

National Cervical Screening Programme Policies and Standards

Section 6: Providing a Colposcopy Service



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NCSP policies and standards

NCSP policies and standards

The National Cervical Screening Programme (NCSP) Policies and Standards document the agreed policies, guidelines and standards of practice for providers of NCSP services.

Their purpose is to support all those involved in the NCSP to achieve the programme's aims and objectives by ensuring a high standard and national consistency of service at each step of the screening pathway.

In this section

This section of the NCSP Policies and Standards contains information, guidance, policies and standards for health professionals providing a colposcopy service.

Defining and monitoring colposcopy services

Colposcopy defined

Colposcopy is the visual examination of the cervix using a low-powered microscope, known as a colposcope. Colposcopy enables the diagnosis and treatment of cervical abnormalities and guides the taking of biopsies for histological diagnoses. It is also used to visualise the cervix during treatment, using a range of treatment methods.

Role of colposcopy

Colposcopy is central to the successful diagnosis and treatment of cervical abnormalities. The primary objective of colposcopy is to undertake a comprehensive visual examination of the cervix in women referred with any of the following:

- cytological abnormalities detected on cervical sampling
- visible abnormalities of the cervix
- symptoms and signs of cervical cancer

in order to locate a possible lesion requiring treatment.

Service providers

Colposcopy services are contracted to district health boards (DHBs), where the service is usually part of a gynaecological or women's health service.

Colposcopy is also provided by gynaecologists working in private practice.

Role of service providers

The role of service providers for colposcopy includes:

- providing information about attending colposcopy
- informing women about referral, assessment and support
- diagnosis
- discussing diagnosis, options for treatment, implications, management and follow-up
- assisting women to make informed decisions
- documenting colposcopy assessment and management decisions
- referral to support services as required
- complying with 'duties of persons performing colposcopy procedures', specified in section 112M of the Health Act 1956, as amended by Part 4A in 2004 (see Appendix 1), which includes providing data as specified by the NCSP (see Appendix 2).

Monitoring colposcopy services – compliance with the Health Act 1956

The NCSP has a statutory obligation to: ‘facilitate continuous quality improvement by allowing and performing regular evaluations of the NCSP’ and to ‘provide information to women about the quality and effectiveness of the NCSP including, if it is appropriate, information based on the result of evaluations’ (section 112D, Objectives of NCSP).

To fulfil its statutory functions the NCSP must collect and analyse data on colposcopy services (see Appendix 2).

In 2009 the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) led the development of an education, certification/re-certification and audit programme for all health professionals performing colposcopy in Australia and New Zealand, the Colposcopy Quality Improvement Program (or C-QuIP, see www.cquip.edu.au).

The aim of C-QuIP is to improve the care of women who are referred for colposcopy and the treatment of screen-detected abnormalities.

Data required for recertification will be incorporated into NCSP standards to help clinicians meet ongoing recertification requirements.

Evidence

The NCSP policies and standards for colposcopy take into account the best available evidence on cervical screening, including colposcopy.¹ Sometimes this relies on expert opinion or is drawn from authoritative statements from organisations such as the British Society for Colposcopy and Cervical Pathology, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, or other guidelines and service delivery indicators used in England, Scotland, Wales, Canada and the USA. Guidelines on *Faster Cancer Treatment: Guidance for implementing high-quality multidisciplinary meetings*, published by the New Zealand Ministry of Health in 2012, provide guidance on waiting times and best practice in line with international evidence.^{1–16}

Evidence of best practice in cervical screening is changing as understanding of the role of high-risk human papillomaviruses (hrHPV) in cervical cancer improves.^{17–20} It is anticipated that updates to these standards will be made as new evidence becomes available and changes to national policies are made.

Women who require colposcopy

Women referred for colposcopy may have:

- clinical suspicion of invasive carcinoma with or without vulval/vaginal pathology
- high-grade cervical smear abnormalities
- persistent low-grade cervical smear abnormalities
- low-grade abnormalities and a positive high-risk human papillomavirus (hrHPV) test
- a positive hrHPV test after being treated for a high-grade lesion within the previous three years (‘test of cure’).

Note that updates to the *Guidelines for Cervical Screening in New Zealand 2008* may incorporate other reasons for referral to colposcopy.

Women who require gynaecological assessment and possible colposcopy

Women referred for gynaecological assessment (who may also be referred for colposcopy) may have:

- an abnormal-appearing cervix
- irregular bleeding
- post-coital bleeding
- pelvic pain.

These women should ideally be seen within two to four weeks of receipt of referral.^{2, 14, 15} This will depend on whether there is clinical concern about invasive cancer. A decision to undertake colposcopy on these women will be at the discretion of the gynaecologist^{1, 2, 3, 7} and should be discussed with the referring clinician.

Note that there is wide variation in published guidelines on referral for gynaecological assessments.²¹ It is recognised that there are difficulties outlining all specific clinical referral criteria for gynaecological assessment for possible cervical cancer, given the multiple causes of symptoms or signs. If there are concerns about inappropriate referrals, gynaecologists should manage this locally, in consultation with referring clinicians.

Support for women policy

Purpose

This policy is to ensure that processes used by colposcopy services:

- encourage women to attend colposcopy appointments, using appropriate links and support services
- provide support for women requiring colposcopy services
- meet each woman's needs
- reduce inequalities.

Policy

Colposcopy services must be available and appropriate for all women and ensure that an individual woman's needs are met.¹⁻¹⁵

Support for women: details

Māori, as tangata whenua (people of the land), have a special relationship with the Crown. The Crown has duties and responsibilities to ensure improved Māori health outcomes, and service providers have an obligation to fulfil these responsibilities.

Colposcopy services must be appropriate and supportive of women from all ethnic groups and must ensure cultural competence throughout the service.

Colposcopy services are also required to meet the diverse needs of women of all ages and sexual orientations.

Colposcopy services must:

- utilise Māori support services, where they are available, to assist in locating, and support and follow-up, of Māori women referred for colposcopy
- utilise Pacific and Asian support services, where they are available, to assist in locating, and support and follow-up, of Pacific women referred for colposcopy
- encourage and provide facilities for the woman's family, whānau or other support people to attend the colposcopy appointment
- provide adequate information regarding colposcopy procedures and their implications
- ensure there is adequate time for decision-making
- have counselling available from a counsellor or social worker, or a health practitioner with counselling experience
- obtain informed consent from the woman for the presence of non-essential personnel.

See also

- NCSP Policies and Standards, Section 1: *NCSP Overview*, URL: www.nsu.govt.nz/health-professionals/1060.aspx
- NCSP Policies and Standards, Section 4: *Providing a Smear Taking Service*, URL: www.nsu.govt.nz/health-professionals/1060.aspx

Notes

There is very good evidence that women demonstrate anxiety and severe stress after receiving an abnormal smear result, particularly if being referred for colposcopy. It is therefore imperative that all women be supported with comprehensive information to reduce anxiety and missed appointments, and to encourage participation at first assessments.^{2, 9, 22, 23, 24}

Providing information to women during and after a colposcopy visit

Purpose

This policy is to ensure that women are provided with accurate and timely information necessary to making a decision.

Policy

Colposcopy services must ensure that women are provided with the necessary information during a visit and after diagnosis.^{2, 7, 22}

Supporting women during and after visit: details

Colposcopy services must ensure that:

- an experienced nurse or support person is available to all women during and after the consultation
- all communication with women is timely and clear – a trained interpreter must be provided if required
- women are informed about the availability of pain relief if required prior to or during the procedure
- women are given information regarding post-procedure care
- women are informed about the results of their procedures
- women are informed that their results will be sent to their GP and smear taker (if not the GP), and their information, smear and biopsy results will be forwarded to the NCSP Register in accordance with Part 4A of the Health Act 1956 (as amended in 2004)
- there is adequate time and space for:
 - education
 - support people
 - decision-making regarding diagnosis and treatment options
 - questions to be answered.

After diagnosis, a woman must be given:

- written and verbal information on treatment options, which must include the advice that she can see her GP/primary care provider or other agencies for further information
- information regarding appropriate anaesthetic options
- information about referral to a gynaecology oncology service, where required, for a diagnosis of cancer
- information on referral to long-term support services, counselling, nursing or voluntary agencies, where required.

Referral for colposcopy

Purpose

This policy is to ensure that:

- processes are in place to ensure timely assessment of women at colposcopy services
- women are well informed about their referral
- the number of colposcopy referrals seen each year is recorded.

Policy^{1–5, 7, 14, 15}

The woman and her smear taker must be notified of receipt of referral to attend colposcopy services as soon as possible after the referral has been received by the clinic.

Prior to the appointment the woman must be provided with the necessary information about the visit, the procedures, and her support options during the colposcopy visit.

The urgency and referral grading of colposcopic examination depend on the degree of abnormality indicated by the smear, the full screening history and/or hrHPV test result, or by clinical indication.

Colposcopists are required to record all cases that are referred for colposcopy assessment for audit and recertification (C-QulP).

Standard 601: Recording referrals and informing women about colposcopy

Standard

All referrals for colposcopy must be recorded and women must receive appropriate information about their referral prior to their visit.

- Record the date the colposcopy referral was received.
- Acknowledge receipt of the referral.
- Provide the NCSP colposcopy pamphlet.
- State that a support person may accompany a woman to her appointment.
- Provide information regarding the waiting times.

(For NCSP referral data requirements, see Appendix 2.)

Informing women prior to visit: details

Prior to the initial visit, women must be:

- sent the NCSP colposcopy pamphlet
- told that they may be accompanied by a support person
- sent appropriately worded information that includes:
 - a contact name, telephone number and times to phone
 - what to do if menstruating at the time of appointment
 - how to notify the colposcopy services if there is a need for an interpreter or any special services
 - what the follow-up procedures are, where appropriate
 - what to expect from the visit, including whether treatment may take place.

Target

One hundred percent of referrals are recorded and all women are informed of receipt of their referral.

Measurement

The following data sources and methods of measurement are used:

- audit
- referral volumes, using NCSP Register data.

Referral data required: see Appendix 2 – woman's identification, colposcopist identification, colposcopy clinic identification, referred by, date colposcopy referral received, method of referral, type of referral (ie, new case or follow-up), reason for referral. (C-QulP, Standard 1³)

Standard 602: Ensuring timeliness of colposcopic assessment

Standard

Women who:

- have evidence of clinical suspicion of invasive carcinoma, or a laboratory report indicating 'features suspicious for invasion', or 'changes consistent with squamous cell carcinoma', or similar,¹ must receive a colposcopy or gynaecological appointment within the next **10 working days** from when the colposcopy unit received the referral from the smear taker/referrer^{2, 14, 15, 23, 25}
- have high-grade cervical smear abnormalities, including glandular abnormalities,¹ must receive a colposcopy appointment to be seen within the next **20 working days** from when the colposcopy unit received the referral from the smear taker/referrer^{2, 14, 15, 23, 25}
- have persistent low-grade abnormalities or a low-grade abnormality and positive hrHPV test,¹ must receive a colposcopy appointment **that should not exceed 26 weeks** of the colposcopy unit receiving the referral from the smear taker/referrer (see 'Notes' below)

- are being referred on the basis of a positive hrHPV test following treatment for a high-grade abnormality within the previous three years ('test of cure')¹ must be sent an appointment to be seen within 4 to 12 weeks of the colposcopy unit receiving the referral (see 'Notes' below)
- are being referred on the basis of a persistent positive hrHPV test alone (ie, historical testing)¹ must be seen within 26 weeks of the colposcopy unit receiving the referral from the smear-taker.

Notes

One week equals five working days.

Most guidelines recommend that women with abnormal screening tests be seen at colposcopy within a 'reasonable time', given the risk of high-grade lesions and the stress associated with an abnormal result.^{2, 5, 6, 8, 9, 10–12, 14, 15}

Most guidelines recommend women be seen within two weeks of referral for an abnormality suggestive of cancer, within four weeks for high-grade cytology and within eight weeks for low-grade cytology. It is recommended that time from referral to colposcopy for low-grade lesions not exceed six months, with clear documented reasons for any delay.^{2, 5, 6, 8, 9, 10–12, 14, 15}

HrHPV clearance after treatment of precancerous lesions is estimated to be 90 percent following a Large Loop Excision of the Transformation Zone (LLETZ) procedure and 80 percent following ablative treatment after two years.²⁷ However, to improve the sensitivity of a post-treatment test (ie, where hrHPV testing is being used as a 'test of cure' to detect possible treatment failures), it is recommended that women with a positive test be seen within a reasonable time to facilitate early reassessment and re-treatment, if appropriate. This is considered to be within 4 to 12 weeks given the possibility of a treatment failure and risk of CIN3.^{2, 5–9, 14, 15, 26–32}

Referral grading: details

The total number of referrals received each week must be recorded and graded. Referral grading must include a review of a woman's full cervical screening history obtained from the NCSP Register.

Referral volumes recorded on the Register will be required to meet C-QulP standards.^{3, 4}

Notes

The smear taker has a responsibility to refer to colposcopy a woman with cervical smear abnormalities based on the *Guidelines for Cervical Screening in New Zealand 2008* and subsequent amendments. The smear taker should provide information about the woman, including all relevant clinical information (see NCSP Policies and Standards, Section 4: *Providing a Smear Taking Service*, URL: www.nsu.govt.nz/health-professionals/1060.aspx)

Target

Ninety-five percent or more of women who:

- have evidence of clinical suspicion of invasive carcinoma, or a laboratory report indicating 'features suspicious for invasion', or 'changes consistent with squamous cell carcinoma', or similar, must receive a date for a colposcopy appointment or a gynaecological assessment that is within 10 working days of receipt of the referral
- have high-grade smear abnormalities must receive a date for a colposcopy appointment that is within 20 working days of receipt of the referral
- have persistent low-grade abnormalities must receive a date for a colposcopy appointment that does not exceed 26 weeks of receipt of the referral
- are being referred on the basis of a positive hrHPV test following treatment for a high-grade abnormality within the previous three years ('test of cure') must receive a date for a colposcopy appointment that is within 4 to 12 weeks of receipt of the referral
- are being referred on the basis of a persistent positive hrHPV test alone must receive a date for a colposcopy appointment that is within 26 weeks of receipt of the referral.

Notes

The date the colposcopy referral was received must be recorded in the colposcopy/oncology referral data set (see Appendix 2).

In calculating the colposcopy waiting times following referral, 'Date of booked appointment' minus 'Date colposcopy referral received' equals the waiting time.

Measurement

The following data sources and methods of measurement are used:

- data extract from electronic reports sent to the NCSP Register within four weeks of the booked appointment date
- audit
- quarterly monitoring using NCSP Register data
- biannual reports externally analysed and reviewed by the NCSP Advisory Group.

Work practices

Purpose

This policy is to ensure that colposcopy service providers adhere to standard work practices and colposcopy assessments are accurately documented.

Policy^{2, 16, 33, 34}

The following standard work practices apply to all colposcopy service providers. The colposcopist must:

- utilise the current NCSP Register online screening history for each woman
- include review of the full NCSP Register screening history at referral grading
- have the referring cytology/hrHPV test report and screening history for the woman during the colposcopy consultation
- document the colposcopic assessment as either a first assessment or subsequent assessment
- once a diagnosis is reached, discuss, advise and record a treatment plan with the woman being assessed, or via a letter
- inform the woman's GP/primary care provider as soon as possible of the:
 - diagnosis
 - options given to the woman
 - choices she makes, if known
- inform the smear taker of the diagnosis if this is not the woman's regular GP/primary care provider
- maintain close liaison with pathologists and attend regular multidisciplinary meetings with the pathologist, cytologist and colposcopy staff
- provide the laboratory with a full relevant clinical history to accompany a smear or biopsy (the laboratory will access the screening history online)
- advise the pathologist whether the biopsy is considered diagnostic or excisional when a biopsy is taken, and indicate where each biopsy is taken from
- initiate/attend regular multidisciplinary meetings
- attend operational and quality meetings at least quarterly with colposcopy staff to discuss:
 - policy/quality issues
 - NCSP biannual monitoring reports
 - volumes (wait list data, DNA rates, referral data)
 - findings of audits
 - peer review.

Note that NCSP Register data can be requested for these meetings.

Standard 603: Documenting colposcopy assessment

Standard

Accurate and complete documentation of initial and subsequent colposcopic assessments must include:

- the name of the GP, nurse or other provider who made the referral, and their facility
 - the date the colposcopy referral was received and the appointment date provided
 - the reason for referral (eg. cytological abnormality, abnormal cervix, other reason)
 - an indication of whether it is a first assessment (new case) or subsequent (follow-up)
 - a review of the full screening history (cytology, hrHPV and histology)
 - the cytological abnormality grade – high grade (HSIL, ASC-H, AGC, AIS, suspicious or consistent with cancer, cancer), low grade, abnormal cervix, other – for which the woman was referred
 - whether a colposcopy was performed
 - the site the colposcopy was performed (cervical, vaginal or both)
 - visibility of the squamo-columnar junction and limits (whether completely or partially visible or not at all)
 - colposcopic appearance: note the presence or absence of a visible lesion or whether normal, abnormal or inconclusive
 - a diagram of the cervix (with squamo-columnar junction, biopsies, number of quadrants involved, findings and a plan of management); a diagram should be a compulsory part of examination documentation, but a photo would be preferable as it is more accurate and allows for peer review at a later date²
 - predictive abnormality grade: low-grade squamous, high-grade squamous, glandular, micro-invasive, invasive cancer
 - visibility of the limits of the lesion
 - actions taken during the visit (biopsy, treatment)
 - results of the histology and whether a biopsy was taken suitable for interpretation
 - whether local or general anaesthesia was used
 - the site and type of biopsy taken
 - reasons for not performing a biopsy
 - recommendations for management and follow-up
- as per colposcopy referral, visit and DNA data requirements (Appendix 2).

Target

One hundred percent of medical notes accurately record colposcopic findings at first and subsequent assessments (as per the data requirements listed in Appendix 2), and these are sent electronically to the NCSP Register and include:

- referral details
- visibility of the squamo-columnar junction
- colposcopic appearance, including the presence or absence of a visible lesion
- number of quadrants of the cervix involved
- visibility of the limits of the lesion
- colposcopic opinion (predicted abnormalities) regarding the nature of the abnormality and the requirement for treatment
- site and type of biopsy taken
- whether the biopsy taken was satisfactory for histological examination
- histology of biopsy taken
- actions taken during first assessment
- actions taken during follow-up appointments
- recommended management and follow-up
- timeframe recommended for follow-up.

Note

Medical notes should be recorded in a standardised single system (electronically or manually) for ease of follow-up and clinical safety reasons.

Measurement

The following data sources and methods of measurement are used:

- audit
- NCSP Register data.

Note also the requirements for C-QulP Standards for Audit, Diagnostic and Therapeutic Colposcopists, Levels 1 and 2.^{3, 4}

MDMs detail

Colposcopists should endeavour to participate in multidisciplinary meetings (MDMs) monthly for case review, where practical. Every effort should be made to attend those meetings at which the colposcopists' own cases are discussed.¹⁶ The minimum attendance expected of colposcopists at MDMs is two monthly.

The purpose of MDMs is to:

- discuss cases
- make decisions on further actions and management

- facilitate ongoing peer review and education.

Records of the outcomes of each case must be maintained. Resubmit any changes made as a result of MDMs to the NCSP Register as an amended result.

Note that a histopathologist and cytopathologist (or nominated senior cytoscientist representative) is also required to attend MDM meetings, and laboratories are required to submit an amended report if a woman's management is altered (as appropriate; ie, cytology, histology or hrHPV test) electronically to the NCSP Register (see NCSP Policies and Standards, Section 5: *Providing a Laboratory Service*, URL: www.nsu.govt.nz/health-professionals/1060.aspx)

Any changes should also be made on the gynaecological database being used.

A letter should be sent to the smear taker recording the outcome of the assessment, treatment proposed and follow-up management.

Providing information about results

Purpose

This policy is to ensure women are adequately informed about colposcopy treatment and follow-up.

Standard 604: Informing women of colposcopy treatment and follow-up

Standard

The colposcopist must ensure all women receive their definitive diagnosis by sending it to them, and/or discussing the diagnosis with them, within 30 working days of their colposcopy visit.

Policy^{2, 22, 35}

Colposcopy services must:

- discuss the likely result with the woman at the time of the colposcopy appointment
- organise a specialist to inform and offer to see (or, if not feasible, telephone) a woman whose actual result is significantly different from the likely result so that they can discuss the results
- inform the woman when definitive results are expected, allowing for pathology and team meetings
- make an arrangement with the woman so that she will receive results by means suitable to her
- if there is a diagnosis of cancer, advise the woman's GP/primary care provider by telephone and/or with a letter covering the diagnosis and planned treatment and refer her to gynaecological oncology.

Target

Ninety percent or more of women will have been sent, and/or will have had discussed with them, the definitive diagnosis within 30 working days of their colposcopy visit.

Measurement

The following data sources and methods of measurement are used:

- audit.

Outpatient treatment

Purpose

This policy is to ensure that timely and appropriate outpatient treatment is provided.

Standard 605: Ensuring the timeliness of, and appropriate selection for, treatment

Standard

- Women with confirmed high-grade lesions^{2, 7, 9, 11} are treated within eight weeks of histological confirmation.
- The number of women who are treated with low-grade lesions (less than CIN2 on histology) is minimised. Note that treatment is *not* recommended for women with low-grade abnormalities.^{1, 2, 11–13}

Target

Ninety percent or more of women with:

- high-grade lesions are treated within eight weeks of histological confirmation.

Notes

One week equals five working days.

The target is calculated using both the 'date the histology result is received by the colposcopy service' and the 'decision to treat date'. Both these dates must be noted in the colposcopy data system and sent to the Register (see Colposcopy data requirements, Appendix 2).

Measurement

The following data sources and methods of measurement are used:

- audit
- monitoring using NCSP Register data.

Standard 606: Delivering appropriate outpatient treatment

Standard

Eighty percent of women receiving LLETZ treatment are managed as outpatients/day patients under local analgesia.

Outpatient treatment: details

It is recognised that there is a range of reasons for women requiring a general anaesthetic for treatment at colposcopy, such as:

- women requesting general anaesthesia
- anxiety
- access issues
- medical issues
- women requiring co-procedures
- extensive lesions
- cold knife cone.

The reason for a general anaesthetic should be recorded and monitored by audit.

Outpatient treatment must be provided in appropriately equipped colposcopy units according to best practice.²

Target

Eighty percent or more of LLETZ treatments are performed as an outpatient/day patient service under local analgesia.

Measurement

The following data sources and methods of measurement are used:

- audit
- quarterly internal monitoring using NCSP Register data.

Note

Use of local anaesthesia or general anaesthesia for treatment must be recorded and sent to the NCSP Register (see Colposcopy data requirements, Appendix 2).

Ablative therapy

Purpose

This policy is to ensure appropriate selection for ablative treatment and appropriate quality of treatment.

Standard 607: Ensuring appropriate selection for ablative treatment and appropriate quality of treatment

Standard

All women who have ablative treatment must have an adequate histological biopsy taken prior to the treatment.

Recommendations

Excisional treatment is considered best practice (the gold standard) as this minimises the risk of missing occult invasion. However, ablative therapy may be considered, provided:

1. colposcopic assessment is satisfactory
2. a targeted biopsy has confirmed the diagnosis
3. there is no evidence of an invasive cancer on cytology, colposcopic assessment or biopsy
4. there is no evidence of a glandular lesion on cytology, biopsy or colposcopy
5. the entire lesion has been visualised.

'See and treat' should only be considered if it is thought this may be the only opportunity to undertake treatment, and:

- circumstances are appropriate or immediate treatment is necessary
- the colposcopic examination is consistent with the cytology referral
- the limits of the lesion are visible
- the whole abnormality can be excised
- there is no suspicion of invasion
- this should be by an excisional method
- a specimen is available for histological examination.

Target

One hundred percent of women who have ablative treatment have had an adequate biopsy taken for histological diagnosis.

Measurement

The following data sources and methods of measurement are used:

- audit
- monitoring using NCSP Register data.

Note

Ablative treatment, if carried out, must be recorded (see Colposcopy data requirements, Appendix 2).

Follow-up to treatment

Purpose

This policy is to ensure that the correct follow-up procedures are followed.

Policy

Women should be followed up according to the *Guidelines for Cervical Screening in New Zealand 2008* (and subsequent updates and revisions).

Standard 608: Timely discharge of women after treatment

Standard

Women who are treated for CIN2 or CIN3 should:

- have a colposcopy and smear within the nine-month period post-treatment
- be discharged back to the smear taker as appropriate.

Notes

If a woman is seen at colposcopy 12 months after treatment, a hrHPV test together with cytology should be done. (Note that hrHPV testing is not used for the follow-up of glandular lesions in this situation.)

This standard aligns with C-QuIP standard (Therapeutic colposcopists, Level 2), Assuring Appropriate and Adequate Follow-Up.^{3, 4}

Target

Ninety percent or more of women treated for CIN2–3 should:

- have a colposcopy and smear within the nine-month period post-treatment²
- be discharged back to the smear taker as appropriate.

Note

Discharge dates and the provider to whom a discharge is made must be recorded (see Colposcopy data requirements, Appendix 2).

Guidelines

- Any symptoms should be appropriately managed.
- A repeat smear and hrHPV test should be taken 12 months after treatment, as per the *Guidelines for Cervical Screening in New Zealand 2008*.¹
- Routine three-yearly screening may resume if a woman tests negative for both cytology and hrHPV testing for two consecutive years.
- A woman with an abnormal smear within the five years following treatment should be referred to colposcopy or followed up according to the HPV guidelines.
- After the age of 70 a woman will not receive communication from the NCSP if she has completed cervical screening according to the New Zealand guidelines, or follow-up may be individualised.

Measurement

The following data sources and methods of measurement are used:

- audit
- NCSP Register data.

Failure or refusal to attend appointments

Purpose

This policy is to ensure that processes are in place to:

- encourage attendance at colposcopy
- manage women who do not attend.

Policy

Every effort should be made to ensure women attend colposcopy, including offering other appointment times.

Colposcopy units must have processes for identifying and following up women who do not attend (DNA) or refuse to attend colposcopy.

Standard 609: Managing women who did not attend (DNA)

Standard

Women who did not attend (DNA) must be appropriately managed.

- All clinics must follow written protocols for the management of DNAs.

Targets

- One hundred percent of clinics have written protocols for the management of DNAs.
- Less than 15 percent of women fail to attend their first appointment.
- Less than 15 percent of women fail to attend their follow-up appointments.

Measurement

The following data sources and methods of measurement are used:

- audit
- NCSP Register data
- monthly reports to NCSP.

Note

The NCSP Register must be informed of DNAs (see Colposcopy data requirements, Appendix 2).

Process for managing women who fail to attend colposcopy

The table below describes the process to be followed when a woman fails to attend a colposcopy appointment.

Notes

It is important to:

- distinguish between failure to attend and refusal to attend a colposcopy visit
- document each stage clearly in the woman's notes.

Stage	Description
1	The woman fails to attend for colposcopy (DNA).
2	Colposcopy service staff make three attempts to contact the woman: <ul style="list-style-type: none">• by telephone or mail• through the GP/primary care provider• through a visit by a community health worker/nurse or cultural services staff, where these services are available.
3	Does the woman attend? <ul style="list-style-type: none">• If yes, there is no further action.• If no, see stage 4.
4	The woman is sent a letter that outlines the importance of the referral for colposcopy, notes the repeated attempts to contact her, and notes that a copy of the letter is being sent to her GP/primary care provider (with whom she is advised to discuss her ongoing care). Note: This should be done in accordance with the Code of Health and Disability Services Consumers' Rights.
5	The woman's smear taker, GP/primary health care provider, NCSP Register Central Team and NCSP regional services (if the woman is enrolled) are advised that the woman failed to attend colposcopy.

Support for Māori and other women

Māori, Pacific, Asian and other support services, where they are available, should be used to assist with the locating, support and treatment of women referred for colposcopy. Women should be given information about the possibility of utilising support services.

Process for women who refuse to attend colposcopy

The table below describes the process to be followed when a woman refuses to attend a colposcopy appointment.

Note: It is important to document each stage clearly in the woman's notes.

Stage	Description
1	The woman refuses to attend for colposcopy.
2	Colposcopy service staff encourage the woman to attend: <ul style="list-style-type: none">• by telephone or mail• through the GP/primary health care provider• through liaison with NGOs (NCSP independent service providers) and health promoters, who can arrange appropriate support services where these are required.
3	The woman is sent a letter that outlines the importance of the referral for colposcopy, notes the repeated attempts to contact her and includes a clear sign-off of responsibility. The letter should state that a copy is being sent to her GP/primary care provider. The woman should be advised to discuss her ongoing care with her GP/primary care provider. Note: This should be done in accordance with the Code of Health and Disability Services Consumers' Rights.
4	The woman's smear taker, GP/primary care provider, NCSP Register Central Team and NCSP regional services (if the woman is enrolled) are advised that the woman refused to attend for colposcopy (ie, the woman is discharged back to her GP).

See also

- Code of Health and Disability Services Consumers' Rights,
URL: www.hdc.org.nz/the-act--code/the-code-of-rights

Colposcopy staffing

Purpose

This policy is to:

- ensure that colposcopy services are provided by appropriately qualified and experienced staff
- identify colposcopy staff roles
- define colposcopy service staff responsibilities.

Policy^{2, 3, 4}

Colposcopists should be certified by the Colposcopy Quality Improvement Programme (C-QulP), or be practising under the supervision of a certified colposcopist while working towards certification by C-QulP.

For a definition of 'supervision', please refer to the Medical Council of New Zealand guidelines.

Colposcopists must:

- be registered to practise in New Zealand and hold a current annual practising certificate (APC) with the New Zealand Medical Council or Nursing Council of New Zealand
- practise according to the *Guidelines for Cervical Screening in New Zealand 2008* and subsequent updates
- maintain a minimum volume and spectrum of new referrals as per the standards
- work closely with other health professionals and participate in multidisciplinary meetings in accordance with New Zealand guidelines.⁵

Colposcopy clinics must have a named clinical leader and lead clinic nurse.

Guidance on the role of a lead colposcopist is provided in the NHS Cancer Screening Programmes publication No. 20, May 2010.²

Colposcopy staffing: details

- As from December 2012 medical practitioners and nurses wanting to practise colposcopy in New Zealand must have obtained C-QuIP certification (under the auspices of RANZCOG) as a practising colposcopist (or be working towards this); see www.cquip.edu.au

Note: there are two certification streams:

- diagnostic
 - diagnostic and therapeutic.
- Colposcopists undergoing training must be supervised by an experienced certified colposcopist.
 - Colposcopists must be registered with the New Zealand Medical Council or Nursing Council of New Zealand to practise in New Zealand.
 - Colposcopists new to practice in New Zealand should undergo a period of orientation to the National Cervical Screening Programme and supervision by a certified colposcopist until full certification has been obtained.
 - Colposcopists must be familiar with the *Guidelines for Cervical Screening in New Zealand 2008* and subsequent updates.
 - Where clinicians undertake diagnostic colposcopy only, women must be informed that they will be referred to a different colposcopist for any treatment required.

Colposcopists must:

- maintain a minimum volume and spectrum of new referrals to enhance diagnostic and treatment skills – this must be a minimum of 50 new cases per annum in New Zealand, but ideally should be at least 100 cases per annum
- participate in continuing medical education, as per RANZCOG guidelines (ie, attendance at one dedicated educational course/meeting related to colposcopy, which is recognised by C-QuIP, every three years)
- attend regular MDMs.

Colposcopists must work closely with:

- an experienced gynaecology nurse (experience and role is to be agreed between the lead colposcopist, lead colposcopy nurse and service manager)
- a pathologist (formal arrangements must be in place for consultation with a pathologist if there is not one on site).

Standard 610: Ensuring colposcopy services are adequately staffed

Standard

For appropriate staffing of colposcopy services, the service must ensure:

- colposcopists participating in the NCSP:
 - are registered to practise in New Zealand and hold a current APC with the New Zealand Medical Council or Nursing Council of New Zealand
 - have obtained C-QuIP certification (under the auspices of RANZCOG) as a practising colposcopist, or are practising under the supervision of a certified colposcopist while working towards certification by C-QuIP
 - have professional accountability and responsibility for adequate training and standards according to RANZCOG guidelines
 - maintain a minimum of 50 new cases per annum in New Zealand (the ideal number is 100 per annum), or a minimum of 150 cases over a three-year period; **note:** this differs from the minimum C-QuIP volumes required for certification, and has been discussed with RANZCOG; case volumes can be a combination of cases from different practices (eg, combined DHB and private) but evidence is required for each practice
 - maintain a minimum number of 10 treatments per year, as per C-QuIP guidance (or 30 treatments in each three-year period)
 - maintain certification and demonstrate participation in the C-QuIP Professional Development Programme (Recertification and Audit) as per the C-QuIP website
- colposcopy clinics are directed/led by a named, appropriately skilled medical specialist responsible for ensuring delivery of services in accordance with the NCSP policies and standards
- there is at least one named lead colposcopy clinic nurse who:
 - has gynaecology skills and experience and whose role is determined in consultation with the lead colposcopist and/or service manager
 - is without concurrent duties in other clinics
 - oversees colposcopy clinic nurses in satellite clinics in conjunction with the attending colposcopist
- there are appropriate support staff (ie, clerical/secretarial) to assist with the effective running of the service and team collaboration (support is also required for data collection and to assist in quality/risk management).

Notes

'C-QuIP' refers to the Colposcopy Quality Improvement Program under the auspices of RANZCOG; see www.cquip.edu.au

C-QuIP offers a free online learning programme for professionals performing colposcopy; see <http://colp.cquip.edu.au>

Maintaining certification

A practising colposcopist is required to attend/participate once every three years in an activity recognised by C-QuIP. This will preferably be to attend a dedicated educational colposcopy course or scientific meeting organised by a society associated with the International Federation for Cervical Pathology and Colposcopy (IFCPC), such as the Australian Society for Colposcopy and Cervical Pathology (ASCCP) or the British Society for Colposcopy and Cervical Pathology (BSCCP). Attendance at any other meeting should be prospectively approved by C-QuIP.

See www.cquip.edu.au/maintaining-certification.html

Alternatively, a practising colposcopist can complete the Colposcopy Online Learning Program (COLP) every alternative triennium. The COLP is available at: <http://colp.cquip.edu.au>

The above information about maintaining certification has been downloaded from the C-QuIP website, updated on 19 February 2013. For further updates, please refer to this website.

Target

One hundred percent of the colposcopy clinics and colposcopists participating in NCSP meet the above requirements.

Measurement

The following method of measurement is used:

- audit.

Standard 611: Maintaining staff skill level

Standard^{3, 4}

Colposcopy units must ensure the maintenance of skill levels of staff performing colposcopy through:

- attaining at least the minimum volumes of new cases (see Standard 610)
- participating once every three years in an activity recognised by C-QuIP (see Standard 610)
- participation of nursing staff in continuing education activities appropriate to their practice.

Preferably staff should attend a dedicated educational colposcopy course or scientific meeting organised by a society associated with the International Federation for Cervical Pathology and Colposcopy (IFCPC), such as the Australian Society for Colposcopy and Cervical Pathology (ASCCP) or the British Society for Colposcopy and Cervical Pathology (BSCCP).

Alternatively, applicants could also have participated in any other formal quality assurance or review processes related to colposcopy practice. Applicants are required to document the nature and duration of the quality activity.

If applicants have not attended a dedicated educational colposcopy course or scientific meeting, or participated in any other formal quality review processes related to colposcopy practice, the reasons for this will need to be documented.

Note

Health practitioners should also be familiar with the Health Practitioners Competence Assurance Act; see <http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203380.html>

Target

One hundred percent of colposcopists:

- maintain a minimum of 50 new cases per annum in New Zealand (the ideal number is 100 per annum), or a minimum of 150 cases over a three-year period
- participate in continuing education activities, including:
 - peer review (including MDMs, audits, collegial review, RANZCOG requirements, case presentations)
 - attendance at a national or international colposcopy meeting at least every three years.

Measurement

The following methods of measurement are used:

- quarterly volumes of new cases – colposcopists must be able to demonstrate that they have met minimum volume and educational requirements, which means that practitioners must keep their own records
- audit.

Providing an adequate clinical environment

Purpose

This policy is to ensure that colposcopy services provide a clinical environment that meets women's needs.

Standard 612: Providing an adequate clinical environment

Standard

Colposcopy services must provide adequate and appropriate space, equipment and facilities, ensuring privacy and cultural appropriateness.

Clinical environment: detail

This should include:

- colposcopy clinic consulting rooms and/or procedure rooms
- a toilet being available for women within the unit
- a private space for women preparing for colposcopy examination, and if they require private time prior to leaving the clinic
- space within the unit for recovery post LLETZ/laser treatment
- adequate private office space for medical and nursing staff (not in an open-plan reception area).

Target

One hundred percent of colposcopy clinics provide adequate and appropriate space, equipment and facilities, ensuring privacy and cultural appropriateness.

Measurement

The following method of measurement is used:

- audit.

External quality assurance policy

Purpose

This policy is to ensure colposcopy service providers have appropriate external systems in place for ensuring quality.

Policy

Colposcopy units are expected to:

- review the NCSP coverage reports and biannual monitoring reports
- use the reports as part of their own quality control and internal monitoring processes against the standards
- request data from the NCSP for monitoring (eg, volumes, waiting times, DNAs).

The NCSP will provide colposcopy units with quarterly data on a spreadsheet for checking, on request.

NCSP monitoring reports

- Reports on NCSP coverage are provided to DHB colposcopy units quarterly and are published on the NCSP website, URL: www.nsu.govt.nz/Health-Professionals/1063.aspx

Independent monitoring of anonymised data on the NCSP Register against predefined programme indicators is undertaken in conjunction with the multidisciplinary NCSP Advisory Group. All colposcopy service providers contracted to the NCSP are monitored using NCSP Register data against a range of indicators, including:

- wait times for assessment for high- and low-grade abnormalities and urgent referrals
- rates of women who do not attend appointments
- total volumes of new assessments undertaken
- rates of women with high-grade lesions who have had a biopsy
- rates of biopsies suitable for histological interpretation
- positive predictive value (PPV) of colposcopy for high-grade lesions
- rates of high-grade treatment failures
- use of hrHPV testing to manage discordant results
- follow-up of women with high-grade cytology, no histology.

Performance against indicators is published in biannual monitoring reports on the NSU website.

Note

Monitoring requires colposcopy referral, visit and DNA data items to be sent to the NCSP Register (see Appendix 2).

Internal quality control

Purpose

This policy is to ensure colposcopy service providers have internal quality control systems that:

- identify potential sources of error
- detect and minimise errors
- continually improve internal processes.

Policy

Colposcopy services must have documented internal quality control systems that will cover all their activities and:

- provide the means of identifying potential sources of error in the colposcopy service operation
- implement controls to detect and minimise errors
- identify ways of improving the quality of service to women
- provide a framework for remedial action to improve operational processes when a problem is identified.

Examples

Examples of internal quality control activities may include systems for:

- reviewing post-treatment recurrences
- follow-up and review following positive cytology and negative histology results
- ongoing monitoring against standards
- use of own data to monitor internal quality control
- use of external monitoring reports to monitor against internal systems
- regular review of significant incident reporting
- formal arrangements for regular discussions of cases with medical colleagues and other health professionals
- carrying out audits to assess and validate:
 - adequacy of referral letters received from smear takers
 - completion of discharge letters to smear takers
 - data quality on internal monitoring systems
 - sending of completed colposcopy referral, visit and DNA data to the NCSP Register
 - audit of clinical files
 - resolution of complaints received.

Providing colposcopy data to the NCSP Register

Purpose

This policy is to ensure colposcopy services provide the required data to the NCSP Register.

Policy

Colposcopy services will provide the NCSP Register with the required data for every referral and visit of every woman attending their service, including women who did not attend appointments (see Appendix 2).

Colposcopy services must supply any missing data to the NCSP Register promptly on notification.

Standard 613: Provision of colposcopy data to the NCSP Register

Standard

All colposcopy referral, visit and DNA data must be sent to the NCSP Register in the manner and form specified by the Ministry of Health.

- All colposcopy services are required to send data electronically. Where this is not possible, all data must be forwarded manually, as an interim measure, to the NCSP Register within 20 working days after the event (referral received, visit undertaken or DNA recorded). Colposcopy services must indicate they are working towards electronic reporting and are using manual reporting only as an interim measure.
- All required data fields must be completed.

For colposcopy services operating out of more than one site, reports must be forwarded from all sites.

When notified of missing data by NCSP Register services, colposcopy services must supply these data, either manually or electronically, to the NCSP Register within 10 working days. This excludes data provided following MDMs, which should be forwarded immediately after there is an agreed change in management decision.

Reporting to the NCSP Register: detail

Reporting to the NCSP is a contractual requirement of all colposcopy services and a requirement under Section 112M of the Health Act 1956, as amended by Part 4A in 2004.

Complete colposcopy data are essential to ensure:

- the NCSP Register has a complete screening history
- tracking of individual women for recall in line with the recommended guidelines
- accurate monitoring and evaluation of provider performance against national standards, indicators and targets
- identification of potential areas of risk
- outcomes from MDMs that may change the management/follow-up are included on the NCSP Register.

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

Target

- One hundred percent of colposcopy referral, visit and DNA data are sent to the NCSP Register (see Appendix 2).

Measurement

The following data sources and methods of measurement are used:

- audit
- NCSP Register data matches against colposcopy DHB and non-DHB data sets.

Data to be supplied

Colposcopy units must provide referral, visit and DNA data (see Appendix 2) on an ongoing basis to the NCSP Register in electronic format. This will enable monitoring to be in line with electronic reporting with laboratories.

See also

- Health Act 1956 Part 4A (as amended in 2004) Section 112M – Duty of persons performing colposcopic procedures (see Appendix 1)
- Colposcopy referral, visit and DNA data requirements (see Appendix 2)
- NCSP monitoring reports, URL: www.nsu.govt.nz/Health-Professionals/1063.aspx

Data collection for promoting best practice in colposcopy

Purpose

This policy is to analyse and report on complete data sets from colposcopy services to promote best practice, emphasising safety and quality.

Quality improvement

Data held on the NCSP Register received from colposcopy services will be analysed to support practitioners with quality improvement.

For example, analyses may include:

- correlation for high-grade lesions (CIN2 or worse) between colposcopy findings and histology results (in order to calculate the positive predictive value of colposcopy for high-grade abnormalities)
- the proportion of biopsies suitable for histological interpretation
- the number of residual high-grade abnormalities, 12 months after treatment
- the reasons no biopsy was taken, when a women with a high-grade abnormal smear has been referred
- the outcome for women who had a high-grade abnormal smear but no biopsy taken.

References

1. National Screening Unit. 2008. *Guidelines for Cervical Screening in New Zealand 2008*. Wellington: National Screening Unit, Ministry of Health. URL: www.nsu.govt.nz/health-professionals/2747.aspx
2. NHS Cancer Screening Programmes. 2010. *Colposcopy and Programme Management: Guidelines for the NHS Cervical Screening Programme* (2nd edition). Sheffield: NHS Cancer Screening Programmes. NHSCSP Publication no. 20. URL: www.cancerscreening.nhs.uk/cervical/publications/nhscsp20.pdf
3. The Colposcopy Quality Improvement Program (C-QuIP). URL: www.cquip.edu.au (accessed October 2012).
4. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2012. *Colposcopy Quality Improvement Program Re-certification and Audit*. URL: www.ranzcog.edu.au
5. NHS Scotland. 2012. *Scottish Cervical Screening Programme: Colposcopy and programme management*. URL: www.nsd.scot.nhs.uk/Documents/addendumnhscspdoc20v2.6may.pdf
6. Cervical Screening Wales: Health Professionals. (nd). *Quality Manuals*. URL: www.screeningservices.org.uk/csw/prof/quality/index.asp
7. Feltmate CM, Feldman S. 2013. *Patient Information: Colposcopy: Beyond the basics*. UpToDate. URL: www.uptodate.com
8. Fung-Kee-Fung M, Howlett RI, Oliver TK, et al. 2010. The optimum organisation for the delivery of colposcopy service in Ontario: evidence-based series: colposcopy in review. *Journal of Lower Genital Tract Disease* 14(1): 11–21.
9. Bentley J. 2012. Colposcopic management of abnormal cytology and histology. *Journal of Obstetrics and Gynaecology Canada* 34(12): 1188–202.
10. Reirson L, Fitzpatrick-Lewis D, Ciliska D, et al. 2012. *Screening for Cervical Cancer*. Ottawa (ON): Canadian Task Force on Preventive Care. URL: www.canadiantaskforce.ca
11. Saslow D, Solomon D, Lawson HW, et al. 2012. American Cancer Society, American Society for Colposcopy and Cervical Pathology and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. *CA: A Cancer Journal for Clinicians*. doi:10.3322/caa.21139.
12. *Screening for Cervical Cancer: A systematic evidence review for the US Preventive Services Task Force*. Evidence synthesis No. 86. AHRQ Publication No. 11-05156-EF-1, May 2011.
13. Canadian Taskforce on Preventive Health Care. 2013. Recommendations on screening for cervical cancer. *Canadian Medical Association Journal* 185(1): 35–45.
14. Ministry of Health. 2012. *Faster Cancer Treatment Programme*. Wellington: Ministry of Health. URL: www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-project
15. Ministry of Health. 2012. *Faster Cancer Treatment Indicators*. Wellington: Ministry of Health. URL: www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-project/faster-cancer-treatment-indicators

16. Ministry of Health. 2012. *Guidance for Implementing High-Quality Multidisciplinary Meetings: Achieving best practice cancer care*. Wellington: Ministry of Health.
17. Munoz N, Bosch FX, de Sanjose S, et al. 2003. International Agency for Research on Cancer Multicentre Cervical Cancer Study Group: epidemiological classification of human papillomavirus types associated with cervical cancer. *New England Journal of Medicine* 348: 518–27.
18. Cuzick J, Clavel C, Petry KU, et al. 2006. Overview of the European and North American studies on HPV testing in primary cervical cancer screening. *International Journal of Cancer* 119: 1095–101.
19. Dillner J, Rebolj M, Birembaut P, et al. 2008. Long term predictive values of cytology and human papillomavirus testing in cervical cancer screening: Joint European cohort study. *BMJ* 337: a1754.
20. Broker TR. 2012. Global prevention and management of human papillomavirus related diseases: the pressing challenges and the compelling opportunities. *Vaccine* 30S: vii-x.
21. Royal College of Obstetricians and Gynecologists. 2011. *Persistent Post Coital Bleeding*. URL: www.rcog.org.uk/womens-health/clinical-guidance/persistent-post-coital-bleeding-query-bank
22. Sharp L, Cotton S, Carsin A, et al. (nd). Factors associated with psychological distress following colposcopy among women with low grade abnormal cervical cytology: a prospective study within the trail of management of borderline and other low grade abnormal smears (TOMBOLA). *Psycho-Oncology*. doi:10.1002/pon.2097
23. Statement on wait times in obstetrics and gynaecology: SOGC policy statement. 2008. *Journal of Obstetrics and Gynaecology Canada* 30(3): 248–57.
24. *Patient Information: Colposcopy: Beyond the basics*. www.uptodate.com/contents/colposcopy-beyond-the-basics?source=search_result&search=colposcopy+patient+info&selectedTitle=2~67
25. Bentley J. 2012. Colposcopic management of abnormal cervical cytology and histology. *Journal of Obstetrics and Gynaecology Canada* 34(12): 1188–202.
26. Gao F, Austin RM, Zhao C. 2011. Histopathologic follow-up and human papillomavirus DNA test results in 290 patients with high grade squamous intraepithelial lesion papanicolaou test results. *Cancer Cytopatho*: 119: 377–86.
27. Aerssens A, Claeys P, Garcia A, et al. 2008. Natural history and clearance of HPV after treatment of precancerous cervical lesions. *Histopathology* 52(3): 381–6.
28. Castle P, Rodriguez A, Burk R, et al. 2009. Short term persistence of human papillomavirus and risk of cervical precancer and cancer: population based cohort study. *BMJ* 339: 327.
29. Paraskevaidis E, Arbyn M, Sotiriadis A, et al. 2004. The role of HPV DNA testing in the follow-up period after treatment for CIN: a systematic review of the literature. *Cancer Treatment Reviews* 30(2): 205–11.
30. Cantor SB, Cardenas-Turanzas M, Cox DD, et al. 2008. Accuracy of colposcopy in the diagnostic setting compared with the screening setting. *Obstetrics and Gynecology* 111–17.
31. Ferris DG, Litaker M, ALTS Group. 2005. Interobserver agreement for colposcopy quality control using digitized colposcopic images during the ALTS trail. *Journal of Lower Genital Tract Disease* 9: 29.
32. Underwood M, Arbyn M, Parry Smith W, et al. 2012. Accuracy of colposcopy-directed punch biopsies: a systematic review and meta-analysis. *BJOG* 119(11): 1293–301. DOI: 10.1111/j.1471-0528.2012.03444.x. (accessed 13 August 2012).

33. Palmer JE, Wales K, Ellis K, et al. 2010. The multidisciplinary colposcopy meeting: recommendations for future service provision and an analysis of clinical decision making. *BJOG* 117: 1060–6.
34. Dina R. 2008. Recommendations that could improve performance of colposcopy and cytology. *Cytopathology* 19: 338–40.
35. Austoker J, Davey C, Jansen C. 1997. Improving the quality of the written information sent to women about cervical screening. United Kingdom: NHS Cancer Screening Programmes. NHSCSP Publication No. 5.

Appendix 1: Health Act 1956, Part 4A

Section 112M: Duty of persons performing colposcopic procedure

- (1) Every person who performs a colposcopic procedure on a woman must –
 - (a) explain the procedure to the woman; and
 - (b) provide information, to the extent that is reasonable in the circumstances, about the objectives of the NCSP and the NCSP Register, the importance of having regular screening tests, who has access to information on the NCSP Register, and the uses to which that information may be put; and
 - (c) if he or she believes that the woman is not enrolled in the NCSP, advise her that she will be enrolled but that she may prevent or cancel that enrolment by notifying the NCSP manager under section 112G; and
 - (d) cause a report in relation to that colposcopic procedure to be forwarded to the NCSP manager.

- (2) A report under subsection (1)(d) must –
 - (a) be provided free of charge; and
 - (b) contain the information specified by the Director-General; and
 - (c) be provided in the manner and form specified by the Director-General.

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		<input type="checkbox"/> DHB
Colposcopist		Registration number		<input type="checkbox"/> Non-DHB
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	<input type="checkbox"/> GP <input type="checkbox"/> Nurse <input type="checkbox"/> Other	
Health facility making referral				
Method of referral	Letter <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone <input type="checkbox"/> Yes <input type="checkbox"/> No	Other (electronic referral) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Type of referral

First assessment (new case)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Subsequent assessment (follow-ups)	<input type="checkbox"/> 1st	<input type="checkbox"/> 2nd	<input type="checkbox"/> 3rd	<input type="checkbox"/> 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

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

NHI =

Colposcopist's assessment of reason for referral

<input type="checkbox"/>	1 Abnormal smear
<input type="checkbox"/>	A. Low grade (ASCUS/LSIL)
<input type="checkbox"/>	B. High grade (ASC-H/HSIL)
<input type="checkbox"/>	C. Suspicious of invasive cancer (squamous/adenocarcinoma)
<input type="checkbox"/>	D. Glandular abnormality (AIS/AGC)
<input type="checkbox"/>	2 Positive/detected hrHPV test results only
<input type="checkbox"/>	A. Low grade clinical assessment (e.g. persistent positive hrHPV test for 'historical testing')
<input type="checkbox"/>	B. High grade clinical assessment
<input type="checkbox"/>	C. Suspicious of invasive cancer clinical assessment
<input type="checkbox"/>	D. Post treatment (ie within three years of treatment for a high-grade abnormality)
<input type="checkbox"/>	3 Positive/detected hrHPV test results plus abnormal smear
<input type="checkbox"/>	A. Low grade (ASCUS/LSIL)
<input type="checkbox"/>	B. High grade (ASC-H/HSIL)
<input type="checkbox"/>	C. Suspicious of invasive cancer (squamous/adenocarcinoma)
<input type="checkbox"/>	D. Post treatment (i.e. within three years of treatment for a high-grade abnormality)
<input type="checkbox"/>	4 Clinical reasons only (e.g. postcoital bleeding, abnormal cervical appearance, pelvic pain)
<input type="checkbox"/>	A. Low grade clinical assessment
<input type="checkbox"/>	B. High grade clinical assessment
<input type="checkbox"/>	C. Suspicious of invasive cancer clinical assessment
<input type="checkbox"/>	D. Other clinical assessment
<input type="checkbox"/>	5 Other reason (e.g. vulval) (specify):
<input type="checkbox"/>	A. Low grade clinical assessment
<input type="checkbox"/>	B. High grade clinical assessment
<input type="checkbox"/>	C. Suspicious of invasive cancer clinical assessment
<input type="checkbox"/>	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 4-12 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	<input type="checkbox"/> Outpatient <input type="checkbox"/> Daypatient <input type="checkbox"/> Inpatient
First assessment (new case)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Subsequent assessment (follow-ups)	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colposcopy performed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colposcopy site	<input type="checkbox"/> Cervical <input type="checkbox"/> Vaginal <input type="checkbox"/> Both cervical and vaginal <input type="checkbox"/> Other

NHI =

Colposcopy findings

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

Actions taken during visit

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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biopsy result	<input type="checkbox"/> Negative <input type="checkbox"/> CIN1/HPV <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN2/3 <input type="checkbox"/> CIN3 <input type="checkbox"/> AIS <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Squamous carcinoma <input type="checkbox"/> Adenosquamous carcinoma <input type="checkbox"/> Other

Did not attend

Scheduled visit date	
For	
1st assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Follow-up after treatment/other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for DNA (if known)	
Rescheduled appointment date	

Discharged from colposcopy

To smear taker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of discharge	<input type="checkbox"/> <3 months <input type="checkbox"/> < 6 months
Name of health worker / health facility			<input type="checkbox"/> <12 months <input type="checkbox"/> >12 months
To oncology	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of discharge	<input type="checkbox"/> <3 months <input type="checkbox"/> < 6 months
Name of health worker / health facility			<input type="checkbox"/> <12 months <input type="checkbox"/> >12 months
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of discharge	<input type="checkbox"/> <3 months <input type="checkbox"/> < 6 months
Name of health worker / health facility			<input type="checkbox"/> <12 months <input type="checkbox"/> >12 months