



National Cervical Screening Programme Review of Colposcopy Services

19 January 2007

The Director-General of Health has written to the CEOs of the country's 21 DHBs following a Review of colposcopy services that identified the need for a number of improvements to ensure the on-going safety and effectiveness of the National Cervical Screening Programme (NCSP).

The improvements are identified in a December 2006 report by the National Screening Unit (NSU), on the findings of a review of District Health Board colposcopy services.

The Director-General, Mr Stephen McKernan, wrote to all DHB CEOs in January this year, with a request to address the issues identified in the report and to provide him with a response on the actions being taken and the timeframes for doing so.

In addition to the request by the Director-General to DHB CEOs, a range of initiatives is being undertaken by the NSU to address the issues identified in the Report. The NSU has completed audits of nine DHB colposcopy services, with the remaining 12 to be audited within the next 12 months. Following completion of the audits, DHBs are provided with a list of corrective actions and areas for improvement. The NSU has also put additional resource into the colposcopy area and is working with DHBs to address the problems identified by the Review, and by the audits.

The Review of colposcopy services was initiated by the NSU in May 2006, following a complaint to the Health and Disability Commissioner regarding the treatment and follow up of a woman with invasive cervical cancer and a subsequent review of colposcopy services undertaken by Waitemata DHB.

The NSU contracts with the 21 DHBs to provide colposcopy services for women who are referred for assessment and/or treatment of a cervical abnormality. Colposcopic examination facilitates the diagnosis of cervical abnormalities and guides the taking of biopsies for histological purposes. Around 30,000 colposcopic examinations are undertaken each year on between 23,000 – 25,000 women.

DHBs were asked to review the provision of colposcopy services in terms of the Operational Policy and Quality Standards for the Programme, which stipulate both the systems and clinical requirements DHBs are required to meet.

The Review identified that whilst considerable progress had been made since the introduction of the Standards in 2001 and the inclusion of new data reporting requirements (under Part4A of the Health Act 1956) which came into effect in 2005, further improvements are required.

The areas of the Standards that are not being consistently met cover processes around:

- Assessment and grading of referrals - inconsistent application of the classification system for the assessment and grading of colposcopy referrals
- Waiting times – the timeframe within which a woman must be seen for colposcopy, depending on the degree of smear abnormality. Issues around reporting to the NSU to enable effective monitoring
- Clinical oversight - inconsistencies and inadequacies in the management and clinical oversight of colposcopy services, from the referral classification and booking/scheduling process, through to the discharge of women. Clinical leadership and oversight is not evident across all DHBs to ensure continuing education of colposcopists, consistency of practice and the oversight of non-vocationally registered medical personnel
- Documentation - documentation regarding the colposcopy consultation, treatment and follow-up is inconsistent and incomplete
- Management of women who fail to attend appointments - the management of women who "did not attend" (DNA) appointments is inconsistent across DHBs. Some DHBs are not managing their DNAs according to the standards and the awareness and understanding of issues pertaining to DNA management is variable

Adherence to the Standards is crucial to ensuring the operation of a successful, national programme. Cervical cancer is slow growing and takes about 10 – 15 years to develop, making it unlikely that women with smear abnormalities have cervical cancer. However, it's important that the guidelines and Standards are followed to ensure follow up occurs within the required timeframes.

The NCSP is a highly successful programme. Since its introduction in 1990, New Zealand has experienced a 40% reduction in incidence and a 60% reduction in mortality from cervical cancer. A woman's best protection against developing cervical cancer is to have regular, 3 yearly cervical smears.