

1Q. QUALITY CONTROL

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1Q.10. THE QUALITY AND PROCEDURES MANUAL

1Q.10.1. Background

The National Service Framework (1999) outlines quality assurance (QA) for the cervical screening programme in Wales. This manual documents the Cervical Screening Wales (CSW) quality system needed to achieve quality in cervical screening.

1Q.10.2. Structure of the Manual

This Manual contains the following sections:

1Q.QUALITY SYSTEM

This section outlines CSW's approach to quality and quality assurance and summarises CSW's management and quality assurance structures and responsibilities.

2R.CORE REFERENCE SECTION

This section sets out the CSW policy and objectives that the quality system is designed to meet. It also contains information common to all disciplines. This section must be read in conjunction with any of the operational procedures.

3A.OPERATIONAL ADMINISTRATION

This section sets out quality standards for CSW's operational procedures for Cervical Screening Administration Department s (CSADs).

4P.PATHOLOGY

This section sets out quality standards for CSW's operational procedures for Pathology Laboratories. This includes both cytopathology and histopathology laboratories.

5C.COLPOSCOPY

This section sets out quality standards for CSW's operational procedures for Colposcopy services.

5CA.COLPOSCOPY ADMINISTRATION

This section sets out quality standards for CSW's operational procedures for Colposcopy Administration.

1Q.20. QUALITY ASSURANCE

1Q.20.1. Principles

Quality assurance depends on effective management, to design, document, implement, maintain and review a quality system. Quality assurance relies on all staff working in, or for, the screening programme complying with the requirements of the quality system; one such requirement is that any deficiencies in the system are reported and remedied.

The system is constantly improved by the feedback mechanism, and every individual has an important part to play in achieving quality.

Each individual must understand his or her contribution to quality, and must be sufficiently trained, motivated and enabled to make that contribution effectively.

The quality assurance system documented in this manual supports all staff working within the cervical screening programme in Wales in meeting their responsibilities under clinical governance.

1Q.20.2. Terminology

Action

The action that is taken when limits are exceeded.

Audits and Reports

The audit(s) and/or reports that are undertaken to monitor compliance with the standard(s). All standards in sections 3, 4 and 5 are cross referenced to Section 1: Quality Audit and Reports.

Clinical Responsibility

The main member(s) of staff responsible for the clinical aspects.

- Regional Programme Coordinators – responsible for the call/recall and management of women in the screening divisions
- Lead Pathologists – responsible for the delivery of laboratory screening aspects including cytology and histology
- Lead Colposcopists – responsible for the diagnosis and treatment of women

Frequency

The frequency with which the quality control procedure is carried out.

Further Guidance

References to additional documents or procedures that provide further guidance on the use of the resource or the meeting of the standard(s).

Key Quality Control Checks

Quality control checks as part of standard working practices aim to minimise the occurrence of risk within the cervical screening programme.

Limits

Quantitative or qualitative limits of acceptability, beyond which action is taken.

Managerial Responsibility

The member of staff responsible for ensuring that the quality standard is achieved. In some areas of the programme the individual holding managerial responsibility will also be a QA Adviser to the Director. In other areas of the cervical screening programme the QA Adviser will not be the line manager but will advise the manager and director on all Quality Assurance matters relating to that standard.

Method

The method used to ensure that the standards are met or that the quality control procedures are carried out. This may include the selection, procurement and maintenance of resources.

Operational Staff

Identifies additional member(s) of staff, if present, who are involved in the procedure or control as part of their normal working or who contribute to the resource.

Quality

The total features and characteristics of a product or service that bear upon its ability to satisfy a given need.

Quality Assurance (QA)

All those planned and systematic actions necessary to provide adequate confidence that a product or service will satisfy given requirements for quality. QA has two components:

- **Quality management** which is that aspect of the overall management function which determines and implements quality policy;
- **Quality control** which includes/checks the operational techniques and activities that are used to fulfil the requirements for quality.

QA Adviser

It is the responsibility of the identified QA Adviser to advise the Director on all Quality Assurance matters relating to standards and delivery of services relevant to their area of specialisation.

Quality Manual and Procedures Manual

Full documentation of the quality system.

If you choose to print this document, it is your responsibility to ensure you **always** refer to the most up to date version, please be aware the electronic version will always be the most up to date

Quality Manual Manager

Overall responsibility for version and document control processes and advising quality group.

Quality Manual Controller

Responsible for updating, issuing and controlling version distribution.

Quality Policy

The overall intentions and direction of an organisation with regard to quality, as formally expressed by management.

Quality Standard(s)

A specification of the quality standard(s) that must be met.

Quality System

The objectives, policies, organisation and procedures which ensure that quality requirements are achieved.

Records

The records made during the carrying out of the quality control procedure, their distribution and filing.

Relevant Quality Standard(s)

The quality standard(s) that are checked when carrying out the quality control procedure.

Reports

The form and mechanism for relaying information on achievement against standards to the Director.

1Q.30. QUALITY POLICIES

The Director of CSW endorses the following extract from Welsh Office circular WHC (89) 35:

“The cervical screening service is being set up on the principle that a high level of quality is essential to maximise the benefits and minimise the adverse effects of screening. Therefore it is essential to develop the quality assurance initiative.”

In order to attain, maintain and continuously improve the quality of the service, CSW is committed to total quality management, whereby quality issues are integral to every aspect of the organisation.

CSW adheres to the NHS Cancer Screening Programme (NHSCSP) standards as set out in Section 2.2. CSW also complies with the NHSCSP guidelines, which include the standards and targets for performance and outcome of the programme, for cervical screening pathology laboratories, colposcopy service and administrative systems for technical and individual professional performance, modifying these where appropriate to reflect the organisational and operational differences of the programme in Wales.

CSW complies with all appropriate legislation.

Where appropriate, the quality standards contained in this manual apply equally to all women who receive a service from CSW, including those who present opportunistically or are referred from the private sector or cross referred from within the NHS.

It is accepted that there will be exceptional circumstances when clinical judgement indicates that there should be a departure from a standard and/or operational procedure, as outlined in this manual. All such departures must be documented and notified to CSW Regional Programme Coordinator and if appropriate the Programme Manager or Director, so that:

- Any quality and/or risk management issues may be identified
- Future policy can be considered
- The documentation in this manual can be reviewed

1Q.40. MANAGEMENT STRUCTURE

1Q.40.1. Organisational Status

Cervical Screening Wales (CSW) is a discrete service incorporated within Screening Services part of Public Health Wales NHS Trust (PHW).

1Q.40.2. CSW - An All Wales Organisation

On 1 April 1999, the Welsh Office gave CSW responsibility for all aspects of the cervical screening programme provided to women resident in Wales, including:

- Programme management and coordination
- Call and recall arrangements
- Cervical cytology services
- Cervical histology services
- Colposcopy services

The Director of CSW has overall responsibility for all of the above elements of the programme, including those which are provided by other NHS Trusts in Wales and England. The Director is managerially accountable to the Chief Executive of Public Health Wales Trust. The Director reports to the National Assembly for Wales (NAW), Business Service Centres (BSC) and Local Health Boards (LHBs) on the performance of the programme and ensures the production of a CSW Director's Report.

CSW features clear lines of direct accountability, which cross organisational boundaries. As stated above, CSW has responsibility for all aspects of the cervical screening programme provided to women resident in Wales. This overall responsibility requires all staff working in every element of the programme to be accountable to the Director of CSW, either directly or via an agreed line management structure, for the quality of the work that they undertake as part of the programme. This includes relevant staff employed local trusts. This accountability is illustrated below:

The Trust is responsible for the clinical governance of all elements of the cervical screening programme, except in clearly defined circumstances. CSW monitors the quality of the service provided by each element of the programme, including those elements provided by other trusts.

CSW commissions cervical cytology and colposcopy services from trusts. Long Term Agreements (LTAs) specify that each trust service complies with the relevant elements of the All Wales Cervical Screening Policy, All-Wales Cervical Screening Standards and All-Wales Cervical Screening Protocols and procedures outlined in this manual.

1Q.40.3. Director

CSW is headed by a Director, who has overall responsibility for the management, quality assurance and evaluation of all aspects of the cervical screening programme in Wales. The Director chairs CSW's All Wales Management Group.

1Q.40.4. All Wales Management Group

The All Wales Management Group (AWMG) meets at least 4 times a year. It is CSW's main decision-making body and deals with strategic issues at an all Wales level. The membership of the AWMG is:

- Director (Chair)
- Programme Manager
- Senior Managers:
 - Head of Business and Service Development
 - Head of Information
 - Head of Nursing
 - Head of Administration
- Finance Manager
- Director of Welsh Cytology Training School
- QA Pathologist
- QA Colposcopist
- Regional Programme Coordinators
- Cytology Manager and Technical Advisor
- GP representative
- Human Resources Officer
- Head of Communications
- HSW/Screening Systems Support Advisor
- Lead CSAD Manager
- Nurse Coordinator Team Leader
- Trust Representation:
 - Director of Finance
 - Director of Personnel

1Q.40.5. Joint Coordinators Group

The Joint Coordinators Group is a sub-group of the AWMG. It meets quarterly. The membership of the JCG is:

- Director
- Programme Manager (Chair)
- Head of Nursing
- Regional Programme Coordinators
- Lead CSAD manager
- Regional Nurse Coordinators
- Information Analyst

1Q.40.6. Local Management Groups

Within each of CSW's geographical divisions there is a Local Management Group (LMG) which aims to meet quarterly. The LMGs are accountable to the AWMG and have delegated responsibility for local operational management and programme planning. The membership of each LMG is:

- Regional Programme Coordinator (Chair)
- Programme Manager
- Local CSAD Manager
- Local CSAD clerical support
- Regional Nurse Coordinators
- Cervical Cytology Managers
- Lead Pathologists
- Lead Colposcopists
- Lead colposcopy nurses
- GP representative

Other members of staff may be co-opted onto LMGs as appropriate.

The Director delegates the Programme Manager (or any other CSW senior manager) and the Regional Programme Coordinator who is also a member of the AWMG to attend each meeting of an LMG, for communication and feedback.

1Q.40.7. Line Management Arrangements

The organisational structure is illustrated at the end of this section.

The Director is managerially accountable to the Chief Executive of Public Health Wales NHS Trust. There are line management relationships linking the Director with all directly employed staff. The CSW Programme Manager and Regional Programme Coordinators, Head of Administration, Head of Information and Head of Nursing are all directly managerially accountable to the Director or Deputy Director. The Finance Manager, although directly responsible to the Trust for financial matters, is also managerially responsible to the Director. The Head of Business and Service Development is accountable to the Director but line managed by the Director of Operations and Service Development for Public Health. The Manager of the Welsh Cytology Training School is accountable to the Director of the School but is line managed by the CSW Programme Manager.

The Head of Administration has managerial responsibility for the lead CSAD manager. The lead CSAD manager is responsible for a CSAD manager in each division and also undertakes the role of a local CSAD manager. The CSAD managers are responsible for all local secretarial and CSAD staff.

The Head of Information has managerial responsibility for the Information and Evaluation team.

The Head of Nursing has managerial responsibility for the Regional Nurse Coordinators in each CSAD.

The Finance Manager has managerial responsibility for his/her supporting staff.

The Head of Business and Service Development has managerial responsibility for the Business Manager.

1Q.40.8. Professional Responsibilities

Individual clinicians within the cervical screening programme have personal professional responsibility for the clinical work they undertake.

Some staff groups have professional responsibilities in parallel with the line management structure.

Specialist advisors are accountable to Programme Manager for cervical screening relevant responsibility.

1Q.40.9. Clinical Governance

The quality system, as documented in this manual, is the main instrument by which corporate responsibility and accountability are exercised for clinical issues within CSW. Management arrangements for clinical governance are aligned with the quality assurance and line management structures.

1Q.40.10. Risk & Assurance Framework

The risk and assurance framework is designed to manage risk to a reasonable level rather than to eliminate all risk. The framework is based on an ongoing process designed to identify and prioritise risks to the achievement of organisational policies, aims and objectives, to evaluate the likelihood of those risks being realised and their impact, and to manage them efficiently, effectively and economically. The risk framework includes standards for clinical risk management, including clinical audit and clinical incidents, complaints and claims recording, investigation and analysis.

The Welsh Risk Pool (WRP) encourage good risk management practice by supporting the development of risk management systems by providing advice, developing education in healthcare risk management and facilitating the exchange of information on good practice and lessons learnt through the Risk Managers and Claims Managers Network meetings.

The Healthcare Standards for Wales (HCS) provide the organisation with a self assessment tool to support the risk and assurance framework. The healthcare standards are used by Healthcare Inspectorate Wales (HIW) as part of their processes for assessing the quality, safety and effectiveness of healthcare providers and commissioners across Wales.

The Screening Services Risk Management Group oversees the risk management of the screening services. Membership of this group includes:

- Director
- Deputy Director
- Head of Administration
- Associate Director for NBHSW
- BSW Programme Manager
- BTW Programme Manager
- ASW All Wales Programme Coordinator
- CSW All Wales Programme Manager
- Head of Nursing
- Head of Business and Service Development
- Risk, Health, Safety and Clinical Governance Manager
- Information Governance Manager

Hazards arising from clinical risks and Health and Safety have been considered throughout the CSW quality system. Any deviation from them (or 'near miss') must therefore be reported and assessed following the Trust incident and accident reporting procedures.

The concept of “acceptable risk” is inherent in the organisational framework of CSW. The ethical considerations of screening are such that, unlike the acute services, CSW cannot accept any risk other than those considered in the programme framework, which is already set within the parameters of national screening policy. All recognised risks are, therefore, managed and monitored throughout the CSW quality system.

Additionally, even a “minor” incident may have the potential for serious consequences:

- The high level of activities increases the likelihood of incidents re-occurring
- Even relatively trivial incidents may be inflated by media interest

1Q.40.11. Whistleblowing procedure

The Screening Services Whistleblowing procedure relates to concerns where the interests of others, and/or those of the Trust itself are at risk and is designed to encourage staff to raise concerns about malpractice at an early stage and in the right way.

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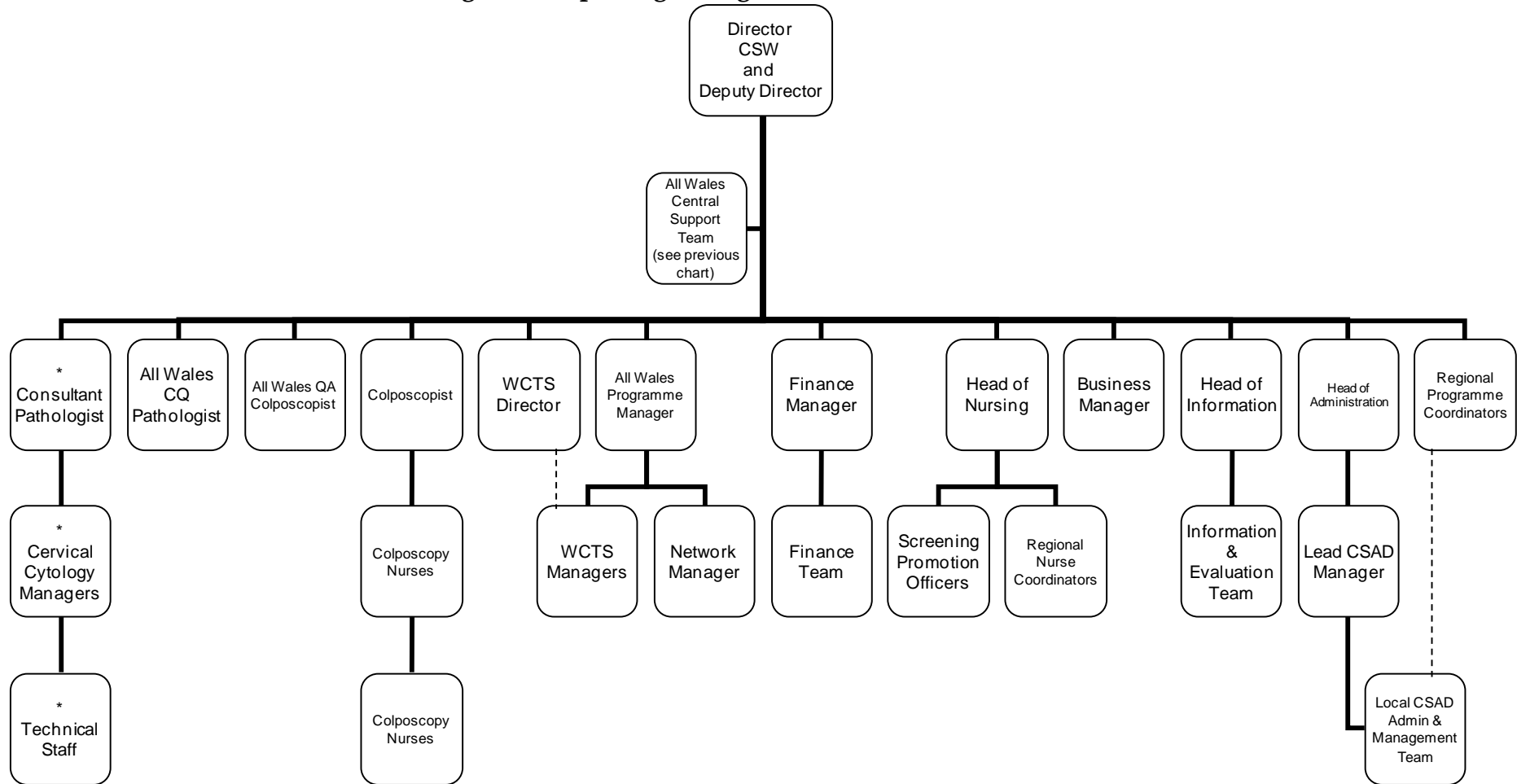
1Q.40.12. Complaints procedure

The Screening Services complaints procedure outlines the process of complaints handling within CSW which is in line with the Trust policy.

All trusts in Wales who contract with CSW for laboratory services **must** inform the Director immediately, both verbally and in writing, of any complaint or legal correspondence received by the Trust which relates to any services covered by the LTA.

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CERVICAL SCREENING WALES - line management reporting arrangements



* Whilst working within the programme

1Q.50. QUALITY ASSURANCE STRUCTURE

1Q.50.1. Relationship between Quality Assurance and Management Structures

The AWMG is responsible for reviewing the CSW quality system, monitoring CSW's compliance with the quality system and recommending appropriate action. All QA advisers are members of the AWMG.

The AWMG considers reports from QA advisers (including quality audits), revisions to documentation, and quality improvement initiatives.

All QA advisers retain ultimate responsibility to the Director for these functions.

Local Management Groups (LMG) are established in each of the five CSW areas. The LMGs are managerial rather than representative groups and will be responsible for problem solving and policy implementation at a local level.

1Q.50.2. QA Role of the Director

The Director has overall responsibility for the quality of all aspects of the cervical screening programme provided by CSW. The Director also represents CSW on the NHSCSP Quality Assurance Directors' Group.

1Q.50.3. QA Role of All Staff

All members of staff working within the cervical screening programme have an individual responsibility to comply with the requirements of the CSW quality policy and to maintain and increase the quality of the services that they provide.

1Q.50.4. QA Advisers

For each professional group an individual is designated as a QA adviser with specific responsibility for ensuring that quality is maintained in line with the requirements of the quality policy. The QA advisers are:

- Programme Manager
- QA Pathologist
- QA Colposcopist
- Regional Programme Coordinators
- Head of Nursing
- Head of Administration
- Head of Information
- Finance Manager

Additionally, Regional Programme Coordinators play a pivotal role in the monitoring and assessment of all aspects of local programme performance.

QA advisers are responsible for:

- Reviewing the quality of the relevant part of the service, across Wales, using information and data collected and collated for the purpose
- Keeping the Director and/or appropriate line manager informed about the performance of the relevant part of the service
- Bringing quality deficiencies to the attention of the Director and/or appropriate line manager
- Recommending corrective action as necessary and verifying the outcome of any action taken
- Providing feedback on quality to colleagues
- Advising colleagues on ways of improving quality
- Convening meetings of the relevant quality related group(s)
- Encouraging the continuous professional development of colleagues
- Co-ordinating the introduction of agreed policies and procedures
- Performing quality audits
- Representing CSW on national QA-related committees within the NHSCSP
- Feeding back information from the NHSCSP to colleagues

1Q.60. CONTROL OF DOCUMENTS

1Q.60.1. Scope

The Cervical Screening Wales Quality Manual details the quality manual process as well as detail standard operating policies and procedures for the cervical screening programme. The Quality Manual is subject to a control procedure designed to ensure that all copies remain up to date and are identical to the master copies held electronically on quality share and the intranet. This procedure is managed by a Quality Manager or his/her designate who is responsible to the Programme Manager.

Many other documents also have an effect on, or influence the quality of CSW's activities. These include:

- Host Trust Policies
- Procedures
- Local work instructions and notices
- Forms for recording information

1Q.60.2. Standard

The Quality Manual is controlled so that:

- The current version is available electronically and is not amendable, except in a documented, controlled manner by a designated person.
- Printed versions are marked as "out of date". It is the responsibility of individuals printing the document to check if any changes have been made electronically.
- A copy of each out-of-date version can be retained by the responsible manager for reference purposes. The dates for which each version was valid are recorded in a standardised manner. All documents either electronic or hard copy, are marked "INACTIVE"
- Changes are approved by an appropriate person prior to issue

1Q.60.3. Protocol

Quality Manual document

The Quality Manual document includes, as a minimum, the following information:

- Date of issue
- Filename
- Version
- Date of issue
- Date of next review
- Full review history and by whom
- Full detailed procedure or guidance
- Person(s) responsible
- Risk and/or COSHH assessments (if appropriate)

The Quality Manager for the Quality Management System or his/her designate will inform the author of a document when the document is due for review. The author is responsible for ensuring that the current version is issued to all relevant staff participating in the review. The Quality Manager (QM) or his/her designate will ensure that out-of-date versions are removed. The author will provide details of any changes to the QM or designate so that a controlled record of any changes made are maintained according to Standard Operating Procedure (SOP – REF).

All drafts or discussion documents are clearly marked as such to avoid confusion with approved documents.

Documentation is inspected as part of the audit procedure to verify that it conforms to the standard.

The manual is controlled via the Quality Manual Review Group (QMRG) which will co-ordinate the update process. The membership of QMRG is:

- Quality Manual Manager (Scientific Adviser to CSW)
- Quality Manual Controller (Corporate Projects Coordinator)
- Personal Assistant to Programme Manager
- Programme Manager
- Head of Administration
- *QA Pathologist
- *QA Colposcopist
- Regional Programme Coordinator(s)
- Lead CSAD Manager
- Team lead Nurse Coordinator/ Training Manager

*The QA Pathologist and QA Colposcopist will not be expected to regularly attend QMRG.

The QMRG meets on a quarterly basis to review, amend and make additions to component documentation within each manual. These may arise from:

- Identification of “best practice”
- Changes to CSW policies and procedures
- Incidents and near-misses
- Suggestions from staff for improvement of quality
- Identification of errors and omissions

The QM or designate maintains a list of amendments and tracks progress through the various stages of consultation. Draft amendments are issued to key groups/staff members for consultation as agreed by QMRG members. All draft amendments are submitted to AWMG, and then to the Director for final approval. Urgent or minor amendments may be submitted directly to the Director for final approval. The QM or designate

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then updates the electronic version and issues notification to service. The QM or designate will maintain an archive of old and current versions.

1Q.70. RESPONSIBILITIES

1Q.70.1. Introduction

This section specifies the quality standards, quality controls and quality audits individual members of staff have, or share, overall responsibility for.

It should be read in conjunction with the chart on the next page which illustrates the Cervical Screening Wales (CSW) line management structure and with Section 1 of this manual.

1Q.70.2. Individual Responsibilities

The responsibilities fall within the following categories:

Managerial Responsibility

The individual's responsibility as a manager, whether as a line manager or for a particular area of work, always includes his/her responsibility for quality. If the area of work involves key skills other than those held by the person with managerial responsibility, the additional QA adviser(s) is/are identified.

QA Responsibility

The individual's responsibility (as QA Adviser) for advice to the Director and to the person holding the managerial responsibility.

Clinical Responsibility

The personal, professional responsibility for the clinical work undertaken by the individual.

Involved as operational staff

Key groups of staff are listed. Other staff may be involved. All staff, whether listed or not, hold an individual responsibility for the quality of the service they provide.

1Q.70.3. Other Responsibilities

The following responsibilities are additional to, and often complementary to, those listed above. They are aligned with the quality assurance and line management structures and are not specifically documented in this manual.

Risk Management and Health and Safety

The Director is responsible for all risk management and health and safety matters within the Division.

Responsibility for Health and Safety is delegated through the line management structure and is managed through the Screening Services

Health and Safety Committee and Local Management Groups.
Management of Health and Safety is set out in the Screening Services Health and Safety Policy.

Controls Assurance

The Director is responsible for the implementation of Controls Assurance within CSW. The development of Controls Assurance standards may lead to new responsibilities being vested in managers within the Division. These will be specified in the individuals' job descriptions.

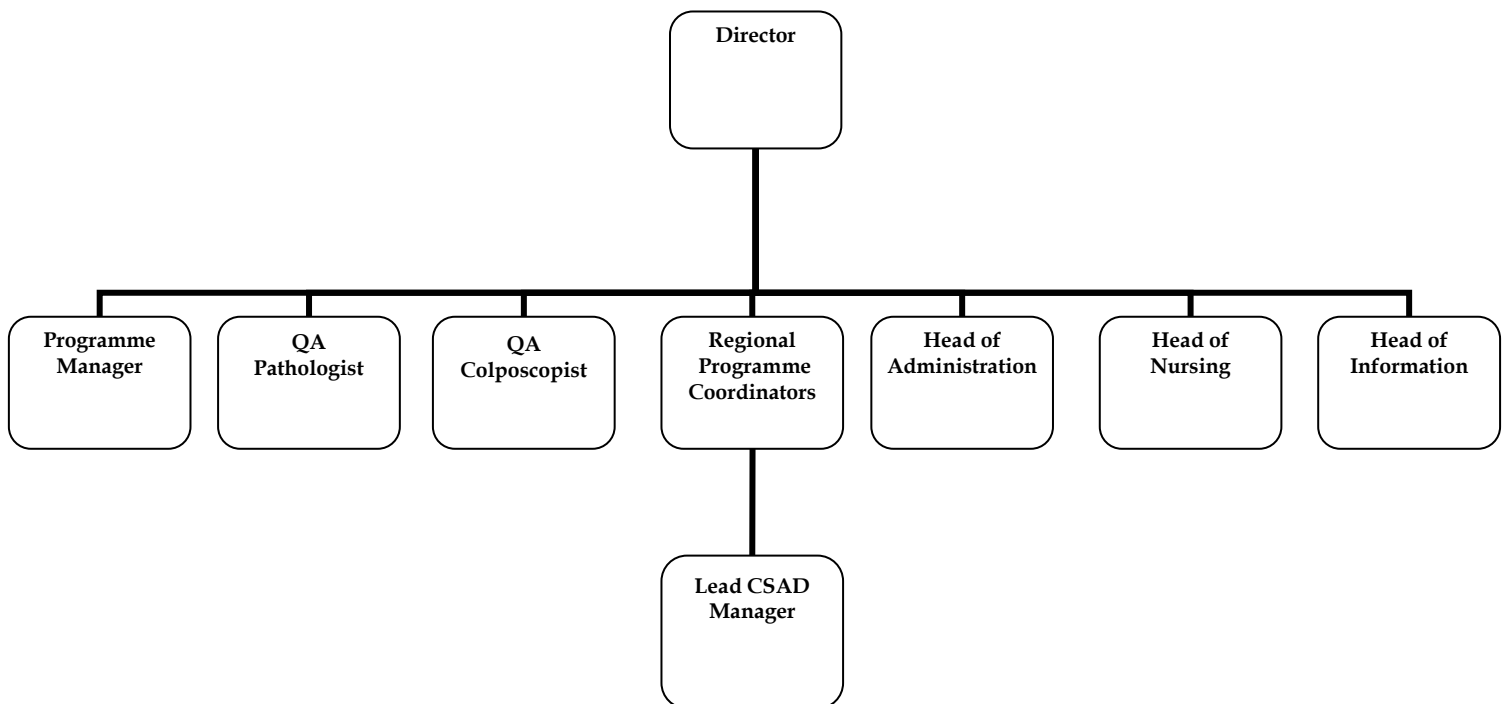
Caldicott Guardian

The Director of the Public Health Division is designated as the Caldicott Guardian. The Head of Information supports the Director in the implementation of this role.

1Q.70.4. Delegation of Responsibilities

In general, managerial responsibility for processes is held by the appropriate senior line manager, as shown in the line management chart in section 1.4. However, the responsibility for certain defined processes is delegated, as specified in the following sections.

The chart below shows staff holding QA responsibilities, as specified in the following sections:



1Q.70.5. Director

The Director of Screening Services has overall responsibility for all aspects of cervical screening in Wales.

The Director retains overall managerial responsibility for all quality standards, controls and audits as documented in this manual, including those, which are delegated to identified managers.

The Director will report on the performance and delivery of the programme and will ensure the production of a periodic CSW Report.

The Director will represent CSW on national committees.

1Q.70.6. Programme Manager - Cytology

The QA Manager post is integrated with the Programme Manager post. The Programme Manager is responsible for all quality standards, controls and audits in relation to pathology. In addition to this the post holder is responsible for standards relating to those staff he/she line manages.

The All-Wales QA Manager will be responsible for:

- Providing professional advice to the Director and the AWMG
- Liaising with and supporting the Cervical Cytology Managers and other technical staff working within cervical cytology and histology
- Developing, running and overseeing a range of QA and proficiency testing schemes, in liaison with the All-Wales QA Pathologist and QA Colposcopist
- Reporting to the Director on the performance of individuals and services within CSW
- Investigating cases where the performance or competence of individuals is called into question
- Taking a lead role in service development
- Liaising with the Welsh Cytology Training School in the development of appropriate courses representing CSW on relevant external groups

1Q.70.7. Cervical Cytology Managers

The Cervical Cytology Manager (CCM) is responsible to the Lead Pathologist for managing the delivery of cervical screening in the provider Trust. The CCM liaises with the Regional Nurse Coordinator in maintaining a quality assured service and is the main link within the Trust for CSW.

1Q.70.8. QA Pathologist

The QA Pathologist advises CSW on the development of screening policy through the All Wales Management Group. The post holder will:

- Advise on policy development and implementation
- Advise on quality systems within pathology
- Providing professional advice to the Director and the AWMG
- Liaising with and supporting all pathologists working in the programme
- Developing and overseeing cytology and histology QA and audit arrangements
- Advising the Director on the performance of pathologists working within CSW
- Ensuring that appropriate investigations are carried out where the performance of a laboratory, or individuals working within a laboratory, is questioned
- Representing CSW on relevant external groups

1Q.70.9. Lead Pathologist

The Lead Pathologist is responsible for ensuring that pathology services including cytology and histology are provided to CSW to the required standard. They work closely with the Cervical Cytology Manager in delivering pathology services and directly accountable to the Director for the services provided to the screening programme.

1Q.70.10. All Pathologists

Pathologists are responsible for maintaining the standard and quality of services provided to CSW. Pathologists are directly accountable to the Director whilst working within the screening programme.

1Q.70.11. QA Colposcopist

The QA Colposcopist advises CSW on the development of screening policy through the All Wales Management Group. The post holder will:

- Advise on policy development and implementation
- Advise on quality systems within colposcopy
- Providing professional advice to the Director and the AWMG
- Liaising with and supporting all colposcopists working in the programme
- Developing and overseeing colposcopy QA and audit arrangements;
- Advising the Director on the performance of colposcopists working within CSW
- Ensuring that appropriate investigations are carried out where the performance of a colposcopy service, or individuals working within a colposcopy service, is questioned
- Representing CSW on relevant external groups

1Q.70.12. Lead Colposcopists

The Lead Colposcopist is responsible for ensuring that colposcopy services including diagnosis and treatment of cervical abnormalities are provided to CSW to the required standard. They liaise with the Regional Nurse Coordinator in delivering the service and are directly accountable to the Director for the services provided to the screening programme.

1Q.70.13. All Colposcopists

Colposcopists are responsible for maintaining the standard and quality of services provided to CSW. They are directly accountable to the Director whilst working within the screening programme.

1Q.70.14. Regional Programme Coordinators

Each screening division will be led by a Regional Programme Coordinator who will be responsible for:

- Chairing the Local Management Group
- Acting as the clinical and medical adviser to the local Cervical Screening Administration Department
- Overseeing and coordinating all of the elements of CSW within the screening division
- Liaising closely with, and providing relevant advice to, smear takers, laboratories and colposcopy services
- Ensuring that links between the different elements of the programme are optimised
- Monitoring the performance of smear takers, laboratories, and colposcopy services against defined standards
- Informing CSW and taking agreed action in cases where the performance of smear takers, laboratories and colposcopy services do not meet the defined standards. Such action should be taken in liaison with other professionals within the screening programme such as the Regional Nurse Coordinator
- Work with the Regional Nurse Coordinator
- Ensuring the implementation of local FailSafe arrangements

Individual Regional Programme Coordinators will also carry out specific tasks and lead projects at an all-Wales level and may represent CSW on relevant external groups.

1Q.70.15. Head of Nursing

The Head of Nursing has responsibility for the Quality Standards, control and audit for the nursing role within the programme. The post holder ensures that appropriate monitoring, training and consultation processes are in place for smear takers through the line management of the Regional Nurse Coordinators.

1Q.70.16. Regional Nurse Coordinators

The Cervical Screening Regional Nurse Coordinator works closely with the Regional Programme Coordinator on the delivery of the services particularly in relation to monitoring and training of smear takers:

- Ensuring the local delivery of initial and update training for smear takers, in line with all-Wales protocols
- Liaising closely with, and providing relevant advice to, smear takers, laboratories and colposcopy services
- Monitoring the performance of smear takers as per guidelines and agreed standards
- Informing the Regional Programme Coordinator and taking agreed action in cases where the performance of smear takers do not meet the defined standards
- Address identified incidents and discrepancies with smear takers
- Plan and deliver initial and update training to all smear takers, in line with all-Wales protocols
- Plan and deliver training to other health professionals requiring cervical screening information
- Work closely with Screening Promotion Team to inform women about cervical screening, particularly in low uptake areas

Individual Regional Nurse Coordinators will also carry out specific tasks and lead projects at an all-Wales level and may represent CSW on relevant external groups

1Q.70.17. General Administration

1Q.70.17.1. Head of Administration

The Head of Administration has responsibility for all quality standards, controls and audits where:

- He/she is identified as managerially responsible (see below), or
- Line manages the person managerially responsible

1Q.70.17.2. Lead CSAD Manager

The Lead CSAD Manager reports to the Head of Administration and line manages local CSAD managers. The post holder assists the Head of Administration in co-ordinating and developing quality standard, controls and audits.

The Lead CSAD Manager has direct responsibility for the delivery of the local administration service and works closely with the Regional Programme Coordinator and Regional Nurse Coordinators.

1Q.70.17.3. CSAD Manager

CSAD Manager has direct responsibility for the delivery of the local administration service and works closely with the Regional Programme Coordinator and Regional Nurse Coordinators.

1Q.70.18. Head of Information

The Head of Information has responsibility for ensuring adherence, within CSW, to Trust and professional information systems including quality standards, controls and audits where:

- He/she is responsible for the strategy and management of information and information systems within Screening Services
- The post holder is responsible for providing functional information technology systems, ensures training and development, maintains confidentiality and security issues, and manages the Information Team

1Q.70.19. Finance Manager

The Finance Manager has responsibility for ensuring adherence, within CSW, to Trust and professional financial quality standards, controls and audits where:

- He/she is managerially responsible, or
- Line manages the person managerially responsible

1Q.70.20. Head of Business and Service Development

The Head of Business and Service Development provides:

- Wide-ranging support to the Director
- Advice on planning issues and the ongoing development of the screening programme
- Develop, negotiate and implement service agreements with other organisations

1Q.80. QUALITY STANDARDS - HUMAN RESOURCES

1Q.80.1. Introduction

This section sets out quality standards for CSW's human resources, including establishments, job descriptions, recruitment, selection and training.

1Q.90. ESTABLISHMENT AND STAFFING LEVELS

1Q.90.1. Managerial Responsibility

All line managers

QA Adviser

If the line manager is not the (only) QA Adviser for that group of staff, then the appropriate QA Adviser should be consulted.

1Q.90.2. Quality Standard

All staff

Staffing levels are sufficient to ensure that all required functions can be carried out to the relevant quality standards. Further detail on specific roles within the screening programme are defined within the relevant professional sections.

1Q.90.3. Method

For staff directly managed by Screening Services planned establishments are produced annually by the manager responsible, based on predicted workload. All plans, and in year changes to plans, are approved by the relevant all Wales manager.

Business cases for any increases in establishment are submitted to the Director for approval and then to the Chief Executive if a request for funding from the Trust reserves is being made. At the discretion of the Director, cases may also be considered by the AWMG.

Establishment changes are made in line with The Trust policies and planned changes are included in the Trust Plan.

1Q.90.4. Quality Control and Audit

Comments and suggestions from women

Complaints

Consumer satisfaction surveys

Monthly performance indicators

Quarterly performance indicators

Performance indicators for Trust Board

1Q.100. CONTRACTS, JOB DESCRIPTIONS & PERSON SPECIFICATIONS

1Q.100.1. Managerial Responsibility

All line managers

QA Adviser

If the line manager is not the (only) QA Adviser for that group of staff, then the appropriate QA Adviser should be consulted.

1Q.100.2. Quality Standard

All staff

All posts are covered by an up to date written job description. All job descriptions include statements about:

- The title of the person to whom the post holder is responsible
- The CSW quality system
- The SS health and safety policy
- Competency
- Supervision (where appropriate)
- Confidentiality and security

All members of staff are issued with terms and conditions of service within 2 months of taking up post.

A person specification is produced for each post prior to recruitment.

Where the appropriate professional organisation details a requirement in relation to supervision, the postholder ensures compliance with this requirement.

QA Advisers

All QA advisers have a specific section within their job description outlining their responsibilities as QA adviser.

1Q.100.3. Method

The Trust 'Recruitment and Selection Procedure' is followed.

The line manager prepares a written job description and person specification for each post prior to recruitment. Existing job descriptions are updated in consultation with the post holder to reflect significant changes in the job.

The relevant QA adviser (if not the line manager) provides advice on the content of job descriptions and person specifications.

Where the appropriate professional organisation details a requirement in relation to supervision, the line manager ensures the postholder is aware of their responsibility to comply with this requirement.

1Q.110. RECRUITMENT, SELECTION AND LEAVING THE SERVICE

1Q.110.1. Managerial Responsibility

All line managers

QA Adviser

If the line manager is not the (only) QA Adviser for that group of staff, then the appropriate QA Adviser should be consulted.

1Q.110.2. Quality Standard

All directly employed staff

All staff recruited are capable of working to a high standard after appropriate training.

All elements of the recruitment and selection process are fair and comply with relevant legislation.

On leaving the service, all staff return CSW property and security measures are taken as appropriate.

1Q.110.3. Method

The personnel department is involved in all recruitment. The Trust Recruitment and Selection Procedure is followed. Selection procedures include at least the following elements:

- Consideration of application forms
- Interviews
- The taking up of references

All staff involved in the recruitment and selection process are aware of relevant legislation.

Prior to the member of staff leaving the service, the centre co-ordinator completes a 'leavers checklist' to ensure all CSW property is returned and appropriate security measures are taken if appropriate. Actions may include changing door codes and computer system passwords.

1Q.110.4. Further Guidance

Trust Recruitment and Selection Procedure

1Q.120. INDUCTION AND COMPETENCE

1Q.120.1. Managerial Responsibility

All line managers
Operational Staff
All Staff
QA Adviser
Director

1Q.120.2. Quality Standard

CSW is founded on recognition that a screening programme needs clear management, monitoring and quality assurance.

Managers must ensure that staff are fully competent to perform the tasks that they are undertaking. Additionally, it is the responsibility of each staff member to declare any concerns and seek assistance if the task that they are engaged in exceeds their level of competence.

1Q.120.3. Method

Induction

All newly directly employed staff receive comprehensive induction training as specified in the Velindre and Screening Services Induction policy and procedure. An induction checklist is completed on induction and signed by the member of staff and their line manager to demonstrate that training has been undertaken.

Clinical staff receive appropriate induction training according to their post and experience.

Managers ensure that all temporary staff receive induction training in line with the CSW Induction policy and procedures. It is recognised that with temporary staff time scales may be limiting but as an absolute minimum.

Competence

Screening staff must be able to demonstrate and maintain their basic and continuing competence. Minimum performance criteria are established in CSW Standard Operating Policies and Procedure documents (SOPPs). This is supported by the Individual Performance Review (IPR) process.

A statement on risk management, supervision and competence is included in all job descriptions.

Risk Management

“You have a responsibility for reducing and controlling non-clinical and clinical risks for those areas under your responsibility”.

Supervision

“Where the appropriate professional organisation details a requirement in relation to supervision, it is the responsibility of the postholder to ensure compliance with this requirement. If you are in any doubt about the existence of such a requirement speak to your Departmental Manager”.

Competence

“You are responsible of limiting your actions to those which you feel competent to undertake. If you have any doubts about your competence during the course of your duties you should immediately speak to your line manager/supervisor”

As part of the quality assurance of the programmes, BTW/CSW staff are subject to a wide range of hard measures of individual performance against specific (and in many cases, national) process objectives and standards on a continual basis. These measures form the basis for rigorous clinical audit and programme evaluation.

Training and Appraisal

The recognition of the importance of continuing development and lifelong learning as part of quality assurance are fundamental aspects of the culture of both organisations. Continuing development needs for all directly employed staff are identified largely through the individual performance review process. The line managers maintain records of training events and all professional staff are encouraged to maintain their own continuing development portfolios.

Training is supported through realistic budget allocations for all groups of staff, appropriate to their training needs. As far as possible, time for study leave and in house training is built into screening schedules.

Performance

Individuals who are concerned about their performance standards should self refer to their line manager. Line managers should treat such requests sympathetically and confidentially.

Capability

Capability/poor performance issue are dealt with in a fair and consistent manner according to Velindre Trust Capability Policy and Procedure.

1Q.120.4. Quality Measures

- 100% of staff receive induction training by their line manager in accordance to the Screening Services Induction policy and procedure
- 100% of newly appointed staff and line managers follow the induction check list and sign off actions at appropriate time intervals
- 100% of staff job descriptions include a statement on competence

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- 100% of staff are aware that if they are concerned about their performance they should inform their line manager immediately
- Managers take appropriate action with regard to competence issues

1Q.120.5. Quality Control and Audit

Screening Services audit of induction processes

Induction handbook to be completed and signed by all new members of staff to confirm that training has been received

Audit of Job descriptions

Induction Policy and induction documents reviewed regularly

1Q.120.6. Further Guidance

Screening Services Induction policy and procedure

Screening Services Induction Workplace Handbook

Trust policy on Individual Performance and Review

1Q.130. TRAINING FOR DIRECTLY EMPLOYED STAFF

1Q.130.1. Managerial Responsibility

All line managers

QA Adviser

If the line manager is not the (only) QA Adviser for that group of staff, then the appropriate QA Adviser should be consulted

1Q.130.2. Quality Standard

All staff receive sufficient initial and subsequent training to enable them to provide a high quality service.

1Q.130.3. Method

All directly employed staff

The Trust Training and Development Strategy is followed.

Training needs are considered as part of the Individual Performance Review system and are incorporated into a personal development plan for each member of staff.

Training needs are considered in relation to the needs of the individual and the objectives of CSW.

The Trust Study Leave Policy and Guidelines are adhered to.

All training is evaluated to determine the benefits to the individual and to CSW.

Records of all training are maintained. These records may be kept in the personnel file of each member of staff. All attendance records for statutory, mandatory.

1Q.130.4. Quality Control and Audit

Review of training assessment sheets

Comments and suggestions from women

Complaints

1Q.130.5. Further Guidance

Trust Training and Development Strategy

Trust Study Leave Policy and Guidelines

1Q.140. INDIVIDUAL PERFORMANCE REVIEW

1Q.140.1. Staff Responsible

All line managers

1Q.140.2. Relevant Quality Standard

All standards

1Q.140.3. Frequency

At least annually, with frequent in-year reviews

1Q.140.4. Method

All directly employed staff participate in individual performance reviews in line with the knowledge and skills framework (KSF) with the appropriate line manager.

Each review considers as one of its elements the individual's compliance with the requirements of this Quality Manual.

Each member of staff has an annual objective setting meeting with their line manager at which an individual personal training and development plan is drawn up. Amongst the objectives set for each individual will be those related to quality.

Individual performance against these objectives and general compliance with the requirements of this Quality Manual are reviewed at further meetings during the year.

Each member of staff is encouraged to feed back to the line manager comments on any issues relating to the quality and/or operation of the service.

Job descriptions and KSF outlines are updated to reflect any significant agreed changes to the role.

1Q.140.5. Records

Records of each individual's objectives and training plans and of the review and revised job descriptions are made by the line manager and copied to the individual.

All records are retained in accordance with Velindre Trust Procedures.

1Q.140.6. Action

If the line manager detects any deficiencies or deterioration in performance, or is informed of any failures to meet quality standards, he/she initiates corrective action.

1Q.150. CAPABILITY AND COMPETENCE

1Q.150.1. Managerial Responsibility

All line managers

1Q.150.2. Quality Standard

All staff are capable of carrying out their duties competently.

All staff limit their actions to those which they feel competent to undertake.

Capability/poor performance issues are dealt with in a fair and consistent manner according to Trust policy.

A process is in place for managing capability issues around staff not directly employed by Velindre Trust but working for the CSW programme.

1Q.150.3. Method

Directly managed staff

Line managers ensure that all staff are made aware of their duty to limit their actions to those which they feel competent to undertake.

Where working patterns, work rotas, minimum workloads and/or update training are relevant to the maintenance of competence, the line manager ensures that these are complied with.

If staff have any doubts about their competence in the course of their duties they immediately speak to their line manager. The manager addresses any training needs or other measures that will support the member of staff in attaining and maintaining their competence.

The principles and actions relating to issues of poor performance or capability (other than those relating to ill health, misconduct, misrepresentation, legal restriction and probationary periods) are set out in full in the Velindre Trust Capability Policy and Procedure.

Initially, poor performance will be approached by the manager with a view to improving the individual's performance. The dismissal of an employee would only be considered after all other avenues had been explored.

Staff not directly employed by CSW

The competence of staff not directly employed by The Trust but working for CSW will be managed via the host Trust through the quality monitoring systems outlined in Long Term Service Agreements.

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All temporary staff working in the programme are required to demonstrate to CSW that they are adequately training and/or qualified to undertake specific roles.

1Q.150.4. Quality Control and Audit

Compliance with Long Term Agreements

Quarterly performance reports

Audit procedures

Accreditation processes and QA visits

1Q.160. QUALITY STANDARDS - PHYSICAL RESOURCES

1Q.160.1. Introduction

This section sets out quality standards for Cervical Screening Wales (CSW's) physical resources, including accommodation, equipment and publicity materials.

1Q.170. ACCOMMODATION - CSAD

1Q.170.1. Managerial Responsibility

CSAD Manager

1Q.170.2. Quality Standard

The accommodation:

- Is kept in a good state of repair and decoration and is clean and tidy
- Provides a pleasant environment for staff to work in
- Is kept in a safe condition and complies with all relevant health and safety policies
- Provides appropriate access and facilities for the disabled

1Q.170.3. Method

Significant changes to the configuration or decoration of the accommodation are agreed by the Joint Coordinator Group (JCG), with approval being given by the AWMG.

The CSAD Manager:

- Is responsible for managing the implementation of any agreed changes
- Ensures that the accommodation is subject to a programme of planned preventative maintenance and decoration
- Arranges for other maintenance, repairs and decoration to be carried out promptly and to a high standard
- Ensures that the accommodation is cleaned regularly to a high standard

1Q.170.4. Quality Control and Audit

- Whole Workplace Risk Assessment Process
- Screening Services Health and Safety Committee

1Q.170.5. Further Guidance

Screening Services Health and Safety Procedure

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1Q.180. ACCOMMODATION – COLPOSCOPY SERVICES

Further details can be found in the Colposcopy section of this manual (5C.40).

1Q.190. TELEPHONE AND FAX SYSTEMS

1Q.190.1. Managerial Responsibility

CSAD Managers

1Q.190.2. Quality Standard

The telephone system:

- Has sufficient internal lines and extensions are available
- Provides direct lines for relevant staff
- Includes a fax machine

1Q.190.3. Methods

New telephone and fax equipment and facilities are selected by the CSAD Manager, with approval for large items being given by the AWMG.

The CSAD Manager:

- Liaises with the host organisation for the procurement, installation and acceptance testing of telephone equipment
- Arranges or liaises with the host organisation for service contracts in accordance with the manufacturer's recommendations and keeps records of servicing

1Q.190.4. Quality Control and Audit

- Incident Reporting
- Local Management Team Reporting
- CSAD Managers Meetings

1Q.190.5. Further Guidance

Telephone system documentation

1Q.200. SECURITY ALARM AND FIRE ALARM SYSTEMS

1Q.200.1. Managerial Responsibility

CSAD Managers

1Q.200.2. Quality Standard

Security alarms and fire alarms are:

- Installed and are operational in the CSAD offices
- Are monitored at all times
- Backed up by a callout system

1Q.200.3. Method

Equipment is selected by the host organisation or CSAD Manager, advised by.

The CSAD Manager liaises with the host organisation for:

- Co-ordinates the procurement, installation and acceptance testing of security and fire alarm equipment
- Arranges service contracts in accordance with the manufacturer's recommendations and keeps records of servicing and callouts
- Ensures that all relevant staff are trained in the use of the equipment

The CSW Security Policy, Lone Worker and local host Fire Policies are followed.

1Q.200.4. Quality Control and Audit

- Incident Reporting Procedure
- Health and Safety Audit Reporting

1Q.200.5. Further Guidance

System documentation

Screening Services Security Procedure

Local Host Fire Policies

Screening Services Lone Worker Policy

1Q.210. MAILING FACILITIES

1Q.210.1. Managerial Responsibility

CSAD Managers

1Q.210.2. Quality Standard

An automatic mailing and franking system is installed and kept in good working order, either directly by the CSW or via the host organisation. Where mailing is undertaken by a contracted 3rd party the local CSAD Manager will monitor quality.

Mailing of invitation runs is processed by an external printing company on behalf of Cervical Screening Wales.

1Q.210.3. Method

Equipment is selected by the host organisation or CSAD Manager, with approval given by the AWMG.

The CSAD Manager, either directly or via the host organisation:

- Co-ordinates the procurement, installation and acceptance testing of automatic mailing and franking equipment
- Arranges service contracts in accordance with the manufacturer's recommendations and keeps records of servicing
- Ensures that repairs are carried out as quickly as possible
- Ensures that all clerk/receptionists are trained in the use of the system
- Ensures that local contingency plans are in place in case of failure of the system

External Mailing Contracts

Where external mailing contracts are used for invitation processing, the local CSAD Manager will monitor local processes in terms of quality and costs via invoicing.

1Q.210.4. Quality Control and Audit

- Performance Statistics
- Monitoring Reports

1Q.210.5. Further Guidance

System documentation

Contract/agreements with the host organisation

1Q.220. STANDARD LETTERS, PUBLICITY AND INFORMATION MATERIAL

1Q.220.1. Managerial Responsibility

Director

Operational Staff

Public Information Lead

Public Information Group

1Q.220.2. Quality Standard

Standard letters are generated by the computer system for invitations, reminders, self-referral invitations, technical recalls, normal results, abnormal results and opt outs. All letters contain the correct information regarding name, address, and appointment.

Standard leaflets are used for invitation to screening, to explain an abnormal smear result, accompanying referral to colposcopy and for general publicity.

The letters and leaflets:

- Are bi-lingual, with Welsh and English given equal prominence
- Provide sufficient information
- Minimise anxiety
- Are easy to read
- Are well presented
- Are in line with CSW's corporate identity
- Meet the standard agreed by the AWMG

1Q.220.3. Method

The director ensures that the letters, leaflets and posters are reviewed regularly, acting on the advice of the Joint Coordinators Group (JCG) and the Public Information Lead for CSW.

Public Information Group ensure that:

- Approved alterations to letters are forwarded to Health Solutions Wales (HSW) to be programmed into the computer system
- Approved alterations are forwarded to the approved printers to be incorporated when subsequent orders for printed materials are placed

1Q.220.4. Quality Control and Audit

- Comments and Complaints Procedure
- Performance Indicators

1Q.230. MANAGEMENT OF MEDICAL DEVICES

1Q.230.1. Managerial Responsibility

Head of Nursing

1Q.230.2. Quality Standard

The Screening Services Clinical Safety Group maintains an inventory of medical devices.

Procurement and use of medical devices takes account of the advice issued by the Medical Devices Agency (MDA DB 9801).

Acceptance checks are carried out on new medical devices.

Staff receive appropriate training on the use of medical devices.

Medical devices are properly maintained.

Medical devices are decontaminated prior to maintenance/repair.

Adverse incidents are reported.

MDA hazard and safety notices are distributed to appropriate people.

Medical devices within the Pathology and Colposcopy services are expected to be maintained to standard by the provider Trust. This relationship is established within the Long Term Agreement.

1Q.230.3. Method

The term “medical device” covers all products (except medicines) used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or handicap.

Decontamination – see Clinical Safety File*.

Training – see 4.50 and Clinical Safety File*.

Incident reporting – see 5.66.

Disseminating hazard and safety notices – see Screening Services “Procedures for dealing with Safety Action Bulletins (SAB), Hazard Notices (HN) and Medical Device Agency Bulletins (MDAs)”.

*A Clinical Safety File is maintained by nominated individuals.

1Q.230.4. Quality Control and Audit

Internal to CSW

Clinical Safety Group audits

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External to CSW
Accreditation and QA visits

1Q.230.5. Further Guidance

MDA DB 9801 Medical device and equipment management for hospital and community-based organisations (Medical Devices Agency 1998).

1Q.240. REPORTING ADVERSE INCIDENTS INVOLVING MEDICAL DEVICES

1Q.240.1. Managerial Responsibility

Head of Nursing (internal reporting)
Programme Manager (external reporting)

1Q.240.2. Quality Standard

All adverse incidents involving medical devices are reported promptly to the Welsh Assembly Government (WAG) and the Medical Devices Agency (MDA) according to the procedures in WHC (97) 28.

All adverse incidents involving medical devices within local provider Trusts must be reported to CSW.

1Q.240.3. Method

All adverse incidents are reported internally according to the procedures in the CSW Health and Safety policy. If an adverse incident involves a medical device (as defined in 5.65.) the line manager completing the incident form:

- Ensures that defective items are removed from use pending investigation
- Labels and keeps secure all material evidence involved
- Contacts the appropriate medical devices liaison officer (see below) immediately

The appropriate medical devices liaison officer assesses the incident to determine whether it should be reported. They take into account MDA guidance and advice from relevant staff. They record their decision on the incident form. If they decide that the incident should be reported they immediately:

- Inform the Director
- Report the incident to WAG using the procedures in WHC(97)28
- Send a copy of the report to MDA and to the BTW Risk Management Group
- Act as liaison between WAG/MDA and CSW during any subsequent investigation

1Q.240.4. Quality Control and Audit

Internal to CSW

Clinical Safety Group audits.

External to CSW

Accreditation and QA visits

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1Q.240.5. Further Guidance

WHC (97) 28 Reporting of adverse incidents, reactions and defective products relating to medical and non medical equipment and supplies, food, buildings and plant, and medicinal products.

NAfW SAB (01) 01 Medical devices – reporting adverse incidents and disseminating safety warnings (and update in NAfW SAB (01)02) Long Term Agreement documentation.

1Q.250. QUALITY CONTROL, AUDIT AND REPORTS

List of reports produced by CSW Pathology Reports

Report	Frequency	Purpose of Report	Who the report is sent to
1. Cases reported for laboratory by month and source of smear.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
1b. Smears screened for other laboratories.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
2. Cases reported by laboratory, by month and final result of test.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
3. Cases reported, cross tabulated by result of test and source of smear, by lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
4. Cases reported from GP and NHS community clinics only, cross tabulated by result of test and by age by lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
5. Cases reported from GP and NHS community clinics only, by result of test and quarter, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
5b. Cases with no evidence of TZ sampling, cross tabulated by age, by lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
6. Cases reported, fully double screened, by source of smear. By lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
7. Cases reported as inadequate, by reason of inadequacy. By lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
8. Cases screened by individual screener.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
9. Cases primary screened, cross tabulated by primary screener opinion and final result of test.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
9b. Cases primary screened, cross tabulated by primary screener opinion and final result of test (GP and NHS community clinics).	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
10. Sensitivity, specificity, cytology PPV and false negative rates, by quarter and annual summary, by laboratory and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
10b. Sensitivity, specificity, cytology PPV and false negative rates, by quarter and annual summary, by laboratory and All Wales (GP and NHS community clinics).	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
11. PPV rates histologically confirmed by Primary Screener, by lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
11b. PPV rates histologically confirmed by	Quarterly	Routine	Lead Pathologists and

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Reporting Pathologist, by lab and All Wales.		monitoring	Cervical Cytology Managers
12. Turnaround time per request, from receipt of slide to issuing report, by lab and All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
12b. Turnaround time per request from receipt of histological specimen to issuing of report, All Wales.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
13. Slides picked out by the screener at rapid review cross tabulated by final result, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
14. Cases recorded as negative by the primary screener, subsequently overturned at rapid review, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
15. Cases recorded as negative by the primary screener, subsequently overturned at targeted double screening, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
16. Cases checked from rapid review and targeted double screening by technical checker opinion and final result, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
17. Cases referred to checker by primary screener, by primary screener opinion, technical screener opinion, technical checker opinion and final result, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
18. Cases reported, cross tabulated by pathologist, result of test and source of smear, by lab.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers
19. Cervical histology specimens reported by pathologist.	Quarterly	Routine monitoring	Lead Pathologists and Cervical Cytology Managers

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1. Number of samples examined, by pathology laboratory and source of test.	Annually	Publication	Public
2. Result of test, by lab.	Annually	Publication	Public
3. Number of adequate samples examined by pathology laboratory, by result of test and age.	Annually	Publication	Public
4. Number of inadequate tests by age and lab.	Annually	Publication	Public
5. Outcome for women recommended for gynae referral – women following a result of inadequate, borderline and mild dysk.	Annually	Publication	Public
5b. Outcome for women recommended for gynae referral – women following a result of moderate dysk or worse.	Annually	Publication	Public
6. Positive predictive value (PPV) for high grade referrals by lab.	Annually	Publication	Public

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Pathology Exception Reports

1. Unknown source of smear.	On request	Routine Monitoring	Cervical Cytology Managers
2. Unknown primary screener initials.	On request	Routine Monitoring	Cervical Cytology Managers
3. Unknown primary screener opinion.	On request	Routine Monitoring	Cervical Cytology Managers
4. Any specimen with any screener initials but missing an opinion, Rapid reviewer, technical checker and Pathologist.	On request	Routine Monitoring	Cervical Cytology Managers
5. Any H (histology) record types without a reporting pathologist.	On request	Routine Monitoring	Cervical Cytology Managers

Other Pathology Reports

1. LBC monthly reports – laboratory reporting rates, inadequate low grade and high grade results.	Monthly	Routine Monitoring	CSW Programme Manager and QA Colposcopist, QA Pathologist
2. Pathology Turnaround times – weekly, quarterly.	Weekly & Quarterly	Routine monitoring	Regional Programme Coordinators & CSW Senior Managers
3. Pathology monthly report.	Monthly	Routine Monitoring	CSW Programme Manager

Colposcopy Reports

1A. Waiting Times: from date of receipt of referral to date of first attended visit, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
1B. Waiting Times: from date of diagnosis of CIN2 or worse, to date of treatment, by colposcopy service, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
2A. Attendance rates for first offered appointments to a new referral, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
2B. Attendance rates for planned treatment appointments, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
2C. Attendance rates for follow-up appointments, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
3A. New cases referred, by reason for referral, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
3B. Total number of visits, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme

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			Coordinators & CSW Senior Manager
3C. Number of new women seen, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
4. Number of clinics held and appointments attended, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
5. Sensitivity and PPV of colposcopic opinion compared with biopsy result; by individual colposcopist, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
6A. Treated women attending post treatment follow up with abnormal cytology results within 8 months; by result, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
6A. Treated women attending post treatment follow up with abnormal histology results within 12 months; by result, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
7A. Biopsies adequate for histological interpretation, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
7B. CIN present in select and treat LLETZ, by colposcopist, colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
8. Timeliness and completeness of data entry onto CANISC-CIS, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
9A. Time taken to send woman the results and future management plans, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers
9B. Time taken to send woman's GP the results and future management plans, by colposcopy service and all Wales.	6 monthly	Routine Monitoring	Lead Colposcopists, Regional Programme Coordinators & CSW Senior Managers

Colposcopy Reports Available On Request

1. Total number of visits each month, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
1B. Number of new women seen each month, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
2. Reasons for referral of new cases seen, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists

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3. New referrals by smear result, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Programme Co-ordinators and Lead Colposcopists
4. Type of visits – Total visits, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
4B. Type of visits – New Women, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
5. Written or verbal consent recorded, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
6. Women having colposcopic assessment prior to treatment of abnormal smear, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
7. Sensitivity and PPV of colposcopic opinion compared with biopsy result; by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
8. Biopsies taken by type, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
9. Treatment details, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
10. Anaesthetic details, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
11. Satisfactory/unsatisfactory, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
12. Colposcopies where the whole lesion was seen, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
13. Attendance rates for the first offered appointments to a new referral, by colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
14. Attendance rates for planned treatment appointments, by colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
15. Attendance rates for follow-up appointments, by colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
16. Women waiting less than 8 weeks from date of receipt of referral to date of Colposcopy (excluding woman instigated delays), by colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
17. Women with moderate or worse smears waiting less than 4 weeks from date of receipt of referral to date of Colposcopy (excluding woman instigated delays), by colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
18. Women with abnormal referral smears assessed having a biopsy, by colposcopist,	6 monthly and on	Routine Monitoring	Regional Programme Coordinators and Lead

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colposcopy service, and all Wales.	request		Colposcopists
19. Percentage of planned treatment biopsies having evidence of CIN on histology by biopsy type, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
20. Women referred with abnormal smears having their histological diagnosis established prior to destructive therapy; by type of therapy, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
20B. All women referred having their histological established prior to destructive therapy; by type of therapy, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
21. Women treated by excisional biopsy at the first visit with evidence of CIN on histology, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
22. Biopsies adequate for interpretation by biopsy type, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
23. Complications at time of visit, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
24. Cases admitted as in women due to treatment complications, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
25. Treated women attending post treatment follow up with cytology results within 8, 8 to 12 and within 12 months, by colposcopist, Colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
26. Confirmed histological treatment failures within 12 months of treatment and by result, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists
27. Number of women still under follow up 2 years after referral, by colposcopist, colposcopy service, and all Wales.	6 monthly and on request	Routine Monitoring	Regional Programme Coordinators and Lead Colposcopists

KC65 Colposcopy Reports

1. Number of new women seen, by referral test result, by colposcopy service and all Wales.	Annually	Publication	Public
2. Time from receipt of referral to first offered appointment (excluding woman instigated delays), by colposcopy service and all Wales.	Annually	Publication	Public
3. Total attended visits, by type of visit, by colposcopy service and all Wales.	Annually	Publication	Public
4. Number of new women seen, by referral test result and most significant procedure at first visit, by colposcopy service and all Wales.	Annually	Publication	Public
5. Number of new women seen, by colposcopic opinion and worst outcome of histology, by colposcopy service and all Wales.	Annually	Publication	Public

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6. Number of new women having a biopsy taken, by type and worst outcome of histology, by colposcopy service and all Wales.	Annually	Publication	Public
7. Number of cervical biopsies taken, by type and outcome of histology, by colposcopy service and all Wales.	Annually	Publication	Public
8. Correlation of outcome from an initial punch biopsy with a subsequent Lletz, by colposcopy service and all Wales.	Annually	Publication	Public

Colposcopy QA Visit Reports, by colposcopy service

1. Number of women still under follow up more than 2 years after referral received date.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
2. Consent recorded.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
3. Diagnostic parameters – Referrals with low grade cytology assessed having a biopsy (at first assessment).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
4. Referrals with high grade cytology assessed having a biopsy (at first assessment).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
5. Biopsies adequate for histological assessment (all types of biopsy).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
6. Rate of incomplete excision (all types of biopsy).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
7. Record of visibility of SCJ (at assessment appointments only).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
8. Colposcopy opinion recorded (at assessment appointments only).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
9. Colposcopists accuracy in predicting high grade lesions or worse (cervical biopsies only).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
10. Treatment – Histological diagnosis established before destructive therapy for CIN (women referred with abnormal smears).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
11. Proportion of women treated at the first visit that have evidence of CIN on histology (women referred with abnormal smears).	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
12. Proportion of women at follow up, with persistent high grade cytological abnormality who undergo an excisional treatment at next appointment.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
13. Select & Treat – Proportion of all referrals with abnormal cytology managed by a select and treat policy?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
14. Proportion of all referrals with abnormal cytology managed by a Select & Treat policy, who do not have CIN on histology.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic

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15. Proportion of high grade referrals managed by a Select and Treat policy?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
16. Proportion of high grade referrals managed by a Select and Treat policy, who do NOT have CIN on histology?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
17. Proportion of high grade referrals managed by a Select and Treat, who have low grade histology?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
18. Complications – Proportion of treatment associated with primary haemorrhage that requires haemostatic technique in addition to the treatment method applied.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
19. Proportion of cases admitted as in-women due to treatment complications.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
20. Clinics – follow up after treatment – Cytology samples taken by GP.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
21. Cytology samples taken in hospital clinic.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
22. Combination of hospital cytology and Colposcopy.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinics
23. How many months after treatment are women seen.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
24. Treatment failures – Proportion of women having a follow up smear within 6-8 months of treatment?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
25. Proportion of women with no dyskaryosis on cytology 6-8 months after treatment?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
26. Proportion of women, who do not have negative smears following treatment, are re-colposcoped within 12 months.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
27. Proportion of histologically confirmed treatment failures within 12 months.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
28. Timeliness of data entry on CANISC – Time from receipt of referral to date referral is entered onto CANISC.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
29. Time from booking the appointment on CANISC to date of visit.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
30. Time from the date of visit to date proforma is entered on CANISC.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
31. Time from the date of receipt of result to date result is entered on CANISC.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
32. Return of laboratory results – How long does it take for the Colposcopy department to receive cytology results from the laboratory?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinics

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33. How long does it take for the Colposcopy department to receive the histology results from the laboratory?	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinics
34. Completeness of data entry on CANISC – Referrals with no appointments booked on CANISC.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
35. Appointments booked on CANISC with no status indicating whether the woman attended/DNA'd.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinics
36. Appointments marked as attended on CANISC with no clinical proforma data entered.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic
37. Samples taken more than 6 weeks ago with no results entered onto CANISC.	Ad hoc – soon to be 2 yearly	Routine reporting	CSW Senior Managers, Hospital Trusts Senior Managers and Colp clinic

Colposcopy Exception reports, by colposcopy service

1. Samples entered missing results more than 6 weeks after being taken.	6 monthly	Routine reporting	Regional Programme Coordinators
2. Direct referrals from CSADs where there is no referral smear or a negative referral smear recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
3. Referrals with no NHS number recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
4. Duplicate referrals on CANISC (same referral date and smear result).	6 monthly	Routine reporting	Regional Programme Coordinators
5. Duplicate visits on CANISC (same date and time).	6 monthly	Routine reporting	Regional Programme Coordinators
6. ColpSafe re-referrals not appearing as new referrals on CANISC with the correct original smear result and date.	6 monthly	Routine reporting	Regional Programme Coordinators
7. Unknown actual visit type.	6 monthly	Routine reporting	Regional Programme Coordinators
8. Smear-only visits with other sample types recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
9. Smear-only visits with a Colposcopy opinion recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
10. Smear-only visits with treatment recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
11. Swab-only visits with other sample types recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
12. Swab-only visits with a Colposcopy opinion recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
13. Swab-only visits with treatment recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
14. Consultation only visits where samples were taken.	6 monthly	Routine reporting	Regional Programme Coordinators
15. Consultation only visits with a Colposcopy opinion recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
16. Consultation only visits with treatment recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
17. Planned treatment and select and treat visits with no treatment recorded.	6 monthly	Routine reporting	Regional Programme Coordinators
18. Colposcopy assessment visits with	6 monthly	Routine	Regional Programme

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treatment recorded; new women.		reporting	Coordinators
19. Colposcopy assessment visits with treatment recorded; follow-up women.	6 monthly	Routine reporting	Regional Programme Coordinators

Other Colposcopy Reports

1. Colposcopy waiting times – all new referrals, high grade referrals and suspected cancer referrals by month, by colposcopy service and all Wales.	Weekly and Quarterly	Routine reporting	Regional Programme Coordinators
2. BSCCP statistics, by individual colposcopist on request.	Ad hoc	On request	Colposcopists

CSAD Reports

1. Resident female population by age and screening status, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
2. Women ceased by age and reason, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
3. Smears input at CSAD by age and source, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
3B. Smears input at CSAD by age and smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
4. Women's worst result by age and result of test, by CSAD and all Wales.	6 monthly	Routine Reporting	Programme Co-ordinators, CSAD Managers and CSW senior Managers
5. Screening tests input by CSAD by time since last smear and result, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
6. Time from smear being taken to issuing of result by CSAD and number of results issued within 4 and 6 weeks, by reporting laboratory and all Wales.	6 monthly	Routine Reporting	Programme Co-ordinators, CSAD Managers and CSW senior Managers
7. Time from smear being taken to receipt by lab, receipt by lab to signing out by lab, signing out by lab to receipt by CSAD and receipt by CSAD to issuing of result by CSAD, by reporting laboratory and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
8. Invitations returned and undelivered by GP practice, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
9. Result letters sent and result letters	6 monthly	Routine Reporting	Regional Programme

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returned unopened by practice, by CSAD and all Wales.			Coordinators, CSAD Managers and CSW senior Managers
10. Cases directly referred for Colposcopy by month and colposcopy service (CSAD data).	6 monthly	Routine Reporting	Programme Co-ordinators, CSAD Managers and CSW senior Managers
10b. Cases referred for Colposcopy by month and colposcopy service (CANISC data).	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
11. Transfers into screening area, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
12. Transfers into screening area with a history of abnormal cytology, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
13. Transfers into screening area with exclusion from target payment markers set, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
14. Change of management by reporting laboratory, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
15. Women who do not attend 2 consecutive Colposcopy appointments by colposcopy service, by CSAD and all Wales.	6 monthly	Routine Reporting	Programme Co-ordinators, CSAD Managers and CSW senior Managers
16. Number of disclaimer letters sent, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
17. Use of smear taker codes at CSAD each week, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
18. Broken, lost and unprocessed samples by sending location, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
19. Discrepancies by sending location and type of discrepancy, by CSAD and all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
20. Smear takers trained by base location and time since last training in years and type of training, all Wales.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers and CSW senior Managers
21. Cases reported as abnormal by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
22. Cases reported as inadequate, by smear	6 monthly	Routine Reporting	Regional Nurse

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taker and source of smear.			Coordinators
23. Cases inappropriately taken for cytology by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
24. TZ sampling rates and inadequate rates for women under 50 by smear taker	Monthly	Routine Reporting	Regional Nurse Coordinators
25. Cases with no evidence of TZ sampling reported: by age (<50 & > 50 only) and by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
26. Cases consisting of 2 or more samples, by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
27. Broken, lost and unprocessed samples by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
28. Discrepancies by type of discrepancy and smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
29. Smear takers trained by base location and time since last training in years and type of training, by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators
30. All smear taker training dates, by smear taker.	6 monthly	Routine Reporting	Regional Nurse Coordinators

Reports to Sample Taking Locations

1. Women registered with GP practice by age and screening status.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices
2. Women registered with GP practice who are ceased from recall, by age and reason.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices
3. Smears input at CSAD by age, smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
4. Cases reported as abnormal by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
5. Cases reported as inadequate by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
5b. Cases reported as inadequate within the last 2 years, by reason for inadequacy, by smear taker.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non

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			GMS Locations
6. Cases inappropriately taken for cytology by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
7. TZ sampling rates and inadequate rates for women under 50 years, by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
8. Transfers in with a history of abnormal cytology and with exclusion from target payment markers set, by GP practice.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices
9. Cases directly referred for colposcopy by month and GP practice.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices
10. Broken, lost and unprocessed samples by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
11. Discrepancies by type of discrepancy, smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations
12. Smear takers trained by base location and time since last training in years and type of training, by smear taker and sending location.	6 monthly	Routine Reporting	Regional Programme Coordinators, CSAD Managers, Regional Nurse Coordinators, GP Practices and Non GMS Locations

Nurse Co-ordinator CSAD Reports

1. Laboratory Inadequate and TZ sampling rates (under 50), by reporting laboratory.	Monthly	Routine reporting	Regional Nurse Coordinators
2. Smears taken in last month and last year, by smear taker and reporting laboratory.	Monthly	Routine reporting	Regional Nurse Coordinators
3. List of new smear takers allocated codes in a given recent time period, with details of training undertaken.	Monthly	Routine reporting	Regional Nurse Coordinators
4. List of smear takers who are actively taking samples, who do not have any LBC training recorded.	Monthly	Routine reporting	Regional Nurse Coordinators
5. List of smear takers who are actively	Monthly	Routine reporting	Regional Nurse

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taking samples, with LBC training information.			Coordinators
6. Smear taker inadequate, abnormal and TZ sampling rates at 3, 8 and 12 months after training.	Monthly	Routine reporting	Regional Nurse Coordinators

KC53 CSAD Reports

1. Test status and coverage of women, by age.	Annually	Publication	Public
2. Test status and coverage of target age group (20 - 64 years) by Local Health Board.	Annually	Publication	Public
3. Number of women invited in the year by type of invitation and age at test.	Annually	Publication	Public
4. Number of women aged 20-64 years invited in the year by type of invitation and Local Health Board.	Annually	Publication	Public
5. Number of women tested by type of invitation and age at test.	Annually	Publication	Public
6. Number of women tested in the year by Local Health Board.	Annually	Publication	Public
7. Number of women aged 20-64 years tested in year by type of invitation and Local Health Board.	Annually	Publication	Public
8. Number of test results by age.	Annually	Publication	Public
9. Number of test results of women aged 20-64 years by Local Health Board.	Annually	Publication	Public

CSAD Exception Reports - under development

1. Women aged under 64 years who have been ceased for age reasons.	6 monthly	Routine Reporting	CSAD Managers
2. Women ceased for unknown reasons.	6 monthly	Routine Reporting	CSAD Managers

Other CSAD Reports

1. Smear taker codes entered on Exeter, by CSAD and all Wales.	Weekly	Routine Reporting	CSW Senior Managers
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CSW Balanced Scorecard

1. Percentage of eligible women in Wales to be invited for screening every 3 years.	Quarterly	Routine Reporting	CSW Senior Managers
2. Percentage of eligible women in Wales aged 25 - 64 years to be adequately tested within the last 5 years.	Quarterly	Routine Reporting	CSW Senior Managers
3. Annual incidence rates of Cervical Cancer.	Quarterly	Routine Reporting	CSW Senior Managers
4. DNA rates for colposcopy appointments.	Quarterly	Routine Reporting	CSW Senior Managers
5. Number of cancelled colposcopy services.	Quarterly	Routine Reporting	CSW Senior Managers
6. Number of inappropriate referrals to colposcopy that have a negative smear or no referral smear and are those women	Quarterly	Routine Reporting	CSW Senior Managers

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referred by GP or smear taker with: Clinically suspicious cervix; Suspicious symptoms; Other reasons – bleeding, symptoms.			
7. Monitor laboratory backlogs - Ensure all technology being used optimally.	Quarterly	Routine Reporting	CSW Senior Managers
8. Proportion of all smears taken that reach laboratory within 1 week.	Quarterly	Routine Reporting	CSW Senior Managers
9. Proportion of results to be issued within 4 weeks of smear being taken.	Quarterly	Routine Reporting	CSW Senior Managers
10. Proportion of results to be issued within 6 weeks of smear being taken.	Quarterly	Routine Reporting	CSW Senior Managers
11. Proportion of results forwarded from laboratory to CSAD within 4 calendar weeks of receiving the smear.	Quarterly	Routine Reporting	CSW Senior Managers
12. Proportion of women referred to Colposcopy with abnormal cytology to be seen within 8 weeks.	Quarterly	Routine Reporting	CSW Senior Managers
13. Proportion of women with moderate or severe dyskaryosis to be seen in colposcopy within 4 weeks.	Quarterly	Routine Reporting	CSW Senior Managers
14. Proportion of cases where cytology indicates suspect invasion and abnormal glandular cells to be seen in colposcopy within 2 weeks.	Quarterly	Routine Reporting	CSW Senior Managers
15. Proportion of results issued to women screened within 5 calendar days of result receipted at CSAD.	Quarterly	Routine Reporting	CSW Senior Managers
16. Proportion of histology reports from biopsy samples taken at colposcopy reported within a week.	Quarterly	Routine Reporting	CSW Senior Managers
17. Proportion of inadequate rates.	Quarterly	Routine Reporting	CSW Senior Managers
18. Variance between number of direct referrals on Safetynet compared to CANISC-CIS.	Quarterly	Routine Reporting	CSW Senior Managers
19. Proportion of report forms received at CSAD coded, inputted and verified on EXETER within 3 working days.	Quarterly	Routine Reporting	CSW Senior Managers
20. Proportion of report forms received at CSAD coded, inputted and verified within 10 days.	Quarterly	Routine Reporting	CSW Senior Managers
21. Number of smear reports entered onto EXETER within 1 week of lab report.	Quarterly	Routine Reporting	CSW Senior Managers