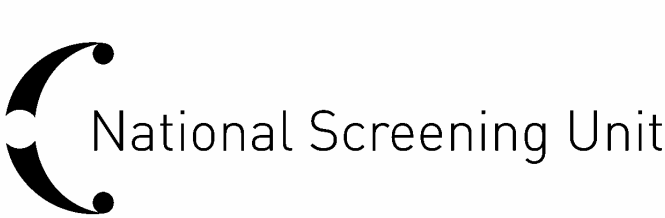


# Report on the findings of a review of District Health Board Colposcopy Services

**Report from the National Screening Unit**
**Ministry of Health**

**December 2006**

# Table of contents

# 1. Executive Summary

The National Screening Unit (NSU) of the Ministry of Health is responsible for the operation of the National Cervical Screening Programme (NCSP). The NCSP is accountable for ensuring that the events which make up the cervical screening pathway are well coordinated and delivered to a high standard. The essentials of a coordinated approach include effective monitoring of defined quality standards and the timely availability and appropriate integration of screening activity with diagnostic and treatment services.

The provision of colposcopy services is a critically important element of the NCSP screening pathway. The women referred to these services are already suspected of having a cervical abnormality. It is well documented that failure to act on abnormalities detected at screening, and ineffective treatment of abnormalities detected, are two ways in which screening programmes can be compromised. The DHBs and the NSU each have important responsibilities to ensure that a consistent and systematic approach to the delivery of colposcopy services is achieved and the quality standards set for the Programme are met.

In October 2005 the Health and Disability Commissioner found that the Waitemata District Health Board (WDHB) had breached Right 4(1) of the Health and Disability Services Code of Consumer Rights, in respect of the care of a woman (Mrs A) with invasive cancer. In his report published in May 2006 he stated:

> *'I am not satisfied that the way the system operated in the gynaecology department at North Shore Hospital was adequate to ensure appropriate quality and continuity of patient care…..It is unacceptable that a disease that is so well known, well described and for which there are clear established guidelines for diagnosis and treatment has gone undetected and untreated for so long in a public hospital setting in 2002/03…..Women in New Zealand are entitled to a far better standard of care and communication from the publicly funded health system…'*[1]

Further to the Commissioner's findings, the WDHB carried out a review of its colposcopy service and identified that of 210 women's files reviewed, 29 women had not been followed up in accordance with the NCSP Operational Policy and Quality Standards (OPQS). The NSU was advised of the findings in March 2006.

The NSU was concerned by the outcome of the Commissioner and WDHB reviews. In May 2006 the NSU communicated with all District Health Boards (DHBs), requesting that they carry out a review of their colposcopy services. This review was in addition to the routine provider compliance audits, which the NSU commenced in 2006 and that have been undertaken in nine DHBs to date. In carrying out their review the DHBs were asked to refer to the NCSP OPQS, specifically the standards in Chapter 6, which relate to the provision of colposcopy services. A set of review questions was constructed by the NSU and the DHBs were asked to complete the exercise by 30 June 2006.

---

[1] Waitemata District Health Board, Dr B, Gynaecologist and Dr C, Gynaecologist, A Report by the Health and Disability Commissioner, Case 03HDC 15479 (page 29)

In his letter of 3 May 2006 the Commissioner commended the NSU for asking DHBs to review their colposcopy services. He stated that:

> '*In my view, any delays in providing colposcopy following abnormal smears within the required timeframes are significant failures for a screening programme that has an emphasis on quality and monitoring. Women are encouraged to participate in the NCSP on the basis of the quality standards and independent monitoring, which have been put in place to ensure the programme delivers what it has promised to do and to make sure that the potential for benefit is maximised and the potential to cause harm is minimised.*
>
> *The NCSP standards for the timeliness of clinical responses are based on what the evidence shows needs to occur to achieve the best outcomes for the women. The health of these women is potentially compromised when the standards are not complied with.'*

The findings presented in this report are based on:

- an analysis of responses to the review questions from 20 out of 21 DHBs
- the findings from the nine routine provider compliance audits undertaken to date
- a review of DHB compliance with contractual reporting requirements.

There was variable information provided in response to the review questions, and similar variations in the data provided by DHBs under the contract monitoring requirements. However, it is apparent that many DHBs are making steady progress towards compliance with the NCSP Operational Policy and Quality Standards for the provision of colposcopy services (OPQS). There are no DHBs that are consistently meeting all of the OPQS and the NSU is working with the providers to address the gaps identified.

The nine routine compliance audits carried out to date confirmed the review findings and provided further indication of where additional effort is required to achieve compliance.

The NCSP OPQS have been in place since October 2000 and have been included in the DHB Agreements for the provision of colposcopy services since July 2001. The standards for colposcopy services were reviewed by an expert working group in 2003.

The NSU is concerned at the time taken to achieve compliance. Despite the hard work of staff in many of the DHBs to address gaps in service delivery, the NCSP OPQS are not being met consistently in relation to DHB processes covering:

- assessment and grading of referrals
- waiting times
- clinical oversight
- documentation
- management of women who fail to attend appointments.

The NSU acknowledges the commitment of DHB colposcopy staff to the provision of high quality care. However the results of the review and the audits carried out to date indicate that unless there is a wider organisational commitment to meeting contractual obligations, lack of compliance with the NCSP OPQS will compromise the effectiveness of the NCSP. It is clear from the feedback given to the NSU audit teams that colposcopy staff mitigate the potential risks from non compliance through hard work, system 'work arounds' and a strong commitment to ensuring the safety of women.

It important to emphasise that when one component of a national screening programme does not meet quality standards, the whole programme is compromised. The full implementation and monitoring of the NCSP OPQS is critical to the maintenance of a safe and effective programme.

The following areas for improvement are of equal priority:

- clinical leadership and oversight
- consistent triaging and classification of colposcopy referrals
- processes in place to ensure that women receive timely initial and follow-up appointments in accordance with the NCSP OPQS
- compliance with the NCSP OPQS for the management of women who fail to attend appointments
- establishment of documented, regular multi-disciplinary case review meetings
- DHB infrastructure to support the delivery of high quality colposcopy services and meeting contractual requirements.

The NSU has made steady progress towards the implementation of recommendations in the Report of the Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in the Gisborne Region (2001), and subsequent reports prepared by Dr Euphemia McGoogan, the Office of the Controller and Auditor-General and the Cervical Cancer Audit (2004). Notwithstanding the improvements in the quality of laboratory services and the quality of information provided to women, the review and audit findings presented here indicate that further work is still required to achieve compliance with the colposcopy standards. The NSU is committed to:

- developing further guidelines to support DHBs to fully implement the Programme Standards
- developing specifications for the establishment of DHB clinical leadership (including nursing) positions and assisting DHBs to understand the requirements for the clinical leadership of colposcopy services
- working in collaboration with lead colposcopists to further develop and stabilise the services
- supporting the colposcopy services to meet their legislated obligation to provide accurate colposcopy data; providing regular and timely data analysis and feedback to DHBs

- referring concerns to senior DHB management where necessary to ensure that compliance requirements for colposcopy services are well understood
- proactively engaging with those DHBs which require the most assistance to achieve compliance with the NCSP OPQS
- giving the highest priority to completing the schedule of colposcopy services audits
- working with the Independent Monitoring Group to continue the development of colposcopy service indicators
- seeking further advice from the NCSP Advisory Group and other stakeholders re additional activities to support DHBs to achieve compliance
- undertaking a process to monitor the progress of DHB colposcopy services in quarter one 2007/08.

The NSU recognises that some DHBs experience difficulties recruiting and retaining experienced colposcopists. Some DHBs' information systems do not support the collection, extraction and reporting of colposcopy data. The sustainability of 21 DHB colposcopy service providers may need to be discussed and consideration given to a lead regional service model.

# 2. Introduction

In October 2005 the Health and Disability Commissioner (HDC) found that the Waitemata District Health Board (WDHB) had breached Right 4(1) of the Health and Disability Services Code of Consumer Rights in respect of the care of a woman with invasive cancer. The Commissioner set out his findings in his report published in May 2006. In response to the Commissioner's findings WDHB carried out a review of its colposcopy services and established that of 210 women's files reviewed, 29 women had not been followed up in accordance with Programme standards. The National Screening Unit (NSU) was advised of the WDHB colposcopy review findings in March 2006.

The NSU was concerned at the findings of the Commissioner and the WDHB review and the implications for the NCSP. As a result the NSU wrote to all DHBs in May 2006 requesting that they carry out a review of their colposcopy services, with particular reference to Chapter 6 of the NCSP Operational Policy and Quality Standards.

This report summarises the findings of the DHBs' review of colposcopy services. In carrying out its analysis the NSU has also drawn upon the findings of recent NCSP provider compliance audits of nine DHB colposcopy services and has reviewed DHB compliance with contractual reporting requirements.

Recommendations are made for further action by DHBs and the NSU.

# 3. Background

The National Screening Unit (NSU) of the Ministry of Health was established in 2001/02 with responsibility for the national operation and strategic management of the National Cervical Screening Programme (NCSP) and BreastScreen Aotearoa. More recently the NSU's role has expanded to include responsibility for the Newborn Metabolic Screening Programme, implementation of antenatal HIV screening and policy work on newer areas of screening including newborn hearing screening, antenatal Downs Syndrome screening, and colorectal cancer screening.

## 3.1 The National Cervical Screening Programme

The National Cervical Screening Programme (NCSP) commenced as a national programme in 1990 with a mandate to reduce the number of women who develop and die from cervical cancer. Since the early 1990's, coinciding with the introduction of the NCSP, incidence has decreased steadily from approximately 12 per 100,000 women in 1991 to below 7 per 100,000 women in 2002 - a decline of approximately 40%. Between 1990 and 2001, mortality fell from 5 per 100,000 women to 2 per 100,000 women - a decline of 60%. Approximately 180 women are diagnosed every year and 70 women die from cervical cancer annually.

In the region of 400,000 smears are taken annually, the majority through primary care. The NSU contracts with nine laboratories throughout the country to provide smear interpretation services. The NSU also contracts with the 21 DHBs to provide

colposcopy services for women who are referred for assessment and/or treatment of cervical abnormality. Women may choose to access private colposcopy services.

The NSU is responsible for ensuring that the NCSP:

- promotes high quality cervical screening, assessment, and treatment services, while recognising and managing the differences between the various types of cervical cancer, with a view to reducing the incidence and mortality rates
- informs women and the community of the risks, benefits, and expected population health gains from participation in the NCSP
- promotes the regular recall of women who are enrolled in the NCSP for screening tests
- facilitates continuous quality improvement by allowing and performing regular evaluations of the NCSP
- ensures that information collected for the purposes of the NCSP is stored safely (including on the NCSP Register), available in an accurate and timely manner to authorised persons, and provides information to women and the wider community about the quality and effectiveness of the NCSP.

The NSU achieves this by:

- setting programme policies and standards
- monitoring adherence to policies and standards
- monitoring programme performance indicators, including through the Independent Monitoring Group
- developing policy to support programme improvements and advances in technology
- undertaking specific evaluation activities and investigations
- operating the NCSP-Register.

In addition the NSU directly funds many of the NCSP services, including laboratory services and enters into national agreements with all 21 DHBs for the provision of colposcopy services in accordance with NCSP Operational Policy and Quality Standards.

## 3.2 Colposcopy services

Colposcopy is the visual examination of the cervix using a low powered microscope or colposcope. Colposcopic examination facilitates the diagnosis of cervical abnormalities and guides the taking of biopsies for histological purposes. The colposcope is also used to visualise the cervix during treatment.

Colposcopic examination 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 with screen detected cytological abnormalities, visible abnormalities of the cervix, or symptoms and signs of cervical cancer.

Each year approximately 26,500 women are referred to colposcopy services following the reporting of an abnormal smear result. The majority of women are referred by their general practitioner to colposcopy outpatient services provided by the 21 DHBs. Depending on the size of the DHB the colposcopy service may operate as a stand-alone unit with service specific accommodation, booking and administration systems, or may share accommodation, booking and administration systems with other clinical groups. Women may also be referred to private colposcopy services that operate in most areas of the country.

## 3.3 Programme monitoring

The NSU has developed twelve quality standards which relate to the provision of colposcopy services. These Standards are documented in Chapter 6 of the NCSP Operational Policy and Quality Standards and are included as a schedule within the national Agreement with DHBs for the provision of colposcopy services. The Standards address both systems and clinical requirements.

Standards for colposcopy services have been in place since July 2001, and were revised in 2004. The adoption of an audit tool for onsite provider compliance audits and the inclusion of new data reporting requirements under Part 4A of the Health Act 1956 (effective 2005), has allowed detailed monitoring against the Standards to be undertaken. The NSU now has a three yearly routine compliance audit plan for all DHBs in place and nine audits have been undertaken to date. Each DHB completing an audit is provided with a detailed report and a plan of action. The NSU works with the DHBs to address the issues and gaps identified.

The Royal Australian and New Zealand College of Obstetrics and Gynaecology has also drawn up quality standards and guidelines relating to the provision of colposcopy services:

- National Quality Assurance in Colposcopy Project 1997, Melbourne
- Guidelines for referral for investigations of intermenstrual and postcoital bleeding, July 2004, statement number C-Gyn 6
- Standards in Colposcopy and Treatment, 2001, (The report of a RANZCOG and ASCCP Working Party)
- RANZCOG/RACGP Joint Statement on Pap Smears, July 2004, number C-Gyn13
- Guidelines for Gynaecological Examinations and Procedures, November 2004.

DHBs are contractually obliged to report waiting time data to the NSU on a monthly basis. The NSU is thus able to monitor the number of women waiting outside the times set out in the Guidelines for the Management of Women with Abnormal Smears and to ascertain what action is being taken by the DHBs to manage ‘outliers’. If DHBs persistently fail to submit these reports, the NSU is able to impose a 5% revenue penalty. This has occurred twice in the past three years with two different DHBs.

Prolonged waiting times for colposcopy pose a significant risk for women with high grade abnormalities, increasing the possibility of a woman with actual cancer being missed. The NCSP is a screening programme; women are invited to participate in the programme where there is an ethical duty to ensure that they are followed up in a timely way.

A number of DHBs have made concerted efforts to decrease the numbers outside the waiting times through a range of initiatives including:

- integration of colposcopy clinics with general gynaecology outpatient clinics
- recruitment of additional colposcopists
- increasing the number of clinics
- ensuring improved follow up of women who fail to attend appointments.

There are a number of DHBs where waiting times for appointments continue to be of concern. The NSU is following up and monitoring these DHBs closely.

DHBs have experienced difficulty in reporting accurately due to the limitations of their information systems. For example, in some DHBs waiting time numbers have been reported for the reporting month only so that the total number of women outside of the waiting times is not known. Manual calculation of the total number of women outside the waiting times has resolved this issue in the interim.

The inclusion of additional data reporting requirements in Part 4A of the Health Act 1956 (effective 2005) provided the opportunity for the NSU to more closely monitor compliance with the colposcopy Quality Standards. Regrettably the data provided has been inconsistent and often incomplete. The NCSP Independent Monitoring Group has expressed concern at the quality of colposcopy service data submitted.

The redevelopment of the NCSP Register, which will be commissioned in July 2007, will assist with collection and analysis of data but will not fully address this issue as not all DHBs have computer systems. A direct electronic interface between the Register and DHB colposcopy data bases, where they exist, will ensure full data capture. Private colposcopy services are also required to provide data to the NSU.

## 3.4 Health and Disability Commissioner and Waitemata DHB reviews

In May 2006 the Health and Disability Commissioner (HDC) released his report in response to a complaint about WDHB's care of a woman with invasive cancer. The complaint was upheld. The HDC recommended that:

- the doctor responsible for the woman's care review his practice, and
- WDHB review the systems currently in place in its gynaecology service.

The Commissioner stated that:

> *'I am not satisfied that the way the system operated in the gynaecology department at North Shore Hospital was adequate to ensure appropriate quality and continuity of patient care…..It is unacceptable that a disease that is so well known, well described and for which there are clear established guidelines for diagnosis and treatment has gone*

*undetected and untreated for so long in a public hospital setting in 2002/03…..Women in New Zealand are entitled to a far better standard of care and communication from the publicly funded health system…*[2]

As a consequence of the complaint and prior to the release of the report WDHB had undertaken a review of its colposcopy services and established that out of 210 women, 29 had not received appropriate management and care. The review found women who needed immediate follow up for assessment or treatment, women who had had treatment but who had not been followed up and women who had not been properly discharged to their general practitioner.

The NSU requested a report on the action taken to address the risks posed to the 29 women, and a follow up report was requested for two months later. An NCSP audit of the Waitemata DHB colposcopy services took place in June 2006 and on going monitoring arrangements are in place.

# 4 Review of DHB Colposcopy Services

The findings of the HDC report and the Waitemata DHB review were of concern to the NSU and in May 2006 all DHBs were requested to undertake a review of their colposcopy services. The NSU provided a review tool (Appendix 1) which set out questions relating to nine areas, the responses to which could inform the NSU on the overall colposcopy service standards at each DHB.

The nine review areas addressed were:

- triaging and classification of colposcopy referrals
- waiting list data
- clerical and booking system processes
- documentation (retrospective audit of 30 clinical records - manual and electronic)
- information provided to referring smear takers - general practitioners or other health professionals
- information provided to women regarding referral, diagnosis and treatment
- multi-disciplinary team meetings for colposcopy case review
- clinical leadership / oversight to ensure the meeting of professional requirements
- quality assurance activities.

DHBs were asked to refer to the NCSP Operational Policy and Quality Standards in carrying out their review and to report back to the NSU by the end of June 2006. The majority of DHBs were able to complete their review and report to the NSU by late July 2006. In the same period the NSU carried out routine provider compliance audits of six DHB services.

[2] Waitemata District Health Board, Dr B, Gynaecologist and Dr C, Gynaecologist, A Report by the Health and Disability Commissioner, Case 03HDC 15479 (page 29)

The NSU received an uneven response from DHBs to the review questions. Some DHBs provided comprehensive information while others provided insufficient information to support a detailed analysis and further follow-up will be necessary. DHBs were able to provide sufficient information to allow meaningful analysis of responses to the questions addressing:

- triaging and classification of colposcopy referrals
- information provided to referring smear takers, general practitioners or other health professionals
- information provided to women regarding referral, diagnosis and treatment
- clinical leadership/oversight to ensure the meeting of professional requirements
- quality assurance activities.

There was insufficient information provided to support the analysis of responses to questions relating to:

- waiting list data
- clerical and booking system processes
- documentation
- multi-disciplinary team meetings for colposcopy case review.

### 4.1 Review outcomes

Information provided by the DHBs is presented under the nine areas listed in the review tool. The results of the routine compliance audits undertaken to date and the colposcopy data available have also been incorporated into the analysis. Several DHBs deliver services from a number of sites. The majority of the information received was derived from their main - and larger - colposcopy service. This may or may not reflect practices at the smaller satellite sites.

### Area 1 Triaging and Classification of Colposcopy Referrals

The questions designed for this area were to ascertain the extent to which DHBs are complying with the colposcopy referrals policy within the NCSP Operational and Policy Standards (reference). The Health and Disability Commissioner's report and the Waitemata DHB's own colposcopy service review highlighted this issue. The Commissioner noted that Mrs A was not seen for colposcopy assessment within the recommended time frame. The DHB audits undertaken to date have also identified this as an area of concern*.*

Standard 602 states that:

- women with persistent low grade abnormalities receive colposcopy within 26 weeks of receipt of referral
- women with high grade smear abnormalities receive colposcopy within 4 weeks of receipt of referral

- women with evidence of clinical suspicion of invasive carcinoma, or a suspicion of invasive disease, receive colposcopy or a gynaecological assessment within one week of receipt of referral.

The DHBs were asked:

- What classification criteria and process is used to triage referrals?
- Is classification consistent with the Operational Policy and Quality Standards?

The responses identified several DHBs utilising a modified classification system that did not conform to the NCSP guidelines for the triage of colposcopy referrals. For example one DHB is using a classification system which allows for women to be seen within six weeks for a high grade referral.

Furthermore, from the responses received it would appear that the processes, frequency and personnel carrying out the grading of referrals vary amongst the DHBs. Lack of standardisation of the assessment and grading of referrals is an important issue to address.

**Area 2 Waiting list data**

The questions developed for this area elicited information on:

- the number of women waiting for colposcopy in each DHB
- the DHBs which identified issues with women waiting outside the NCSP Standards waiting times
- the ethnicity of women waiting
- the reason women are outside the waiting times and strategies undertaken to address this.

The NSU contract monitoring and provider compliance audits undertaken to date have identified waiting time as an area of concern.

Information systems and difficulties with data collection and extraction appear to be an issue for some DHBs. A number have encountered problems with the extraction and submission of complete data sets to the NSU. This is appears to apply particularly to the DHBs using non synchronised colposcopy clinic databases and patient management systems.

The data generated from colposcopy databases and patient management systems in respect of women on the waiting list is often inconsistent, which means that for some DHBs waiting time data may not be accurately reported. Variation in triaging, classification of referrals, clerical and booking system processes can also impact on the accuracy of waiting list data.

The volume of colposcopy procedures carried out and the number of women on waiting lists does not always reflect the volume expected from the population served. It appears that service capacity is the constraining factor in these instances. DHBs where this is an issue report that the lack of appropriate clinic space has an impact

on waiting time management. Some DHBs provide colposcopy clinics at more than one site and others are implementing initiatives to try and better utilise satellite locations where there is capacity.

### Area 3 Clerical and booking system processes

The HDC report identified clerical and booking system processes as contributors to the delay in Mrs A receiving an appointment. The questions developed for this area were designed to explore the extent to which DHBs are managing the women who do not attend appointments (DNA) and whether there is a process in place to ensure that women who are treated under a general anaesthetic are scheduled for a follow up appointment.

The review asked:

- Is there a DNA policy and does it align with the policy outlined in the NCSP OPQS?
- Does the DHB know how many women were DNA for the month of April '06?
- Does the DHB know the ethnicity of the DNA women?
- Does the DHB know whether the DNA women are 'suspicion of cancer', 'high grade' or 'low grade'?
- Is there a policy/protocol for women who refuse to attend? What process is in place for women who require a follow up appointment after treatment under a general anaesthetic?

A number of DHBs were unable to provide ethnicity data for women on waiting lists or for women who did not attend first appointments because ethnicity data is not collected until the first attendance. Some DHBs are unable to report waiting list data and DNA's by type of referral. The non availability of ethnicity data for women on waiting lists or who do not attend a first appointment limits monitoring and planning for appropriate service delivery.

Some colposcopy services have developed and implemented strategies to manage non attendance at colposcopy appointments, including providing access to support services for women and the use of a variety of approaches to communication in an effort to meet the differing needs of the population more effectively.

Booking systems utilised by DHBs vary. Some DHBs operate one system for appointments for women with low grade abnormalities and a different system for appointments for women with high grade abnormities. Low grade abnormality referrals may be held for some time before an appointment is sent to the woman, which may have implications for the ongoing engagement of the woman.

Audit of clinical records has highlighted the importance of checking processes that ensure that all women that are assessed and/or treated by colposcopy services receive the appropriate follow up.

## Area 4 Documentation

The HDC report highlighted the importance of accurate recording of patient information to ensure quality and continuity of patient care. The review tool asked DHBs whether their documentation in clinical and electronic records complied with the OPQS, and what quality checks were in place to ensure that colposcopy database reports accurately reflect the numbers of women seen. The services were also asked to undertake a reconciliation of 30 clinical records and their data bases.

It was unclear from the responses whether DHBs had completed a retrospective audit of files, or a reconciliation of the clinical file data and the data base reports. The responses do not provide assurance that all DHBs appreciate the importance of undertaking this exercise, to ensure that all women are receiving appropriate follow up.

It appears that a number of DHBs have commenced or plan to commence an audit and reconciliation of their clinical files. The NSU plans to follow up with the services to discuss their findings. Some DHBs are using manual systems to report data to the NCSP and issues of data completeness and inaccuracy are common.

Further to the HDC report, Waitemata DHB undertook a review of their colposcopy service. This review identified a number of women who had not received appropriate follow-up. A checking process to ensure that all women receive and attend follow up appointments is critical.

The review also established that the documentation within clinical notes is variable. Clinicians in the services have identified this is an area for improvement so that greater consistency within and between services is achieved.

## Area 5 Information Provided to Referring Smear Takers

The case of Mrs A highlighted the lack of communication between the colposcopy service and the referring smear taker. The review questions in this area asked DHBs to ascertain whether correspondence is reliably sent to the referring health professional, the smear taker (if not the general practitioner or referring health professional) and the women.

The review findings indicate that services appreciate the importance of ensuring that correspondence is sent to smear takers, general practitioners, referring health professionals and women. Some services are able to provide assurance on this matter as they have the ability to set up their electronic systems to generate letters automatically. Others remain dependant on staff to ensure that communication is complete in all instances.

## Area 6 Information Provided to Women

The NCSP OPQS emphasise the importance of providing timely and accurate information to women. The HDC report highlighted the significance of this requirement, noting that Mrs A was not provided with adequate information relating to her diagnosis and treatment.

The services were asked to indicate what information is provided and when it is provided. They were also asked whether the information relating to referrals and waiting times complies with the requirements set out in the Standards, and whether results are communicated within the recommended time frames. The NSU has developed a colposcopy pamphlet for DHBs to provide for women.

DHBs are providing women with the NCSP pamphlet when the appointment letter is sent and DHB specific information is conveyed either at the time of the colposcopy appointment, or when colposcopy results are communicated. In some instances the smear taker also provides the pamphlet.

### Area 7 Multidisciplinary Team Meetings for Colposcopy Case Review

The routine colposcopy service audits undertaken to date have identified that practices regarding multidisciplinary team meetings for colposcopy case review are inconsistent. Multidisciplinary meetings for colposcopy case review are a recommendation of the 1999 Guidelines for the Management of Women with Abnormal Cervical Smears.

The review responses have identified that attendance at and frequency of multi-disciplinary team meetings is variable across DHBs. These may be monthly, quarterly or even intermittent. When these meetings do occur the documentation of the meetings and of the recommended case review outcomes is also variable.

### Area 8 Clinical Leadership

Clinical leadership and oversight of clinical and administrative processes is essential to ensure consistency and continuity of care. Co-ordination, oversight and support of staff are key factors in the overall management of women attending colposcopy services.

The review has identified that while most DHBs have appointed a clinical director for gynaecology or gynaecology/obstetric services, there is often no formalised lead colposcopist role identified. Within some of the smaller DHBs the responsibilities of the clinical director for gynaecology/obstetric services and the lead colposcopist may be undertaken by the same person. These findings have significant implications for the services' ability to achieve the requirement to co-ordinate regular multi-disciplinary colposcopy case review meetings as this forum requires dedicated clinical leadership and coordination.

Clinical leadership is also critical for the provision of supervision for non-vocationally registered staff and staff in training.

### Area 9 Quality Assurance Activities

Some DHBs have achieved Quality Health New Zealand Accreditation for their hospital services. None of these DHBs recorded a request for corrective action or any recommendations relating to colposcopy services as an outcome of the Quality Health New Zealand accreditation process.

All DHBs have processes in place for management of incident reports and a number of DHBs stated they have internal audit plans.

# 5 NCSP Routine Colposcopy Audits

The inclusion of new colposcopy data reporting requirements in Part 4A of the Health Act (effective March 2005) has facilitated the ability of NSU to undertake audits of DHB colposcopy services, within the already established NCSP provider audit programme. An audit tool has been developed and a schedule for audits has been agreed. The primary purpose of routine compliance auditing is to assess the level of compliance with contractual requirements. The audits involve measurement and documentation of performance against the OPQS and other legislated and/or contracted obligations. Auditing activity also provides the opportunity for NSU staff to identify areas where further engagement and support may be indicated, to assist services to meet the Programme's requirements.

An NCSP provider audit is specific to the services provided. All DHBs are contracted to provide colposcopy, however not all DHBs provide the full range of Programme services. NSU audit teams are comprised of an independent lead auditor, two clinical experts - colposcopist and lead colposcopy nurse - an independent auditor with experience in addressing the cultural and consumer components of the audit tool and an NSU staff member.

To date the NSU has undertaken audits of nine colposcopy services and the following positive themes have emerged:

- colposcopy service staff display competence and professionalism at all levels of the service
- colposcopy service staff welcome the audit process and are willing to address the issues and challenges raised
- women focussed colposcopy services are being provided.

The key findings from the audits include:

- some confusion relating to the application of criteria for the assessment and grading of referrals
- some inappropriate assessment and grading of referrals which inturn impacts on scheduling booking processes to create waiting times which are outside the NCSP guidelines
- instances where incomplete data compromises the ability to monitor the timeliness of treatment
- examples of inadequate documentation of multidisciplinary case reviews
- evidence of inconsistent and incomplete documentation of consent, colposcopic assessment and the information given to women and general practitioners regarding colposcopy treatment and follow up

- some poor management of women who failed to attend appointments
- inconsistent levels of clinical supervision and oversight arrangements for non vocationally registered medical staff
- the need for improved incident reporting and monitoring at clinic/service level to foster continuing quality improvement
- examples of non clinical staff providing women with clinical information without appropriate clinical supervision and input
- inconsistent clinical oversight to ensure that colposcopists meet the minimum volume standards, and participate in ongoing education, training and peer review activities
- inconsistent availability of support services for women
- some services which lack space for recovery after treatment under local anaesthetic in the colposcopy clinic.

# 6 Recommendations

The review of DHB colposcopy services, the nine routine colposcopy service audits and the analysis of colposcopy data have generated the following recommendations:

1. the NSU continue to follow up with each DHB colposcopy service to support the development of plans to address the issues identified at audit
2. the DHBs be encouraged and supported to identify key performance indicators and to establish a programme of internal monitoring against the NCSP OPQS
3. the NSU engage with the DHB managers of women's services to identify areas where the development of infrastructure support for colposcopy units is needed to ensure contractual requirements are met
4. the DHBs address the infrastructure requirements to support clinicians in their quality assurance processes
5. the NSU undertakes a scoping exercise to determine whether additional resources are required for DHBs to achieve compliance with the NCSP OPQS
6. the NSU collaborates with lead colposcopists to support the development of services and education opportunities for staff which could include assistance with the development of specifications for the lead colposcopist and nurse roles
7. the NSU reprioritises the routine colposcopy service audits within the NCSP audit programme
8. the NSU undertakes a process to monitor the progress of DHB colposcopy services in quarter one 2007/08.

# Appendix One: Colposcopy Service Review Tool

This tool is to be used alongside NCSP Operational Policy and Quality Standards and in particular Chapter 6 “Providing a Colposcopy Service”

| Review Criteria | Review Questions | Current Process / Status | Action Required / Planned |
|---|---|---|---|
| 1. The triaging and classification of colposcopy referrals. | • What classification criteria and process is used to triage referrals?<br>• Is classification / grading consistent with the OPQS? | | |
| 2. Waiting list data. | • How many women are on your Colposcopy waiting list as at 30 April 2006?<br>• What is the ethnicity of these women?<br>• How long have women been waiting outside the standard time period for each category (suspicion of cancer, high grade or low grade)?<br>• What are the reasons these women are waiting outside the time period and what actions have been undertaken to address the problem? | | |
| 1. Clerical and booking system processes. | • Do you have a DNA policy / protocol?<br>• Does the policy align with NCSP OPQS page 6.19?<br>• How many women were DNA for the month of April 2006?<br>• What is the ethnicity, in each category (suspicion of cancer, high | | |

| Review Criteria | Review Questions | Current Process / Status | Action Required / Planned |
|---|---|---|---|
| | grade or low grade) for these women?<br>• Do you have a policy / protocol for women who refuse to attend?<br>• Does this policy align with the NCSP OPQS page 6.19?<br>• For women having treatment under general anaesthetic what process is in place to ensure they receive a follow up appointment? | | |
| 2. Documentation (Retrospective audit of 30 clinical records (manual and electronic)). | • Does your documentation in clinical and electronic records comply with the NCSP OPQS Standard 603 page 6.24?<br>• What quality checks are in place to ensure that colposcopy database reports accurately reflect women seen? (Do a reconciliation check between the 30 clinical records and your database). | | |
| 5. Information provided to referring smear takers - general practitioners or other health professionals. | • Does correspondence sent to smear takers align with the name of the referring health professional (audited during 4) above?<br>• If correspondence is being sent to the woman regarding treatment and management options is a copy sent to the referring practitioner?<br>• If the woman has a different smear taker from her GP how do you determine this and is the information sent to the GP as well | | |

| Review Criteria | Review Questions | Current Process / Status | Action Required / Planned |
|---|---|---|---|
| | as the referring practitioner? | | |
| 6. Information provided to women regarding referral, diagnosis and treatment. | • When is information provided to women?<br>• What information is provided?<br>• Does the information regarding referrals / colposcopy waiting times provided to women comply with NCSP OPQS standard 601 page 6.22?<br>• Are results communicated within the recommended time frames as per OPQS standard 604 page 6.25? | | |
| 7. Multidisciplinary team meetings for Colposcopy case review. | • How often are multidisciplinary team meetings held?<br>• Who attends these meetings?<br>• Is a record kept of these meetings?<br>• Does case review occur at these meetings?<br>• How are case review outcomes documented?<br>• How are cases with discordant cytology and histology managed? | | |
| 8. Clinical leadership / oversight to ensure the meeting of professional requirements. | • Who is the clinical director for gynaecology?<br>• Who is the 'lead colposcopist' for your DHB?<br>• What supervision arrangements are in place for non-vocationally registered medical staff? | | |

| Review Criteria | Review Questions | Current Process / Status | Action Required / Planned |
|---|---|---|---|
| | • What supervision is in place for staff in training? | | |
| 9. Quality Assurance activities. | • Does your service review the NCSP Independent Monitoring Group (IMG) quarterly reports?<br>• Does your service have an internal audit plan and key performance indicators?<br>• How are incident reports managed and monitored?<br>• Has your service received Accreditation or other external audit reports with requests for corrective action or recommendations for improvement for colposcopy service processes, including booking processes? | | |