MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20110163

REPORT FROM THE MINISTRY OF HEALTH ON THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE CERVICAL SCREENING INQUIRY 2001: MAY 2009 TO JANUARY 2011

Purpose

1. This report records the progress made to implement the recommendations from the *Report of the Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in the Gisborne Region*, otherwise known as the Cervical Screening Inquiry 2001. The last report on this subject was provided in June 2009 (HR 20090362 refers).

Background

2. The Inquiry report was released in April 2001. It contained 46 recommendations for future action that the Government or its agencies should consider taking.

3. The then Minister of Health accepted all 46 recommendations and directed the Ministry of Health to implement them. For implementation of the recommendations, $3.96 million was allocated from within health baselines for 2001/02 and outyears (HR 20010396 refers).

4. Recommendation 46 of the Inquiry requires a process be put in place to ensure that the recommendations are implemented. In response to this recommendation the Director-General of Health previously supplied monthly update reports to the Minister of Health. As more recommendations have been completed or become business as usual, the length of the reporting period has been increased.

Public access to reports

5. In 2000, a website was set up to keep women informed of the purpose and progress of the Cervical Screening Inquiry (www.csi.org.nz). Once the Inquiry was completed, the website was updated with reports on progress with the recommendations of the Inquiry. The Inquiry website is no longer updated, and all reports are now published on the National Screening Unit website (www.nsu.govt.nz).

Progress to date

6. Of 46 recommendations, 41 have been implemented or have become part of core business of the Ministry of Health. Recommendation 23 is in the final stages of completion. Recommendation 2 is not being implemented. Recommendation 13 has not been implemented as recommended and is being reviewed. Further work is being undertaken on recommendation 15. Recommendation 33 has been overtaken by progress.

Recommendation in final stages of completion

7. **Recommendation 23** calls for the establishment of an appeal process for ethics committee decisions. In 2010 the Minister of Health authorised the Health Research Council Ethics Committee to undertake the additional function of considering appeals against decisions made by Health and Disability Ethics Committees. The Health Research Council is currently finalising the appeal process and terms of reference.

Recommendations not being implemented or overtaken by progress

8. **Recommendation 2** refers to the re-enrolment and re-screening of all women in the event that the national evaluation throws doubt on the accuracy of high-grade abnormality reporting rates. The findings of the Cervical Cancer Audit 2004 did not support the implementation of this recommendation.

9. **Recommendation 33** refers to the development of a population register for the Programme. Circumstances surrounding the provision of cervical screening services have changed markedly since 2001 and there are now systems in place that were not available when this recommendation was made. Advances made in primary care registers and systems of invitation and recall have addressed many of the issues that were intended to be resolved by a population register. The Programme continues to monitor and participate in developments that will help to increase coverage. Further information is given in (HR 20082228).

Recommendations under review / for further work

10. **Recommendation 13** refers to the management of the Programme being under the control of a second or third tier manager within the Ministry who has a specialist medical qualification in public health or epidemiology. In 2002 the National Screening Unit appointed a Programme Manager and Clinical Leader to jointly manage the Programme at the fourth tier. The Clinical Leader does have specialist medical qualifications in public health. Subsequent structural changes have resulted in changes to the Clinical Leader position. The position no longer holds line management responsibilities and reports at the 6th tier. This position is currently under review to bring it in line with similar clinical leadership positions in the Ministry of Health.

11. **Recommendation 15** Further work is being undertaken to maintain timely access to Māori women's aggregate data on the NCSP Register.

Summary

12. Status of Cervical Cancer Inquiry's Recommendations as at January 2011:

Status of the Recommendation	Recommendation Number	Total
Implemented – no further work required.	5, 11, 12, 14, 16, 17, 18, 19, 20, 21, 22, 34, 35, 36, 39, 40, 41, 44	18
Implemented – have become "business as usual".	1, 3, 4, 6, 7, 8, 9, 10, 24, 25, 26, 27, 28, 29, 30, 31, 32, 37, 38, 42, 43, 45, 46	23
Substantially implemented - for full implementation during 2011	23	1
Decision not to implement	2	1
Overtaken by progress	33	1
Under review	13	1
Further work	15	1

List of recommendations

13. List of all 46 recommendations, including a brief comment on each.

Ref.	Recommendation	Comment
1.	**Evaluation of National Cervical Screening Programme.** The remaining two phases of the national evaluation designed by the Otago University Team must proceed. Until those phases are completed the Programme's safety for women cannot be known. It is imperative that this exercise is completed within the next six months. Particular attention should be given to the discrepancy between the average reporting rate of high-grade abnormalities of Douglass Hanly Moir Pathology (2.5%-3.7%) for the re-read of the Gisborne women's smear tests and the current New Zealand national average for reporting high-grade abnormalities (0.8%). Unless this exercise is carried out the possibility that the national average is flawed and that there is a systematic problem of under-reporting in New Zealand laboratories cannot be excluded.	The Ministry of Health and the University of Auckland completed a review of 371 women who had developed cervical cancer between 1 January 2000 and 30 September 2002. The *New Zealand Cervical Cancer Audit*. *Screening of Women with Cervical Cancer: 2000- 2002* (referred to as the Cervical Cancer Audit) published its findings in November 2004. The Audit found that the Programme operated to a generally high standard for women who are having regular cervical smears. It did not find systemic issues in the laboratory reading and reporting of cervical smears. The Audit made 31 recommendations, which the Ministry of Health has been addressing.
2.	**Re-enrolment and re-screening of women.** If the national evaluation throws doubt on the accuracy of the current national average then the Committee recommends that all women who are or who have participated in the programme should be invited to re-enrol and offered two smear tests 12 months apart. Women who have never enrolled on the Register or who have had their names removed from the Register should be invited through notices in the print media to also go through the process of having two smear tests twelve months apart.	This recommendation will not be implemented, as there was no indication from the Cervical Cancer Audit that recommendation 2 needs to be responded to.
3.	**Evaluation of National Cervical Screening Programme.** A comprehensive evaluation of all aspects of the National Cervical Screening Programme, which reflects the 1997 Draft Evaluation Plan developed by Doctors Cox and Richardson, should be commenced within 18 months. This exercise should build upon the three phase evaluation referred to in recommendation 1.	Parts 5, 6 and 8 have been included within the scope of Part 3 (Cancer Audit) – see recommendation 1 above. Parts 4, 7 and 10 are included within the scope of Programme statistical reporting. Refer also to recommendation 7 below.

Ref.	Recommendation	Comment
4.	**Operational Policy and Quality Standards, and Evaluation and Monitoring Plan.** The Policy and Quality Standards for the National Cervical Screening Programme and the Evaluation and Monitoring Plan for the National Cervical Screening Programme prepared by Dr Julia Peters and her team must be implemented fully within the next 12 months.	The Standards were implemented in October 2000 and a number of sections have been revised since. In accordance with the Evaluation and Monitoring Plan, an Independent Monitoring Group was contracted to provide quarterly and annual monitoring reports. Since January 2009, monitoring reports have been published six monthly with expert review undertaken by the National Cervical Screening Programme Advisory Group. Quarterly reporting is undertaken by the Programme.
5.	**Full legal assessment of Operational Policy and Quality Standards.** There needs to be a full legal assessment of the Policy & Quality Standards for the National Cervical Screening Programme and the Evaluation and Monitoring Plan for the National Cervical Screening Programme to ensure that the requisite legal authority to carry out these plans is in place.	A report from Kim Murray (Barrister) was provided to the National Screening Unit in December 2001.
6.	**Legal assessment of National Cervical Screening Programme Authority.** The National Cervical Screening Programme should be thoroughly evaluated by lawyers to determine whether or not those persons charged with tasks under the Programme have the necessary legal authority to discharge them.	This issue was also included in the report from Kim Murray (Barrister) provided to the National Screening Unit in December 2001.
7.	**Statistical Reporting.** The National Cervical Screening Programme should issue annual statistical reports. These reports should provide statistical analysis to indicate the quality of laboratory performance. They should also provide statistical analysis of all other aspects of the Programme. They must be critically evaluated to identify areas of deficiency or weakness in the Programme. These must be remedied in a timely manner.	Independent monitoring against a range of programme indicators and targets has taken place quarterly and, from 2008, six monthly. These reports are available at www.nsu.govt.nz/health-professionals/1063.asp Independent review and recommendations on these reports was provided to the NSU by a contracted Independent Monitoring Group and since 2008 by the NCSP Advisory Group. The NSU reports on actions taken in response to this advice.

Ref.	Recommendation	Comment
8.	**Regular Statistical Information.** Meaningful statistical information should be generated from both the National Cervical Screening Register and the Cancer Registry on a regular basis. Attention must be paid not only to laboratory reporting rates but also trends and the incidence of disease, assessed by regions that are meaningful to allow some correlation between reporting profiles of laboratories and the incidence of cancer. Because cervical smear tests may be read outside the region in which the smear test is taken, a recording system needs to be devised which identifies the region where smears are taken.	Monitoring against programme indicators is undertaken regularly using NCSP Register data (see recommendation 7). It has been the considered opinion of the National Screening Unit and University of Otago that it is not possible to correlate laboratory reporting with regional incidence of cervical cancer in New Zealand.
9.	**Minimum Standards for Cytology Laboratories.** The compulsory setting of a minimum number of smears that should be read by laboratories each year must be put in place. The proposal to impose three minimum volume standards on laboratories must be implemented. These are: each fixed site will process a minimum of 15,000 gynaecology cytology cases, each pathologist will report at least 500 abnormal gynaecological cytology cases, cytotechnical staff must primary screen a minimum of 3,000 gynaecological cytology cases per annum. This should be implemented within 12 months.	NCSP Laboratory Agreements began incorporating minimum volume standards from July 2001. All laboratories have been meeting the minimum volume standards since December 2005. Minimum standards for staff were reviewed in consultation with the sector and updated in 2008. In 2009 additional standards and policy were incorporated including minimum volumes in an automated screening environment.
10.	**Balanced Approach for National Cervical Screening Programme.** There needs to be a balanced approach, which recognises the importance of all aspects of the National Cervical Screening Programme. The emphasis on smear-taking and increasing the numbers of women enrolled on the Programme needs to be adjusted.	The Programme now has a more balanced approach.
11.	**Culture of the National Screening Unit.** The culture which was developing in the Health Funding Authority regarding the management of the National Cervical Screening Programme under the management of Dr Julia Peters needs to be preserved and encouraged now the Health Funding Authority has merged into the new Ministry of Health.	NSU strategic planning supports continuous quality improvement of its programmes through comprehensive monitoring and evaluation systems.

Ref.	Recommendation	Comment
12.	**Management of the National Cervical Screening Programme.** The National Cervical Screening Programme must be managed within the Ministry of Health as a separate unit by a manager who has the power to contract directly with the providers of the Programme on behalf of the Ministry. The Programme's delivery should not be reliant on the generic funding agreements the Ministry makes with providers of health services. For this purpose the unit will require its own budget.	The National Screening Unit was established July 2001 as a separate business unit with the delegated power to contract directly with providers of the Programme. The NSU has subsequently been re-integrated into the Ministry of Health. The NSU has been part of the National Health Board since its introduction in November 2009.

Ref.	Recommendation	Comment
13.	**Management of the National Cervical Screening Programme.** The National Cervical Screening Programme should be under the control of a second or third tier manager within the Ministry. The Manager of the unit should as a minimum hold specialist medical qualifications in public health or epidemiology. As a consequence of the Programme's link with the Cartwright Report it has always had a female national co-ordinator. While there are understandable reasons for having the Programme managed by a woman it is not necessary for cervical screening programmes to have female managers. The cervical screening programme in New South Wales is managed by a male medical practitioner. The time has arrived for the National Screening Programme to be treated as a medical programme which is part of a national cancer control strategy. In the past its link with the Cartwright report has at times resulted in its purpose as a cancer control strategy being compromised for non-medical reasons.	In 2002 the National Screening Unit appointed a Programme Manager and Clinical Leader to jointly manage the Programme at the fourth tier. The Clinical Leader does have specialist medical qualifications in public health. Restructuring of the Ministry of Health placed the NSU into an operational group under National Services Purchasing. At this time the title Clinical Leader was downgraded to Clinical Advisor. The change in title was not supported by Group Manager, NSU. The subsequent restructure of the Ministry of Health brought the NSU in under the National Health Board. A parallel review of the NSU internal structure moved the Clinical positions into the relevant operational screening programmes. The net effect of these processes resulted in the clinical positions sitting at Tier 6. These changes risk compromising the credibility of the position to external clinical directors in the sector and wider stakeholder interest groups. The Group Manager is preparing papers to put forward a change of the Clinical Advisor position to that of Clinical Director overseeing the NCSP. This aligns the role with other national clinical positions and clinical positions in the sector.

Ref.	Recommendation	Comment
14.	**Amend section 74 of the Health Act 1956.** The Health Act 1956 should be amended to permit the National Cervical Screening Programme to be effectively audited, monitored and evaluated by any appropriately qualified persons irrespective of their legal relationship with the Ministry. This requires an amendment to section 74A of the Health Act to permit such persons to have ready access to all information on the National Cervical Screening Register.	The Health (National Cervical Screening Programme) Amendment Act 2004 contains provisions to permit the effective monitoring, audit and evaluation of the Programme.
15.	**Kaitiaki Regulations.** There needs to be reconsideration of the Kaitiaki Regulations, and the manner in which those regulations currently affect the Ministry of Health gaining access to aggregate data of Māori women enrolled on the National Cervical Screening Register. The Ministry of Health and any appropriately qualified persons engaged by it (be they independent contractors, agents or employees) require ready access to the information currently protected by the Kaitiaki Regulations in order to carry out any audit, monitoring or evaluation of the Programme.	A review of the Health (Cervical Screening (Kaitiaki)) Regulations was undertaken in 2002 and the decision of Cabinet was to retain the status quo. Work is continuing to gain timely access to Māori women's aggregate data on the NCSP Register.
16.	**Legal right to access information from the Cancer Register.** The present legal rights of access to information held on the Cancer Registry need to be clarified. The Ministry and any appropriately qualified persons it engages to carry out (external or internal) audits, monitoring or evaluation of cervical cancer incidence and mortality require ready access to all information stored on the Cancer Registry about persons registered as having cervical cancer.	The amendment to the Health Act 1956 contains provisions to permit screening programme evaluators to access all information on the Cancer Registry that relates to a relevant woman.
17.	**Amend Health Act 1956 to enable access to medical files.** The Health Act 1956 requires amendment to enable Ministry of Health and any appropriately qualified persons it engages to carry out (external or internal) audits, monitoring or evaluation of cervical cancer incidence and mortality, to have ready access to all medical files recording the treatment of the cervical cancer by all health providers who had a role in such treatment.	The amendment to the Health Act 1956 contains provisions to permit the effective monitoring, audit and evaluation of the Programme, including access for evaluators to health information and specimens relating to a relevant woman.

Ref.	Recommendation	Comment
18.	**Change guidelines under which ethics committees operate.** There needs to be change to guidelines under which ethics committees operate to make it clear that any (external and internal) audit, monitoring and evaluation of past and current medical treatment does not require the approval of ethics committees.	The operational standards for ethics committees have been amended.
19.	**Review of operations of ethics committees.** There should also be a review of the operation of ethics committees and the impact their decisions are having on independently funded evaluation exercises and on medical research generally in New Zealand.	Ethics committees have been reviewed and a new ethics committee structure put in place. The National Ethics Advisory Committee undertook this work in 2002/03, culminating in the presentation of advice to the Minister of Health in December 2003 and implementing of the National Ethics Advisory Committee's recommendations.
20.	**Provide guidelines to ethics committees regarding Privacy Act & Code.** Ethics Committees require guidance regarding the application of the Privacy Act and the Privacy Health Information Code. Ethics Committees need to be informed that the interpretation of legislation relating to personal privacy is for the agency holding a patient's data to decide. They would, therefore, benefit from having at least one legally qualified person on each regional committee.	The operational standards for ethics committees have been updated. See also recommendation 18 above.
21.	**Guidelines to ethics committees for observational studies.** Ethics committees require guidance regarding the weighing up of harms and benefits in assessing the ethics of observational studies.	The guidelines were released in December 2006.
22.	**National ethics committee – multi-centre studies.** A national ethics committee should be established for the assessment of multi-centre or national studies.	A national multi-region ethics committee was established in December 2004.

Ref.	Recommendation	Comment
23.	**Appeal process for ethics committee decisions.** The procedures under which ethics committees operate need to be re-examined. Consideration should be given to processes to allow their decisions to be appealed to an independent body.	In March 2009 the Health Research Council (HRC) undertook consultation on the document *A New Appeals Process for Ethical Review in New Zealand* which contained draft terms of reference and an appeals process for a Health Research Council Ethics Committee on Appeal (HRC ECA). The appeals process gained Ministerial approval in 2010 and the final appeals process and terms of reference are anticipated to be finalised shortly.
24.	**National Cervical Screening Programme Complaints System.** The National Cervical Screening Programme requires its own system to deal with complaints regarding the Programme's delivery. It also needs to have in place a user-friendly system which can respond to complaints of Programme failures, such as under-reporting. The difficulty that witness A experienced in having her medical misadventure recognised as a failure of the Programme and a failure of Gisborne Laboratories must be avoided in the future.	The National Screening Unit complaints process has been implemented. See also recommendation 45.
25.	**Electronic Link Cancer Registry & National Cervical Screening Programme Register.** The National Cervical Screening Register needs to be electronically linked with the Cancer Registry.	A process for linking and matching data has been implemented.
26.	**Performance Standards for National Cervical Screening Programme Register and Cancer Registry.** Performance standards should be put in place for the National Cervical Screening Register and the Cancer Registry. The currency of the data on both Registers needs to be improved. The Cancer Registry should be funded in a way that enables it to provide timely and accurate data that is meaningful.	In June 2010, the NCSP Register administration and technical and support functions were transferred to an external agency. The management and accountability for the NCSP Register and the Programme remains with the Ministry. Standards for the NCSP Register are currently under revision. A plan is currently underway to upgrade the Cancer Registry to enable data to be available to clinicians online.

Ref.	Recommendation	Comment
27.	**Standards for the National Cervical Screening Programme should be reviewed every two years.** Standards for the National Cervical Screening Programme should be reviewed every two years and more frequently if monitoring indicates that some of the standards are inappropriate.	Review and updating of the NCSP Operational Policy and Quality Standards (OPQS) is an ongoing process, reflecting changes to the Programme and best practice. This process is now well established and considered routine business. The NCSP OPQS are available on the website www.nsu.govt.nz
28.	**The Government must ensure sufficient cytotechnologists and cytopathologists and training sites.** The Government in consultation with other bodies or agencies needs to ensure that there are sufficient trained cytotechnologists and cytopathologists and that there are appropriate training sites for them. There should also be a review of training requirements and maintenance of competence of smear test readers and cytopathologists.	The Vocational Registration Programme in Cervical Cytology for BMLSc graduates and cytotechnicians was implemented in 2004/5. This has been embedded in the NCSP OPQS as compulsory for all new practitioners. Training and education for the NCSP laboratory cytology workforce has been provided since 2005 by a contracted laboratory and in 2011 is being extended to include histology and human papillomavirus (HPV) testing. Staff workload is included in the OPQS and is also audited on site annually.

Ref.	Recommendation	Comment
29.	**Amend Medical Laboratory Technologists Regulations 1989.** The Medical Laboratory Regulations 1989 should be amended to permit only registered medical practitioners with specialist qualifications in pathology and appropriate training in cytopathology or appropriately trained cytoscreeners to read cervical smear tests.	The Health Practitioners Competence Assurance Act 2003 was passed and replaced the older regulations. The Act contains provisions that give effect to the intent of the recommendations from the Inquiry including the establishment of new registration authorities and the development of gazetted scopes of practice. The registration authority is now the Medical Laboratory Science Board (MLSB). The Act is common to all Health Practitioners and includes technicians. It also includes the requirement for continuing professional development activity for issue of annual practising certificates from the MLSB.
30.	**Impose legal obligations on storage of slides.** Legal obligations in addition to those mandated by IANZ must be imposed on all laboratories reading cervical cytology requiring them to retain records of patients' cytology and histology results (including slides, reports and any other material relating to the patient) in safe storage for a period of no less than five years from the date on which the results were reported. Secondly all laboratory owners must be made legally responsible for ensuring that a patient's records are readily accessible and properly archived during the five year storage period irrespective of changes in the laboratory's ownership through a sale of shares or a sale of the laboratory's business. The vendor of the shares or the laboratory's business should carry a primary legal responsibility to store the records, though the option to transfer this legal responsibility as a condition of the sale to the purchaser should be permitted. Similar provisions should apply to laboratory amalgamations. In this case the newly merged entity should be responsible for storing the records.	The NCSP OPQS require laboratories to keep slides and tissue in accordance with current guidelines recognised by IANZ (aligned with Australian guidelines). Storage of slides is also further specified in the NCSP Laboratory Service Agreement. Routine diagnostic testing has been excluded from the standard for the Non-Therapeutic Use of Tissue.

Ref.	Recommendation	Comment
31.	**Ensure electronic linkage between National Cervical Screening Register and Cytology Labs.** The cervical smear test and histology histories of women enrolled on the National Cervical Screening Register should be made electronically available online to all laboratories reading cervical cytology.	All laboratories now have immediate access to online screening histories. This also includes HPV test results. Access by practitioners is mandated in the NCSP OPQS and system checked at annual audit.
32.	**Develop standards for accuracy of laboratory coding.** Standards must be developed for ensuring the accuracy of laboratory coding and this aspect of the National Cervical Screening Register must be subject to an appropriate quality assurance process.	Laboratory coding is standardised throughout the country and will be updated as part of some Ministry of Health projects. All cytology laboratory coding was revised and updated on July 1st 2005 as *Bethesda 2001 NZ Modified*, in conjunction with a sector working group. The NCSP Register was reprogrammed to accept all new codes as well as retain former Bethesda codes. All laboratories use this coding. Coding is mandated in the NCSP OPQS. See also recommendation 27.
33.	**The National Cervical Screening Programme should develop a population-based register.** The National Cervical Screening Programme should work towards developing a population based register and move away from being the utility based register that it is now.	This recommendation has been overtaken by progress. Advances made in primary care registers and systems of invitation and recall have addressed many of the issues that were intended to be resolved by a population register.

Ref.	Recommendation	Comment
34.	**Legal mechanisms should be in place to allow the ACC, Medical Council and the Health & Disability Commissioner to share relevant information with the National Cervical Screening Programme.** There should be a legal obligation on the Accident Compensation Corporation, the Medical Council and the Health and Disability Commissioner to advise the National Cervical Screening Programme's manager of complaints about the professional performance of providers to the Programme when complaints are made to those various organisations about the treatment of a patient in relation to the Programme.	The Accident Compensation Corporation is required to report complaints to the Medical Council under the Injury Prevention, Rehabilitation, and Compensation Act 2001. Under the Health and Disability Commissioner Amendment Act 2003, the Health and Disability Commissioner may refer a complaint to the Director-General of Health if it appears that the complaint is a result of inadequacies of the healthcare provider that may harm the health and safety of the public. Under the Health Practitioners Competence Assurance Act 2003, the Health and Disability Commissioner is required to raise with the Medical Council matters where there is a potential risk of harm to the public from a health practitioner's practice. In addition, under the Health Practitioners Competence Assurance Act 2003, the Medical Council must inform the Director-General of Health of possible harm posed by the health practitioner.
35.	**Medical Tribunal to supply information to National Cervical Screening Programme.** Consideration should be given to the addition of an express requirement in the provisions governing medical disciplinary proceedings which would oblige the Tribunal seized of the facts of any given case specifically to consider whether there are any grounds for concern that there may be a public health risk involved. If that concern is present the Tribunal should be required to inform the Minster of Health.	This recommendation is covered by the comments on recommendation 34 above.

Ref.	Recommendation	Comment
36.	**The Accident Compensation Corporation and the Medical Council should exchange relevant information regarding claims for medical misadventure.** There should be an exchange of information between the Accident Compensation Corporation and Medical Council regarding claims for medical misadventure and disciplinary actions against medical practitioners.	Implemented through the Injury Prevention and Rehabilitation Act 2001.
37.	**Liaison with the College of Pathologists.** It is recommended that the Programme liaise with the Royal College of Pathologists of Australia. In its submissions the Royal College advised that it believed that the collaborative relationship the college had with the Federal Government in Australia might be a model worth consideration by the Inquiry. It was suggested that it was appropriate to use medical colleges as an over-arching body to provide advice on issues. The benefit of this is, if the College is asked to provide an opinion on issues such as professional practice, quality or standards, it has access to the views from multiple professionals and also a critical evaluation of current literature in contemporary standard practices. It is suggested that the National Cervical Screening Programme, which has achieved a great deal, would benefit from greater professional input at a College level. In particular, it is suggested that a National Cervical Cancer Register and a Cervical Cancer Mortality Review process be a means of continually evaluating the Programme's effectiveness. The Committee supports the College's submission and recommends that it be acted upon.	College members are represented on the NCSP Advisory Group, on guidelines development working groups, and are regularly included in consultations on NCSP policy and strategic planning.
38.	**Information to Women.** The Programme must provide women with information to enable them to make informed decisions about screening and provide them with information regarding potential risks and benefits. Until the Programme has been monitored and evaluated in accordance with the current three phase national evaluation the Programme has an obligation to inform women that the quality of the performance of some of its parts has not been tested. Women should also be informed that screening will not necessarily detect cervical cancer.	The Health (National Cervical Screening Programme) Amendment Act 2004 requires all smear takers to provide information for women on the benefits and risks of screening. NCSP resources which inform women of the benefits and limitations of screening are actively made available to women.

Ref.	Recommendation	Comment
39.	**Letters to Medical Practitioners.** Medical practitioners need to be reminded that cervical smear tests are not a means of diagnosing cervical cancer. They need to be alert to signs of cervical cancer, and they should not place too much reliance on a patient's smear test results to discount the possibility of cervical cancer being present.	Letter sent December 2001. Clinicians are frequently reminded to be alert to signs and symptoms and to exercise clinical judgement, for example through clinical guidelines and smear taker operational policy.
40.	**Appropriately trained personnel should do cervical screening.** Primary screening of cervical smears should only be performed by individuals who are appropriately trained for that task. Consideration should be given to requiring pathologists to train as cytoscreeners if they want to function as primary screeners.	Primary screening policies and standards are covered in the NCSP OPQS. Screening is limited to appropriately qualified and trained cyto-scientists and cyto-technicians. Pathologists are not permitted to screen. The OPQS was revised in 2008 to include screening of LBC samples and standards for use of automated screening devices. Refer also to 28 above.
41.	**All pathologists undertaking cytology should be appropriately trained.** If cytology is a significant component of a pathologist's practice then he or she must participate in continuing medical education in that subject.	Pathologist qualifications and continuing education requirements are covered in the NCSP OPQS. Participation is audited annually. There are also continuing medical education requirements within the Health Practitioners Competence Assurance Act 2003 for maintaining an annual practising certificate.
42.	**Cytopathologists must participate in continuing education in cytopathology.** If cytology is a major component of a pathologist's practice, it is desirable that he or she should have added qualifications in cytopathology; either a fellowship slanted towards cytopathology or a diploma in cytopathology. Consideration should be given to making this a mandatory requirement.	Pathologist qualification requirements are covered in the NCSP OPQS. These policies and standards are made mandatory through the agreements with the laboratories. The Health Practitioners Competency Assurance Act 2003 also enforces qualification requirements.
43.	**Pathologists ought to be more open-minded.** Pathologists should be more open minded and critical of laboratory performance. They should be alert to the possibility that their practice or the practice of their colleagues may be sub-optimal.	Pathologists have demonstrated their open-mindedness through participation in advisory and working groups, and participation in external quality assurance programmes.

Ref.	Recommendation	Comment
44.	**The Medical Council should ensure that systems are in place to support the early reporting of errant medical practitioners by their colleagues.** The Medical Council should ensure that systems are in place whereby medical practitioners are not deterred from reporting to it their concerns about the practice of an individual medical practitioner. Complainants should be assured that their reports will not result in them being penalised in any way.	The recommendation has been given effect by the Health Practitioners Competence Assurance Act 2003. Section 34 of the Act protects health practitioners who report concerns about other health practitioners from civil or disciplinary proceeding, unless the reporting was done in bad faith.
45.	**National Cervical Screening Programme should have a system for identifying deficiencies.** The screening programme should have in place a system over and above the audit of monitoring reports, to identify deficiencies in the process. A form of survey of users so that they can be proactive rather than reactive in the delivery of the programme would be useful.	A National Screening Unit complaints process has been implemented. User feedback is received through advisory and working groups. See also recommendation 24.
46.	**There should be a process for monitoring the implementation of the Committees Recommendations.** A process to ensure that the recommendations made by the Committee are implemented should be put in place.	Reports on the Ministry's progress in implementing the recommendations include: • Dr McGoogan's six-Month Report (December 2001). • Dr McGoogan's second and final report (June 2003). • Office of the Controller and Auditor-General first report (14 February 2002). • Office of the Controller and Auditor-General second report (8 December 2003). Section 112O of the Amendment to the Health Act 1956 requires that the Programme is independently reviewed at least once every three years. A Parliamentary Review is currently being undertaken. The Ministry of Health also provides the Minister of Health with regular updates detailing progress made on the recommendations.