day.
- Suction equipment filters should be changed according to policy (please refer to the diathermy loop excision section).

6.2. Set up of the Colposcopy Treatment Room

The following procedure should be followed prior to each clinic:

1. General Equipment

- Oxygen and suction to be checked prior to the start of the clinic.
- Ensure the couch is clean and has a sufficient supply of blue roll available along with a clean cover for each patient.
- Ensure the couch is switched on at the mains and functional i.e. moves up and down.
- Ensure the stainless-steel receptacle (if used) is in position under the couch and has paper towels covering the bottom. This is cleaned and changed after each patient.
- Ensure the smoke evacuation equipment is plugged in and positioned next to the couch and that the filters are in clean and working order. Disposable smoke evacuation kits should be available and attached; this must be changed after each patient.
- Ensure the diathermy machine is plugged in and positioned next to the couch. A supply of diathermy pads should be available. A monopolar lead should be attached to the machine. This is changed after each patient.
- A supply of biopsy and post treatment information leaflets should be within easy reach.
- Ensure the colposcope is positioned at the foot of the couch and attached to the camera system. A check should be made that the bulb is working by switching it on and that a spare bulb is available should the need arise.

2. Instrument Trolley

- the instrument trolley should be cleaned with Clinell wipes and then covered with a sterile towel / Inco sheet after each patient.
- the following equipment should then be available/ placed on the trolley:
  - Endocervical speculum
  - Eppendorfer biopsy forceps
  - Cusco's vaginal speculum - medium
  - Sponge holding forceps.
  - Gauze balls should be counted onto the trolley before and after each patient's procedure by two nurses. If extra packs are required these should also be counted to ensure no discrepancies occur. The swab count must be recorded on the Colposcopy Safety Standards form and signed by two nurses.
  - Rocket swabs
  - Cotton bud applicators
  - A pot of Monsels solution
  - A cervix broom and cytobrush
  - KY jelly / Normacel / Acetic Acid/Iodine
  - A histology pot and/or a cervical screening sample pot
  - A selection of the above supplies should be in the equipment trolley or on the work surface.
  - Medium and large non-sterile gloves

3. Work surface / Equipment trolley / Storage racks

The clinic nurse should check prior to each clinic that these areas have:

- Cusco's vaginal speculum – virgin, small, medium, and long
- Laser Cusco speculum - medium/large
- Rocket swabs
- Cotton bud applicators
- A selection of small, medium, and large disposable diathermy loops
- Disposable diathermy balls
- Non toothed forceps
- Dental syringes with 3 vials of Citanest
- Bacterial and Chlamydia swabs
- Histology and cervical screening sample pots
- Iodine
- Acetic acid
- Sharps box
- Monsels solution
- Kougans speculum
- Dental / other needles
- Eppendorfer biopsy forceps
- Uterine sounds / endometrial samplers
- Smoke evacuation equipment.
- Diathermy pads and pencils
- Aprons
- Litmus paper (if used)
- Disposable syringes

6.3. Colposcopy clinic staffing

- There must be two nurses in the examination room at all times, one of whom must be a registered nurse.

6.4. Colposcopy clinic: daily nurses' checklist

The following should be checked daily:

- Resuscitation trolley
- Colposcope – in working order, light on and spare bulbs available in clinic.
- Adequate instrumentation available including diathermy equipment, Cryocautery equipment (if used)
- Monsels solution ready for use
- Sufficient and appropriate paperwork in rooms
- Changing areas adequately equipped
- Board in waiting room filled in (if used)
- Patient list in room for the start of clinic
- Cleaning of equipment and clinical area as per individual unit's schedule
- Store cupboard / general stock should be checked on a weekly basis.

6.5. Record keeping and documentation.

- The patient's notes are prepared prior to the clinic by Xerox/Colposcopy administrative staff. This includes patient labels and a HMR101 form if required.
- It is the colposcopists responsibility to ensure all the above documentation/ request forms are filled in correctly.

- The clinic nurse is responsible for; documenting on the clinic list / in the log book against each patient which procedures have been performed, completing the Colposcopy Safety Standards form (see appendix 2) , ensuring the swab and needle count has taken place, is correct and documented correctly after each procedure, logging all specimens in the clinic log book and ensuring they are all present and correct (along with a second nurse) at the end of clinic (the log book is signed by both members of staff), labelling and placing the results ticket on the patients notes(where used) and completing the outcome forms for Oasis.
- If any reusable instruments are used the traceability sticker must be secured in the patients notes / logbook, this is the clinic nurses. responsibility. All single use instruments that are used for each patient are recorded in the notes or on a patient record of sterile items used sheet.
- Only the notes relating to the patient undergoing the procedure should be easily accessible in the clinic room. If this is not possible then those not in use should be stored in a transportation box so no cross contamination can occur.

6.6. Visitors to the clinic

- Women may have a friend or relative present if they wish.
- The patient's consent **must** be sought prior to colposcopy if anyone not essential for its performance is to be present (e.g. trainees, undergraduates, or visitors).
- The patient has the right to decline non-essential personnel being present.
- All visitors to clinic must be appropriately dressed and wear a visible name badge.
- **There must not be more than one observer in the examination room at any one time.**

6.7. Cervical screening samples

Consent for the procedure should be gained by the colposcopist prior to the sample being taken.

The clinic nurse should:

- Ensure that a cervix broom and cytobrush (if required) are available.
- Check that the sample pot has not expired.
- Once the colposcopist has signed a patient identifiable label, check with the patient that the name, date of birth and address are correct before affixing the label to the pot. The label should be placed on top of the existing label and **not** cover any exposed plastic. The nurse should also confirm with the patient who their GP is and check this is correct on the HMR101 form. Alterations should be made as required.
- The pot should only be labelled and placed on the trolley once the colposcopist has confirmed that the sample is being taken. If after labelling the pot the sample is not taken the pot should be discarded.
- As the colposcopist hands the nurse the broom/brush after taking the sample they should be placed in the pot **immediately**. The brush should then be mashed against the base of the pot **10** times and spun round **5** times to ensure the collected cells have been dispersed. The broom can be used to "wipe" the cells off the cytobrush. Once this has been completed the lid can be applied ensuring the two black marks on the pot meet.
- The sample should then be placed in the provided bag along with the completed HMR 101 form.

- The sample should be logged in the Clinic logbook and checked and signed by two nurses before the next patient enters the room. It can then be placed in the blue transport bags along with the completed log sheet and all other samples collected that day.
- The transport bag is placed in the post basket for transportation to Wolverhampton.
- Ensure the patient is aware that they will receive their results within four weeks and that any relevant information leaflets are given out e.g. HPV testing leaflet.

6.8. Punch Biopsy Samples

Consent for the procedure should be gained by the colposcopist prior to the sample being taken

The clinic nurse should:

- Hand the biopsy forceps (Tischler Morgan's / eppendorfers) to the colposcopist when requested.
- Ensure the formalin specimen pot is in date, correctly labelled with a patient identifiable label and check these details verbally with the patient.
- The pot should only be labelled and placed on the trolley once the colposcopist has confirmed that the sample is being taken. If after labelling the pot the sample is not taken the pot should be discarded.
- Reassure the patient, accordingly, offering support where required.
- Transfer the biopsy sample from the biopsy forceps/ litmus paper into the formalin pot. A needle or the shaft of a cotton tip snapped in half to reveal a sharp point can be helpful in getting the sample off the forceps and into the pot.
- Confirm the visual presence of the specimen in the pot with the colposcopist
- Post procedure the nurse should ensure the patient has sanitary protection as required and is given both verbal and written information regarding the procedure.
- The patient should be offered refreshments and the opportunity to recover as required.
- The sample should be logged in the Clinic logbook and checked and signed by two nurses before the next patient enters the room.

6.9. Diathermy Loop Excision / Cautery

Consent (either verbal or written) for the procedure should be gained by the colposcopist prior to the sample being taken

The clinic nurse should:

- Make sure they are familiar with the NHSCSP document **Guidance notes on the safe use of diathermy loop excision for the treatment of Cervical Intraepithelial Neoplasia** a copy of which is in the clinic room / office.
- Ensure there are two nurses within the clinic so one may support the patient whilst the other assists the Colposcopist.
- **Make sure the diathermy equipment is ready and set appropriately in accordance with guidelines**.
- As the patients advocate under the NMC code of conduct ensure that the patient has given verbal consent to the procedure and that this is documented

on the Colposcopy Safety Standards form (appendix 2). Ensure the patient is aware of the aftereffects and any implications this may have e.g. on holidays and that the relevant patient information leaflet is given.

- Ensure the patient is correctly positioned on the couch and as comfortable as possible.
- Safety checks for treatment include:
  1. **Does the patient have metal prostheses such as pins or plates in the area adjacent to treatment?** If so an alternative site for the diathermy plate must be used.
  2. **Does the patient have a pacemaker?** If so, the treatment should be deferred and advice sought.
  3. **Have piercings from the waist down been removed?** There is a small risk of burns if they are insitu
  4. **Does the patient have an insulin pump/spinal stimulator?** Advice should be sought regarding the risks/compatibility with diathermy.

- Ensure the formalin pot is in date, correctly labelled with a patient identifiable label and check these details verbally with the patient.
- The pot should only be labelled and placed on the trolley once the colposcopist has confirmed that the sample is being taken. If after labelling the pot the sample is not taken the pot should be discarded.
- Ensure that the appropriate treatment speculum is available, along with the local anaesthetic and requested loop and ball.
- Ensure the patient return electrode is securely attached and the green light is present on the diathermy machine.
- Ensure the colposcopist is able to reach the suction tubing to attach this to the speculum and that the foot pedal, if used, for the smoke evacuator is within reach.
- Hand the colposcopist the forceps for them to retrieve the loop specimen and ensure the formalin pot is ready to receive the sample.
- Confirm the visual presence of the specimen in the pot with the colposcopist
- Post procedure the nurse should ensure the patient has sanitary protection as required.
- Encourage the patient to have a drink post procedure and sit within the clinic for at least 10 minutes after the procedure /until fit for discharge.
- Ensure that the patient's details / procedure is recorded in the Clinic log book and checked and signed by two nurses before the next patient enters the room.
- On discharge from the clinic ensure the patient is given a procedure information leaflet including named nurse details and telephone number for the department for any concerns. Ensure they are aware results will be posted within four weeks but could take up to eight weeks. (if applicable)

7. Cryocautery treatment (where used)

Consent for the procedure should be gained by the colposcopist prior to the treatment commencing.

The clinic nurse should:

- Ensure the cryocautery machine is ready for use including safety check of gas flow.
- Give the colposcopist a choice of cryocautery tips, and fix the chosen size to the probe, along with the protective plastic cover.
- Reassure the patient that the treatment takes several minutes and during this time they may experience some period type discomfort.

- Assist the colposcopist by timing the application of the probe for exactly two minutes and support the patient throughout.
- Document the procedure in the patient's notes/logbook.
- Offer post treatment advice and offer sanitary protection to the patient and advise them to expect watery discharge for approximately two to four weeks (refer to the patient advice leaflet).
- If any patient feels unwell post treatment, encourage them to sit and recover primarily on the couch with a glass of water, and afterwards offer refreshments in the recovery room prior to discharge from clinic. Vital signs should be monitored until the patient has recovered.
- On discharge from the clinic ensure the patient is given a procedure information leaflet including named nurse details and telephone number for the department for any concerns. Ensure they are aware results will be posted within four weeks but could take up to eight weeks. (if applicable)

7.1. Process for Colposcopy logbook

- Following attendance at colposcopy the nurses in the clinic room should enter a patient identifiable sticker into the logbook. Any specimens that are obtained (cervical screening samples, histology, and microbiology) should be recorded at the side of this entry. Prior to the next patient entering the room two nurses must check any specimens taken against the logbook to ensure all details in the book, on the pot and on the request form match. Once this has been confirmed each nurse must initial by the patient's entry to confirm it was correct and has been checked and sent off.
- Each patient entry (even those with no specimens taken) should be checked and signed by the two nurses in the clinical room.
- The specimen should be placed in the specimen collection receptacle at the Alexandra Hospital and Kidderminster treatment Centre. At WRH after an afternoon session it should be taken down to the pathology reception.

7.2. Patient Information Leaflets

New referrals to colposcopy are sent the Colposcopy information leaflet. This leaflet comprehensively explains what an abnormal cervical screening result means as well as the possible treatment outcomes. There is a practical question section at the back covering 'commonly asked questions' and contact details for the clinical nurse specialists (CNS) for patient queries prior to their appointment.

All staff should be familiar with these leaflets to ensure continuity of patient information. (see appendix 3)

In addition, the colposcopy department has colposcopy patient information leaflets and for each procedure that takes place. These are listed below:

Colposcopy leaflets

- Colposcopy Information Leaflet
- Punch Biopsy
- HPV
- Loop diathermy excision of cervix
- Cryocautery/cervical cautery
- Information Leaflet for the Gynaecology Emergency Assessment Unit at Worcester (out of hours contact for patients who have undergone treatment)

It is important that these are well stocked within the clinic rooms and are given out to patients, as appropriate.

8. Management of Post Treatment Haemorrhage

- In case of an excessive amount of bleeding after loop diathermy, direct pressure should be applied to the cervix. In Nurse colposcopist's clinics the gynaecology registrar or above should be fast bleeped via the hospital switch board if required.
- Spongestan is available for use in all clinics if required.
- Staff should ensure that the colposcopist has contacted all the relevant people in case the patient needs to be transferred to a ward or theatre, i.e. ward, theatre, anaesthetist and whoever is on call.
- Call the porters so that they can send a wheelchair/bed to transfer the patient.
- Try to make sure that IV access is achieved before transfer to a ward if the patient is likely to be going to theatre.
- Before the patient is moved from the colposcopy department make sure that their observations have been carried out and documented on the nursing sheet in the notes.
- Finally ensure that the patient has a safe transfer from the department to either the ward or theatre. A trained member of the colposcopy nursing staff should accompany the patient and give an effective handover to a member of staff on the ward.
- **In the event of post treatment haemorrhage at the Alexandra Hospital or Kidderminster Treatment Centre, a vaginal pack should be inserted/ Spongestan and 999 called for emergency transfer to Worcestershire Royal Hospital.**

9. Management of Non-Surgical Complications of Colposcopy

9.1. Fainting

This may occur as a result of a vasovagal reflex due to cervical stimulation.

- Immediately stop instrumentation /examination of the cervix.
- Reassure patient and calmly try to rouse them by talking to them.
- Place the patient in head-down position by lowering the backrest of the couch.
- Give oxygen, if prescribed.
- Monitor pulse rate and blood pressure and record in the notes.
- Continue to assess patient and transfer to allocated Ward if they are not able to be discharged from outpatients.

9.2. Severe bronchospasm or other severe allergic reaction:

This may occur rarely in response to injection of local anaesthetic.

- Stop procedure and administer prescribed oxygen if appropriate.
- **Call the CRASH TEAM on 2222**
- Get the crash trolley from:
  The Alexandra Hospital = opposite reception in clinic
  Kidderminster Treatment Centre = Ante natal clinic
  Worcestershire Royal Hospital = Clover suite by the nurse's station

9.3. Epileptic seizures

These may occur as a result of injection of local anaesthetic or spontaneously in a susceptible patient.

- Make the environment around the patient as safe as possible by making maximum space in close proximity. **Do not restrict the patient in any way.**
- Lower the couch to lowest level possible and lower backrest if appropriate for patient's comfort using the appropriate foot pedals
- In severe cases **call CRASH TEAM on 2222** and maintain airway/basic life support until arrival.

10. Infection Control

- Please refer to the Trusts' Management of Infection Prevention and Control Policy on the trusts intranet. Ref: WAHT-CG- 043

11. DNA policy

NEW PATIENTS

Non urgent referrals

First DNA - Send standard DNA letter to patient requesting contact within one month (copied to patient's GP). If no contact made, discharge the patient back to their GP sending a copy of the letter to the patient.

Urgent referrals

First DNA - standard DNA letter along with a second appointment will be sent to the patient. Copy sent to the GP.

Second DNA

Colposcopist sends letter to GP practice informing GP of patient's failure to attend and suggesting future management/discharge. Copy sent to patient.

REVIEW PATIENTS

First DNA

Send standard DNA letter to patient requesting contact within one month (copied to patient's GP). If no contact made, discharge the patient back to their GP sending a copy of the letter to the patient.

RETURN FOR TREATMENT

First DNA

The Colposcopy secretaries will attempt to contact the patient by telephone. If no contact is made, then the standard DNA letter along with a second appointment will be sent to the patient. Copy sent to the GP.

Second DNA / Non responder

Colposcopist sends letter to GP practice informing GP of patient's failure to attend and suggesting future management. Copy sent to patient and the cytology laboratory at Royal Wolverhampton Hospital Trust.

Exceptions to the above policy may occur with specific patients at the clinician's request.

12. Patient cancellations

Any patient who telephones the Department to cancel their appointment must be redirected / have their details given to the reception staff or to the Colposcopy secretaries for a further appointment to be made.

All cancellations either by patients or the clinic **must** be entered onto the database by the Colposcopy secretaries.

13. Telephone counselling

If a patient telephones the unit for advice, it is essential that their notes are accessed before any further discussion takes place. This is to avoid any misunderstanding regarding their procedures or management plan that may have either taken place or been discussed during their appointment.

Any qualified member of the Nursing team can advise patients over the telephone and if necessary forward queries to the Nurse Colposcopist for further advice. Patient identification must always be confirmed in the interest of Confidentiality through a simple checking procedure e.g. full name, DOB, first line of address and last clinic attendance if appropriate. Any advice given should be documented in the patients notes, including dates and times and points of discussion.

If the patient needs to return to the clinic for further examination/management, it is vital that the reception staff and the colposcopy secretaries are informed so their notes are ready on arrival.

14. Colposcopy Failsafe Procedure for Data collection and Results Management

See Colposcopy Administration Guidelines

15. Reducing anxiety information and communication

- Each individual referred to colposcopy should be offered verbal information and should be sent written information before and after a cervical screening test and before colposcopy (95%).
- Counselling must be available as an integral part of colposcopy.

- Individuals must be sent an appropriately worded invitation with a contact name, telephone number and clinic times.

- Results should be communicated to the patient within four weeks (best practice 90%) or eight weeks (minimum standard 100%) of her attendance.
- Clinics operating a 'See and Treat' policy must ensure that individuals who are offered treatment at their first visit are sent adequate and appropriate information in advance of their appointment.
- Results and management plans should be communicated to the referring practitioner within four weeks of the patient's attendance at the clinic (best practice 90%) or eight weeks (minimum standard 100%).
- Information leaflets should be individualised to each clinic.

16. Health and Safety / Risk Management

- Please refer to the trusts Health & Safety Policy on the Trusts' intranet. Ref: WAHT-CG- 125

17. Moving and Handling

- Please refer to the trusts Manual Handling Policy on the Trusts' intranet. Ref: WAHT-CG-026

18. Incident Reporting

- Please refer to the trusts Incident Reporting Policy on the trusts intranet. Ref: WAHT-CG-008 and Managing Safety Incidents in NHS Screening Programmes March 2024

19. Colposcopy Department Fire Procedures

- Please refer to the trusts Fire Safety Strategy. Ref: WAHT-CG-483

20. Appendices

Appendix 1

Nurse competency record - new member

Appendix 2

PF WR5273 Colposcopy Safety St

Appendix 3

Colposcopy Information & HPV (Human Papilloma Virus) Leaflet (WAHT-PI-0230)

Appendix 4

Your Colposcopy Procedure – Loop Diathermy Of The Cervix (LLETZ) Leaflet (WAHT-PI-0679)

Appendix 5

Your Colposcopy Procedure – Punch Biopsy Leaflet (WAHT-PI-0680)

Appendix 6

Your Colposcopy Procedure – Cryotherapy of the Cervix Leaflet (WAHT-PI-1094)

Appendix 7

Your Colposcopy Procedure – Cautery to the Cervix Leaflet (WAHT-PI-1095)

Appendix 8

HPV (Human Papilloma Virus) Leaflet (WAHT-PI-1097)

21. Quality Assurance Standards - NHS CERVICAL SCREENING PROGRAMME QUALITY ASSURANCE STANDARDS

Colposcopy and Programme Management guidelines for the NHS Cervical Screening Programme NHSCSP Publication No 20 third edition

Updated February 2020

	Objective	*Measure*	*Target*
1	To ensure individuals are adequately informed about colposcopy and treatment.	▪ All individuals referred for colposcopy should be offered verbal information and be sent written information before and after cervical screening and before colposcopy.	95%
		▪ Individuals must be sent an appropriately worded invitation with a contact name, telephone number and clinic times.	
		▪ Counselling must be available as an integral part of colposcopy	
		▪ All individuals needing treatment should be informed that treatment will be required and have that treatment explained. Their consent, either written or verbal, should be recorded.	
		▪ Information concerning the visit and results of investigations should be communicated to the patient within four week or eight weeks of their attendance	90% within four weeks (best practice) or 100% within eight weeks (minimum standard).
2	To provide an adequate clinic environment (see also 3.1).	All clinics should have the following facilities:	
		▪ Permanently sited specific room for colposcopy (100%)	
		▪ Dedicated private area with toilet and changing facilities.	
		▪ A suitable couch, colposcope and other equipment necessary for diagnosis and treatment.	
		▪ Appropriate sterilising facilities must be available in accordance with local and national health and safety recommendations.	
		▪ At least one method of satisfactory treatment of CIN or automatic referral to a unit where treatment is available.	
		▪ If laser or diathermy equipment is in use, there must be adequate safety guidelines in place with all staff trained in their operation.	

	Objective	*Measure*	*Target*
		▪ Resuscitation equipment and the ability and training to use it correctly.	
		▪ Written emergency guidelines with which all clinic staff are familiar.	
3	To provide appropriate clinic staff (see also 3.1)	▪ All clinics should have a named colposcopist with appropriate skills who leads the service. The named lead colposcopist must have a job description.	
		▪ All clinics should have a named lead nurse with appropriate skills and without concurrent out-patients' duties.	
		▪ There must be at least two nurses for each clinic one of which must be a level 1 registered nurse.	
		▪ All colposcopists working in a clinic must receive the same level of nursing staff support.	
		▪ There must be adequate dedicated clerical support for each clinic.	
		▪ Consent should always be obtained to the presence of non-essential clinic personnel e.g. trainees, undergraduates, visitors.	
4	To ensure appropriate and accurate data collection	▪ There must be suitable information technology equipment and software to facilitate collection of data for the BSCCP minimum data set and for submission of the standard	
		▪ Appropriate and sensitive enquiries regarding sexual history should be made only when necessary.	
		▪ Multi-disciplinary audit must be an integral part of the service.	
5	To reduce default	▪ All clinics should have written protocols for the management of non-attenders.	
		▪ Minimal default rate at first appointment.	<10% of women fail to attend for first appointment.
		▪ Minimal default rate when returning for treatment	<10% of women fail to attend when returning for treatment.

		▪ Minimal number of defaulters at follow up appointment.	<15% of women fail to attend for follow up appointment.
6	To reduce the failure of diagnosis of early cancers	▪ An excisional form of biopsy is recommended when: - Most of the cervix is replaced with high grade abnormality - Low colposcopic change is associated with severe dyskaryosis or worse	95%
		A lesion extends into the canal (sufficient canal must be removed in these situations).	
		Reasons for not performing a biopsy must be recorded	100%
		All individuals should have had histological diagnosis before destructive treatment	100%
7	To improve the quality, accuracy and timeliness of diagnosis	Individuals should be referred to colposcopy after 2 consecutive HR HPV+ with inadequate cytology samples/ HPV result unavailable	
		Individuals should be referred for colposcopy after a sample reported as negative but positive to high-risk HPV	
		Individuals should be referred for colposcopy after a sample reported as HR HPV+ with Borderline change in squamous cells or endocervical cells (2WW)	
		Individuals should be referred for colposcopy after a sample reported as HR HPV+ with Mild dyskaryosis.	
		Individuals should be referred to colposcopy after one test reported as HR HPV+ with Moderate dyskaryosis.	100%
		Individuals should be referred to colposcopy after one test reported as HR HPV+ with Severe dyskaryosis	100%
		Individuals referred with a high-grade cytological abnormality/Borderline change in endocervical cells must enter a 28-day cancer pathway (FDS).	100%

		Once cancer has been excluded these individuals must enter the 18-week pathway	
		Individuals must be referred to colposcopy after one test reported as HR HPV+ with possible invasion. They should be seen urgently, within two weeks of referral	100% 93%
	Objective	***Measure***	***Target***
7	To improve the quality, accuracy and timeliness of diagnosis (continued)	Individuals must be referred to colposcopy after one test reported as HR HPV+ with possible glandular neoplasia. They should be seen urgently, within two weeks of referral	100% 93%
		Waiting time for colposcopic assessment for all referrals.	≥99% in less than six weeks
		Waiting time for individuals with a test result of moderate or severe dyskaryosis should be seen within two weeks of referral.	≥93% in less than two weeks
		Individuals with moderately or severely dyskaryotic cytology having a biopsy (i.e. material excised and sent for histological interpretation) when an atypical transformation zone is present.	100%
		Individuals with persistent borderline or mildly dyskaryotic cytology having a biopsy within two years of the index (first) cytology.	≥90%
		The proportion of individuals being offered an appointment for definitive treatment for high grade CIN within four weeks of the colposcopy clinic receiving a diagnostic biopsy report. All individuals having definitive treatment for high grade CIN must be treated within eight weeks. Pregnant individuals are the exception to this.	≥90% 100%

		The reason for any delay should be specified.	
		▪ Accurate recording of colposcopic findings to include: 1. Reason for referral 2. Grade of cytological abnormality 3. Whether the examination is satisfactory. This is defined as the entire squamocolumnar junction having been seen and the upper limit of any cervical lesion also being seen. 4. Presence or absence of a visible lesion 5. Colposcopic opinion regarding the nature of the abnormality and requirement for treatment	100% 100% 100%
	Objective	***Measure***	***Target***
7	To improve the quality, accuracy and timeliness of diagnosis (continued)	Proportion of biopsies adequate for histological interpretation	>90%
		If a colposcopically directed biopsy is reported as inadequate for histological interpretation, it should be repeated if there is a residual colposcopic lesion	95%
		Evidence of CIN on histology when treated at first visit	≥90%
		Biopsy should be undertaken in individuals with moderate or severe dyskaryosis (high grade) on their test result	>95%
		Individuals referred with moderate dyskaryosis or worse cytological abnormalities who have a colposcopically low-grade lesion and who are not treated should have multiple biopsies	95%
		All patients who are immunosuppressed must be managed in a centre with demonstrable skill and expertise, with sufficient access to patient numbers to maintain that expertise	
		All individuals aged 25-65 years with renal failure requiring dialysis must have cervical cytology performed at, or shortly after diagnosis	

		Reporting of any abnormal glandular sample must be supplemented with a written description report	100%
		Individuals with atypical endometrial cells on a sample, with or without irregular vaginal bleeding and regardless of menopausal status, should be seen urgently, within two weeks of referral, by a gynaecologist	
		The investigation of abnormal bleeding after the menopause must include direct visual inspection of the cervix	
		Colposcopic assessment is essential in the presence of cytological glandular abnormality	100%
		If colposcopy has been performed during pregnancy, postpartum assessment of individuals with an abnormal cytology or biopsy proven CIN is essential	100%
	Objective	***Measure***	***Target***
		If invasive disease is suspected clinically or colposcopically in a pregnant individual, a biopsy adequate to make the diagnosis is essential	100%
		All patients in the cervical screening age range undergoing a hysterectomy for other gynaecological reasons should have a negative cytology sample within the screening interval or as part of their preoperative investigations	100%
		All patients being considered for hysterectomy who have an undiagnosed abnormal cytology sample or symptoms attributable to cervical cancer should have diagnostic colposcopy and an appropriate biopsy	100%
		The MDT should meet once each month (best practice) or at least once every two months (minimum standard)	
		All colposcopists should attend at least 50% of MDT meetings to ensure	50%

		the timely management of difficult cases and discordant results (minimum standard). Attendance at MDT meetings should be recorded (minimum standard)	
		The MDT's decisions on each case must be recorded in patients' medical records (minimum standard). The minutes of each meeting, including the outcome of any discussion should be recorded, and a letter describing the recommendation for future care must sent to the colposcopist responsible for the patient (minimum standard). All cases of cervical cancer must be reviewed by a gynaecological cancer centre MDT (minimum care)	
8	To ensure appropriate selection for and quality of treatment	All individuals needing treatment should be informed that treatment will be required and their consent, either written or verbal, recorded.	100%
		All treatments should be recorded.	
	Objective	***Measure***	***Target***
		Clinic staff must always be familiar with the treatment method(s) used	
		Biopsy should be carried out unless an excisional treatment is planned, when the cytology indicates moderate dyskaryosis or worse, and always when a recognisably atypical transformation zone is present. Pregnancy is an exception	100%
		All individuals should have had their histological diagnosis established prior to destructive therapy.	100%
		All individuals needing treatment must have had a colposcopic assessment	100%
		The proportion of individuals treated at the first visit who have evidence of CIN 2/3 or CGIN on histology	≥90%
		Proportion of individuals managed as outpatients under local analgesia.	≥85%

		Proportion of treatment associated with primary haemorrhage that requires a haemostatic technique in addition to the treatment method applied.	≤5%
		The proportion of cases admitted as in-patients due to treatment complications.	≤2%
		Proportion of treated individuals with no dyskaryosis on cytology at six months.	≥90%
		▪ Ablative techniques are only suitable when: − the entire transformation zone is visualised − there is no evidence of glandular abnormality (100%) − there is no evidence of invasive disease (100%)	100% 100% 100%
		Cryocautery should only be used for low grade CIN and a double freeze–thaw–freeze technique must be used	100%
		When excision is used, at least 80% of cases should have the specimen removed as a single sample.	80%
		For ectocervical lesions, excisional techniques should remove tissue to a depth of greater than 7 mm.	95%
	Objective	***Measure***	***Target***
		Treatment at first visit for a referral of borderline or mild dyskaryosis should be used only in exceptional cases, and only when audit has identified that CIN 2/3 or CGIN is present in ≥ 90% of the excised specimens	90%
		All individuals over the age of 50 years who have CIN 3 at the lateral or deep margins and in whom satisfactory cytology and colposcopy cannot be guaranteed must have a	100%

		repeat excision performed to try to obtain clear margins	
		Individuals with CGIN can be managed by local excision for those wishing to retain fertility. Incomplete excision at the lateral or deep margins requires a further excisional procedure to obtain clear margins and exclude occult invasive disease	95%
9	To ensure appropriate and adequate follow up	All individuals are at risk following treatment and must be followed up	100%
		All individuals who do not have negative cytology after treatment should be re-colposcoped at least once within 12 months	100%
		Proportion of treated patients having a follow up cytology within six to eight months following treatment.	≥90%
		The proportion of treated individuals with no dyskaryosis six months following treatment	≥90%
		Proportion of confirmed (histological) treatment failures within 12 months of treatment	≤5%
		If at follow up a high-grade cytological abnormality persists, excisional treatment is recommended	90%
		If a low-grade lesion has not resolved within two years of referral to colposcopy, at least a biopsy is warranted	>90%
10	To ensure adequate communications with referring practitioner	Proportion of results and management plans communicated to the referring practitioner	>90% within four weeks (best practice) or eight weeks (minimum standard 100%) of patient's attendance at clinic
	Objective	***Measure***	***Target***
11	To maintain skill levels	All practising colposcopists must be able to demonstrate that they have received an adequate training.	

		All colposcopists in the team should be certificated through the BSCCP/RCOG scheme and should comply with the re-certification process every three years	
		All colposcopists must attend one BSCCP recognised colposcopy meeting every three years	
		Number of new abnormal cytology referrals managed by an individual colposcopist per annum	≥50
		If training unit, number of cases directly supervised by an individual colposcopist per annum	≥50

22. Audit

Colposcopy is an area under constant audit as we strive to maintain the national quality assurance standards recommended by the NHS Cervical Screening Programme and the regional quality assurance standards recommended by SQAS. (On previous pages)

23. Colposcopy database

WAHT uses the MASEY colposcopy database provided by NHS England. All data is entered by the Colposcopy clinic administration staff and colposcopists.

24. Validation of KC65 return.

The KC65 return is ran by the Colposcopy administration staff on all three sites when requested. Once complete the data is sent to the Countywide Lead Nurse for Colposcopy for validation. Once validated the final reports are sent to the Countywide Lead Colposcopist who signs off the header sheets for the three sites and sends to SQAS.

25. Patient Satisfaction surveys

Patient satisfaction surveys are conducted Countywide on an annual basis.

26. Infection control audits

Other audits take place throughout the year on an ad-hoc basis according to areas of special interest. If any staff have any audit ideas or areas that they feel could be improved through audit, such as patient information, please discuss at staff meetings so we can take this forward.

27. Review, monitoring and revision arrangements

Monitoring	Method	Frequency	Lead	Reporting to
Countywide Lead Nurse (CLN)	**Policy and procedure review**	**Annually**	**CLN**	**Countywide Lead Colposcopist**

28. Supporting Document 1 – Equality Impact Assessment 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	✓	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	**Lead Nurse Colposcopist/Cervical Screening Provider Lead**	**jo.underhill1@nhs.net**
Date assessment completed	**30/05/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** WAHT Colposcopy Nursing SOP (Operational Guidelines) V1
What is the aim, purpose and/or intended outcomes of this Activity?	To provide clear instruction for nursing staff working in the colposcopy clinics countywide on the processes involved and running of the clinics. To ensure an equitable and safe service countywide.

Who will be affected by the development & implementation of this activity?	X X X X	Service User Patient Carers Visitors	X ❑ ❑ ❑	Staff Communities Other _____	
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?				
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Based upon National Guidance and standards within the NHS Cervical Screening Programme and W.A.H.T policies and procedures.				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation with countywide nursing staff				
Summary of relevant findings	N/A				

Section 3

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

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			
Disability	X			
Gender Reassignment	X			

Marriage & Civil Partnerships	X			
Pregnancy & Maternity	X			
Race including Traveling Communities	X			
Religion & Belief	X			
Sex	X			
Sexual Orientation	X			
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	X			
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			

Section 4

What actions will you take to mitigate any potential negative impacts?	**Risk identified**	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Timeframe**
N/A		.		

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	Jo Underhill
Date signed	30/05/2024
Comments:	
Signature of person the Leader Person for this activity	Jo Underhill
Date signed	30/05/2024
Comments:	

29. Supporting Document 2 – Financial Impact Assessment

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

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

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