NATIONAL CERVICAL SCREENING PROGRAMME

Colposcopy Standards 2013
Data Dictionary

Version 1.1
June 2014

Introduction

Purpose

The purpose of this Data Dictionary is to provide a clear definition of the data elements to be collected and stored for the Colposcopy Standards 2013 as published by the Ministry of Health in July 2013 (see Appendix 1). The aim of these definitions is to avoid any ambiguity on the use of data items and ensure the Ministry of Health is collecting the data needed to meet the aims and objectives of the National Cervical Screening Programme (NCSP).

Complete, accurate and timely receipt of colposcopy data ensures the NCSP Register has a complete screening history. This enables the tracking of individual women for recall in line with recommended guidelines. It also provides the ability to complete accurate monitoring and evaluation of provider performance against national standards, indicators and targets, and to identify potential areas of risk.

The data held in the NCSP Register is used to calculate wait times for assessment of high-grade abnormalities, urgent referrals, low-grade abnormalities and the rates of women who do not attend appointments (DNAs). Performance against colposcopy indicators will be published in the biannual NCSP monitoring reports.

Audience

It is intended this Glossary will be used by:

- clinicians and administrators in colposcopy clinics
- vendors that supply colposcopy data (eg, SolutionsPlus Limited)
- NCSP Register users.

Using this document

The data element refers to the name as referenced and listed in order as detailed in Appendix 2 of the *National Cervical Screening Programme Policies and Standards* – Section 6: Providing a Colposcopy Service, issued in July 2013. The third column indicates for each data element the particular standard the data element is associated with. Those standards are all referred to in the tables by numbers; the titles of these are listed below.

601 – Recording referrals

602 – Ensuring timeliness of colposcopic assessment, waiting time calculated from this date to the date of visit

603 – Documenting colposcopic assessment

605 – Ensuring the timeliness of, and appropriate selection for first treatment

606 – Delivering appropriate outpatient treatment

607 – Ensuring appropriate selection for ablative treatment and appropriate quality of treatment

608 – Timely discharge of women after treatment

609 – Managing women who did not attend

610 – Ensuring colposcopy services are adequately staffed

611 – Maintaining staff skill level

Colposcopy Standards 2013 data elements

Data element name	Data element definition	Refer to Colposcopy Standard 2013
Recorded by DHB colposcopy/oncology service or non-DHB colposcopy specialist service		
Colposcopy clinic name	The name that identifies the colposcopy clinic or health organisation, such as a DHB or private colposcopy clinic.	601 603 609 610 611
Clinic number	The National Screening Unit Identification number assigned to a clinic.	601 603 609 610 611
DHB/Non-DHB	Indicates whether the colposcopy service is a private clinic or a DHB.	601 603 609 611
Colposcopist name	The colposcopist who carried out the consultation and who accepts responsibility for the referral and woman's care. This person should be certified by the Colposcopy Quality Improvement Programme (C-QulP), RANZCOG.	601 603 609 610 611
Registration number	The registration number of the colposcopist, which is assigned by the Medical Council of New Zealand. For HL7 an active Health Centre Member (HCM) number is required.	601 603 609 610 611
Date referral accepted by colposcopy service	Date that the colposcopy service or oncology service accepts/registers the woman referred to the clinic.	601 602 603 609 611

Women's details		
NHI	**The National Health Index is a unique seven-digit identifier of a woman receiving health or disability care and is assigned by the Ministry of Health. NHI numbers are used to track a person through different parts of the health system, for instance from a practice to a laboratory.** http://www.health.govt.nz/our-work/health-identity/national-health-index/nhi-information-health-consumers/national-health-index-questions-and-answers	601 603 609
Date of birth	The date the woman was born.	601 603 609
Ethnicity (code)	**This is the ethnicity code of the ethnic group or groups that the woman identifies with. The codes used are as defined by the national collections reporting guidelines. (Refer to Appendix 4 in the *Ethnicity Data Protocols for the Health and Disability Sector*, 2004 and *Ethnicity Data Protocols Supplementary Notes*, 2009.)** http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables	601 603 609
Last name	The woman's last name (surname).	601 603 609
First name(s)	The woman's first (given) name(s).	601 603 609
Residential address	The address where the woman lives; not a box number.	601 603 609
Referred by		
Name	The name of the health practitioner who is making the referral.	601 603
Health practitioner (clinician), such as GP, nurse, specialist.	The registration number that identifies the referring health practitioner making the referral (the smear taker or other clinician). This must be the health practitioner's active Health Centre Member (HCM) number.	601 603
GP, nurse, specialist, other	The role of the referring health practitioner (clinician).	601 603

Health facility (clinic) making referral	The name of the health facility making the referral, such as the general practice or medical centre, via HL7. This is the health centre member ID (NSUID) that is held on the register.	601 603
Date referral received by colposcopy service (public or private)	Date the referral is physically received at the DHB or colposcopy service.	601 603
Appointment date	The date set for the woman to be seen by the colposcopist.	601 603
Method of referral	Indicates how the referral was received at the colposcopy clinic – phone, letter or other.	601 603
Type of referral		
First assessment (new case)	Indicates whether the referral is for a first assessment – yes or no.	601 602 603
Subsequent assessment (follow-ups)	When this is not the first assessment, indicates the referral follow-up number: 1st, 2nd, 3rd or 4th.	601 602 603
Smear taker reason for referral	This is the reason given by the smear taker (clinician) for the referral.	
1. Abnormal smear *A.* Low grade (ASCUS / LSIL) *B.* High grade (ASC-H / HSIL) *C.* Suspicious of invasive cancer (squamous/adenocarcinoma) D. Glandular abnormality (AIS/AGC)	Referring clinician to select appropriate reason(s) for the referral from the list. Low-grade smear, includes ASCUS and LSIL smears. High-grade smear includes ASC-H and HSIL smears. Suspicious of invasive cancer smear. Glandular smear.	601 602 603
2. Positive / detected hrHPV test result, only	hrHPV detected and reported by laboratory.	
3. Positive/detected hrHPV test result plus abnormal smear	hrHPV detected and reported in addition to abnormal smear result.	
4. Clinical reasons only, such as post-coital bleeding (PCB), abnormal cervical appearance, pelvic pain	The smear taker referral is for a clinical reason only. This could include PCB, abnormal bleeding, pelvic pain or an abnormal looking cervix.	

5. Other reason, such as vulval (specify)	Includes any other reason for a referral to colposcopy.	
6. Optional comments about referral	A free-format data element that provides additional information not detailed elsewhere in the referral data. Information held here should only contain details that are directly relevant to the cervical screening management.	601 602 603
Colposcopist assessment of reason for referral	This is the priority (or grading) given by the colposcopist. It then determines the priority waiting time (booking priority) for seeing the woman as defined in the colposcopy standards 2013.	
1. Abnormal smear A. Low grade (ASCUS/LSIL) B. High grade (ASC-H/HSIL) C. Suspicious of invasive cancer (squamous/adenocarcinoma) D. Glandular abnormality (AIS/AGC) 2. Positive/detected hrHPV test results only A. Low-grade clinical assessment (eg, persistent positive hrHPV test for 'historical testing') B. High-grade clinical assessment C. Suspicious of invasive cancer clinical assessment D. Post-treatment (ie, within three years of treatment for a high-grade abnormality) 3. Positive detected hrHPV test results plus abnormal smear A. Low grade (ASCUS/LSIL) B. High grade (ASC-H/HSIL) C. Suspicious of invasive cancer (squamous/adenocarcinoma) D. Post-treatment (ie, within three years of treatment for a high-grade abnormality) 4. Clinical reasons only A. Low-grade clinical assessment B. High-grade clinical assessment C. Suspicious of invasive cancer clinical assessment D. Other clinical assessment 5. Other reason A. Low-grade clinical assessment B. High-grade clinical assessment C. Suspicious of invasive cancer clinical assessment D. Other clinical assessment 6. Optional comments about referral	The colposcopist should select their preferred reason from the list. This will determine the priority booking for the woman. Category 1 refers to the cytological assessment provided by the laboratory. Category 2 refers to a laboratory result in addition to the clinical assessment. Category 3 refers to the laboratory results. Categories 4 and 5 refer to the clinical assessment made by the colposcopist following review of the woman's full clinical history. **Note**: Standard 602 states the maximum waiting times for a colposcopic assessment: • within 10 working days for suspicious of invasive cancer • within 20 working days for high-grade abnormalities (including glandular) • within 4 to 12 weeks for post-treatment hrHPV test and other clinical assessment (ie 4D and 5D) • must not exceed 26 weeks for low-grade abnormalities.	602 603 607

Colposcopy visit details		
Date of visit	The date the woman attends the colposcopy clinic.	602 603 604 605
Admission type	The nature of the admission – inpatient, day stay or outpatient.	603 606
First assessment (new case)	Indicates whether the visit is for a first assessment – yes or no.	603 611
Subsequent assessment (follow-ups) This can include referral from a specialist	When this is not the first assessment, indicates the visit follow-up number: 1st, 2nd, 3rd or 4th.	603
Pregnant	Indicates whether the woman is pregnant at the time of the visit – yes or no.	603 606
Colposcopy performed	Indicator to show whether or not a colposcopy was performed at the visit – yes or no.	603 606
Colposcopy site	If a colposcopy was performed at the visit, this indicates the site as cervical or vaginal, or both cervical and vaginal, or other.	603
Colposcopy findings		
Transformation zone visible	The level of visibility of the transformation zone expressed as completely, partially, not visible or not applicable.	603 607
Lesion present	Indicator as to whether a lesion(s) was observed to be present, as yes, no or inconclusive, irrespective of whether any lesion seen is benign or worse, for example, for benign: endometriosis, benign polyp.	603 607
Number of quadrants involved	Indicates how many quadrants of the cervix were found to be affected: 1, 2, 3 or 4.	603 607
Normal findings noted	Appearance of cervix morphologically/clinically normal, so no abnormality, benign or worse, seen.	603 607
Abnormal visible lesion	Indicates whether an abnormal lesion was visible – yes or no. If yes, a predicted grade(s) of abnormality is expected to be identified.	603 606 607
Limits of lesion visible	If a lesion(s) is found to be present, this indicates whether the limits of the lesion(s) were visible – yes or no.	603 606 607

Predicted grade(s) of abnormality	Indicates the grade or level of abnormality of the most severe lesion observed during the visual examination/assessment conducted during this visit, as one of the following (yes or no): ○ low-grade squamous ○ high-grade squamous ○ glandular ○ micro-invasive cancer ○ invasive cancer (squamous/glandular).	603 606 607
Review / results discussed	This indicates whether or not the results of the previous visits/tests have been discussed with the patient at the current visit, yes or no.	604
Arranged treatment	Indicates whether a treatment plan has been discussed with the patient and treatment has been arranged for a future date/time.	604
Actions taken during visit		
Cervical/vaginal smear	Indicates whether a cervical/vaginal smear was taken during the visit – yes or no.	603 605
hrHPV test	Indicates whether an hrHPV test was requested during the visit – yes or no.	603 605
Biopsy	Indicates whether a biopsy was taken during the visit –yes or no.	603 605 607
Site of biopsy (biopsies) taken	If a biopsy (biopsies) was taken during the visit, this details the site of the biopsy as: ○ cervical ○ vaginal ○ both cervical and vaginal ○ other.	603 605 607
If no biopsy taken, give reasons	If no biopsy was carried out at the visit, this free-format text data item holds details of the reason why this action was not taken. These reasons could include that endometrial or other genital lesion is suspected.	603 605 607
Treatment this visit	Indicates whether the woman received any treatment during the visit – yes or no. If yes, then at least one of the actions under type of treatment must be selected as yes.	603 605 606
Type of treatment		
Wireloop excisional procedure (Lletz)	Indicates whether a wireloop excisional procedure was performed on the woman at the visit – yes or no.	605 606
Laser ablation	Indicates whether a laser ablation treatment was carried out during the visit – yes or no.	605 606 607

Ablation by means other than laser	Indicates whether the woman had an ablation (non-laser) treatment during the visit – yes or no.	605 606 607
Cold knife cone	Indicates whether the woman had a cold knife cone treatment at the visit – yes or no.	605 606
Diathermy cone	Indicates whether the woman had a diathermy cone treatment at the visit – yes or no.	605 606
Laser cone	Indicates whether the woman had a laser cone treatment at the visit – yes or no.	605 606
Hysterectomy	Indicates whether a hysterectomy was performed during the visit – yes or no.	
Hysterectomy – total or subtotal	If a hysterectomy was performed at the visit, whether it was a total or subtotal hysterectomy.	
Other (describe)	Indicates there were other types of treatment carried out at the visit. This free-text data item, which describes the treatment provided to the woman, must be completed if indicated as other.	
Diagram/photo of lesion	Indicates whether a diagram or photo of the lesion is available from the visit – yes or no. Note the diagram or photo is not stored on or to be sent to the NCSP Register.	603
Local or general anaesthesia used	Indicates whether local or general anaesthesia was used during the visit. If not applicable, n/a is used.	603 606
Follow-up management recommended	Indicates whether the woman is expected to: o return for another colposcopy visit o return to the care of the smear taker (ie, discharged) o be referred to oncology services (ie, discharged from colposcopy). Note if the woman is to be discharged to the smear taker this will require a discharge referral. Done automatically via HL7 currently.	603
Next visit recommended in	This is the timeframe when the next visit should be.	603
Follow-up visit data		
Date histology specimen report received by colposcopy service	This is the date the histology specimen report was received by the colposcopy service.	605
Decision to treat date	This the date a decision was made to treat the woman.	605

Date woman informed	The date the woman was advised of the diagnosis by the colposcopy service and whether the colposcopy service has decided to treat her.	604 605
Histology specimen satisfactory for interpretation	Indicates whether the histology specimen taken was satisfactory for interpretation – yes or no.	603 607
Biopsy result	This is the result of the biopsy. None, one or multiple results can be selected: ○ negative ○ CIN1/HPV ○ CIN2 ○ CIN2/3 ○ CIN3 ○ AIS ○ adenocarcinoma ○ squamous carcinoma ○ adensoquamous carcinoma ○ other.	603 605 607 608

Did not attend		
Scheduled visit date	This is the date the woman was scheduled to visit the colposcopist.	609
For: First assessment Treatment Follow-up after treatment/other	Indicates the intended purpose of the visit (yes or no): • first assessment • treatment • follow-up after treatment/other.	609
Reason for DNA (if known)	Indicates why the woman may have not attended the visit: ○ transport ○ change of address ○ pregnant ○ menstruation ○ refusal ○ other (to provide further details).	609
Rescheduled appointment date	If a subsequent colposcopic visit has been made, this is the date of that appointment.	609
Discharged from colposcopy		
To smear taker	Indicates the woman is to be discharged to a smear taker – yes or no.	608
To oncology	Indicates the woman is to be discharged to oncology – yes or no.	608

Other	Indicates the woman is to be discharged to someone other than a smear taker or oncology – yes or no.	608
Name of health worker	The name of the health worker the woman has been discharged to.	608
Name of health facility	The name of the health facility the woman has been discharged to.	608
Date of discharge	The date the woman's discharge is effective on.	608
Timeframe when woman should be seen	Indicates when the woman should be seen by the health facility she is discharged to: < 3 months, < 6 months, < 12 months or > 12 months.	608

Appendix 1

Colposcopy referral, visit and DNA data requirements

NHI: _____

Colposcopy referral, visit and DNA data requirements

Recorded by DHB colposcopy/oncology service or non-DHB colposcopy specialist service

Colposcopy clinic name		Clinic number		☐ DHB ☐ Non-DHB
Colposcopist		Registration number		
Date referral received by colposcopy service				
Date referral accepted by colposcopy service				
Appointment date				

Woman's details

NHI		Date of birth		Ethnicity	
Last name		First name(s)			
Residential address					

Referred by

Name		Health practitioner	☐ GP ☐ Nurse ☐ Other
Health facility making referral			
Method of referral	Letter ☐ Yes ☐ No	Phone ☐ Yes ☐ No	Other (electronic referral) ☐ Yes ☐ No

Type of referral

First assessment (new case)	☐ Yes	☐ No					
Subsequent assessment (follow-ups)	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th			

Note: If a woman is referred from another DHB or specialist for follow-up or treatment, this should be noted as a subsequent assessment (follow-up).

Smear Taker's reason for referral

	1 Abnormal smear
☐	A. Low grade (ASCUS/LSIL)
☐	B. High grade (ASC-H/HSIL)
☐	C. Suspicious of invasive cancer (squamous/adenocarcinoma)
☐	D. Glandular abnormality (AIS/AGC)
☐	2 Positive/detected hrHPV test results only
☐	3 Positive/detected hrHPV test results plus abnormal smear
☐	4 Clinical reasons only (eg, post-coital bleeding, abnormal cervical appearance, pelvic pain)
☐	5 Other reason (eg, vulval) (specify):
6	Optional comments about referral:

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NHI: _____

Colposcopist's assessment of reason for referral

	1 Abnormal smear
☐	A. Low grade (ASCUS/LSIL)
☐	B. High grade (ASC-H/HSIL)
☐	C. Suspicious of invasive cancer (squamous/adenocarcinoma)
☐	D. Glandular abnormality (AIS/AGC)
	2 Positive/detected hrHPV test results only
☐	A. Low-grade clinical assessment (e.g. persistent positive hrHPV test for 'historical testing')
☐	B. High-grade clinical assessment
☐	C. Suspicious of invasive cancer clinical assessment
☐	D. Post-treatment (ie, within three years of treatment for a high-grade abnormality)
	3 Positive/detected hrHPV test results plus abnormal smear
☐	A. Low grade (ASCUS/LSIL)
☐	B. High grade (ASC-H/HSIL)
☐	C. Suspicious of invasive cancer (squamous/adenocarcinoma)
☐	D. Post-treatment (ie, within three years of treatment for a high-grade abnormality)
	4 Clinical reasons only (e.g, post-coital bleeding, abnormal cervical appearance, pelvic pain)
☐	A. Low-grade clinical assessment
☐	B. High-grade clinical assessment
☐	C. Suspicious of invasive cancer clinical assessment
☐	D. Other clinical assessment
	5 Other reason (eg, vulval) (specify):
☐	A. Low-grade clinical assessment
☐	B. High-grade clinical assessment
☐	C. Suspicious of invasive cancer clinical assessment
☐	D. Other clinical assessment
6	Optional comments about referral:

Note: Standard 602 states the maximum waiting times for a colposcopic assessment:

- within 10 working days for suspicious of invasive cancer
- within 20 working days for high-grade abnormalities (including glandular)
- within 4 to 12 weeks for post-treatment hrHPV test and other clinical assessment (ie, 4D and 5D)
- must not exceed 26 weeks for low-grade abnormalities.

Colposcopy visit details

Date of visit	
Admission type	☐ Outpatient ☐ Day patient ☐ Inpatient
First assessment (new case)	☐ Yes ☐ No
Subsequent assessment (follow-ups)	☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Pregnant	☐ Yes ☐ No
Colposcopy performed	☐ Yes ☐ No

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NHI: _____

Colposcopy site	☐ Cervical ☐ Vaginal ☐ Both cervical and vaginal ☐ Other
Review / results discussed	☐ Yes ☐ No
Arranged treatment	☐ Yes ☐ No

Colposcopy findings

Transformation zone visible	☐	Completely	☐	Partially	☐	Not visible	☐ N/A
Lesion present	☐	Yes	☐	No	☐	Inconclusive	
Number of quadrants involved	☐	1	☐	2	☐	3	☐ 4
Normal findings noted	☐	Yes	☐	No			
Abnormal visible lesion	☐	Yes	☐	No			
Limits of lesion visible	☐	Yes	☐	No			
Predicted grade(s) of abnormality							
Low-grade squamous	☐	Yes	☐	No			
High-grade squamous	☐	Yes	☐	No			
Glandular (AIS)	☐	Yes	☐	No			
Micro-invasive cancer	☐	Yes	☐	No			
Invasive cancer (squamous/glandular)	☐	Yes	☐	No			

Actions taken during visit

Cervical/vaginal smear	☐	Yes	☐	No	hrHPV test	☐	Yes	☐ No
Biopsy	☐	Yes	☐	No				
Site of biopsy (biopsies) taken								
If no biopsy taken, give reasons								
Treatment this visit	☐	Yes	☐	No				
Type of treatment								
Wireloop excisional procedure	☐	Yes	☐	No				
Laser ablation	☐	Yes	☐	No				
Ablation by other means other than laser	☐	Yes	☐	No				
Cold knife cone	☐	Yes	☐	No				
Diathermy cone	☐	Yes	☐	No				
Laser cone	☐	Yes	☐	No				
Hysterectomy	☐	Yes	☐	No	☐	Total	☐	Subtotal
Other (describe)								
Diagram/photo of lesion	☐	Yes	☐	No				
Local or general anaesthesia used	☐	Local	☐	General	☐	N/A		
Follow-up management recommended	☐	Yes	☐	No				
Next visit recommended in		months						

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NHI: _____

Follow-up visit data

Date histology specimen report received by colposcopy service	
Decision to treat date	
Date woman informed	
Histological specimen taken satisfactory for interpretation	☐ Yes ☐ No
Biopsy result	☐ Negative ☐ CIN1/HPV ☐ CIN2 ☐ CIN2/3 ☐ CIN3 ☐ AIS ☐ Adenocarcinoma ☐ Squamous carcinoma ☐ Adenosquamous carcinoma ☐ Other

Did not attend

Scheduled visit date	
For First assessment Treatment Follow-up after treatment/other	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Reason for DNA (if known)	
Rescheduled appointment date	

Discharged from colposcopy

To smear taker Name of health worker/ health facility	☐ Yes ☐ No	Date of discharge		☐ <3 months ☐< 6 months ☐<12 months ☐ >12 months
To oncology Name of health worker/ health facility	☐ Yes ☐ No	Date of discharge		☐ <3 months ☐< 6 months ☐<12 months ☐ >12 months
Other Name of health worker/ health facility	☐ Yes ☐ No	Date of discharge		☐ <3 months ☐< 6 months ☐<12 months ☐ >12 months

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