IRISH CERVICAL SCREENING PROGRAMME

COLPOSCOPY QUALITY ASSURANCE

2003 VISIT REPORT

2005

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Mid-Western Area

ICS
IRISH CERVICAL SCREENING programme
foreword

This is the report of the first series of visits to Colposcopy Services in the Republic of Ireland by the Irish Cervical Screening Programme (ICSP) Colposcopy Quality Assurance team. The visits were carried out over a 2 year period and completed in February 2005. This report presents an outline of current services which builds on the findings of the ICSP National Colposcopy Survey carried out in 2001. Service provision was measured against the standards of the British Society for Colposcopy and Clinical Pathology (BSCCP) and the ICSP QA 1999 Guidelines. Following each visit, a written report was provided to colposcopy staff and hospital management to identify needs for their service planning process.

The outcome of this process has been well received, as it is evidence-based against standards that are internationally accepted.

I would like to acknowledge the huge personal contribution of Professor Walter Prendiville, Consultant Gynaecologist and Vice-President of the BSCCP who led the visits with Jim Gallaghe, ICSP Quality Manager and to thank them for their hard work.

Marian O’Reilly

Dr. Marian O’Reilly
A/ Director ICSP

June 2005
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introduction

The Irish Cervical Screening Programme (ICSP) is a population based public health screening programme for women aged 25-60 years. Regular tests are carried out in the primary care setting in an organised approach through the provision of a national database held at the central programme office. The screening is carried out in cytology laboratories and specialist referral is to the colposcopy clinic with the histology laboratories providing the diagnostic service. Policy is derived from the Report of the Department of Health Cervical Screening Committee, December 1996. External review reports published in July 2004 indicate recommendations that would change some policy elements and were provided to the Department of Health and Children Cancer Services Division. The International Agency for Research on Cancer stated in May 2004 that a structured quality assured programme would reduce the incidence and the death rate from cervical cancer by 80%. Our nearest neighbours, the UK, have verified these estimates in their hugely successful screening programme.

Of course, screening per se, doesn’t prevent cervical cancer but allows the identification of women who may then be treated in the colposcopy clinic. The colposcopy service is itself supported by the histology service which defines the diagnostic outcome for smear correlation. The role of the colposcopy service is vital to sustaining the Irish Cervical Screening Programme. International standards must be met and stand up to external scrutiny. Electronic exchange of data to and from ICSP demands critical appraisal of data quality with the requirement of a minimum dataset for a woman including the personal public service number (PPSN). The introduction of a single national cytology referral form is the basis of the information pathway for the woman in the Programme.

This report paves the way for the continuous improvement model in developing services for women, who are central to the Irish Cervical Screening Programme. It is critical in supporting current planning for the national programme.
aims and objectives

2.1 aim

To visit all colposcopy service providers as identified by the 2001 ICSP national colposcopy survey, to undertake an assessment of the service and provide a feedback report to each centre as a guide to service development. The QA team will determine the interest of the centres to link with the ICSP and their readiness for extension of the programme nationally.

2.2 objectives

- To quantify the current level of colposcopy service provided
- To describe the quality of the service provided
- To document improvements in the service since the baseline survey in 2001
- To make recommendations on future developments of colposcopy services in the Republic of Ireland in line with the requirement of the Irish Cervical Screening Programme
- To assess the commitment of clinicians and hospital management to provide a colposcopy service
- To identify the challenges to prepare for extension of ICSP
- To make recommendations for development of the service.
methodology

3.1 Introduction

This is the second report on colposcopy services in the Republic of Ireland; the first was published in 2001. To initiate the second round of visits, on which this report is based, the ICSP Director wrote to the then Chief Executive Officers of each health board seeking permission to allow an ICSP Quality Assurance (QA) team visit each colposcopy centre. The key objectives of the ICSP QA team were to:
- assist the colposcopy clinics in their efforts to provide a patient-centred colposcopy service
- provide an objective assessment of the operation of the colposcopy service
- provide positive feedback when good practices were demonstrated
- provide support where opportunities for improvement were identified.

The process included a pre-visit questionnaire which would gather data on the service. The managers of the hospitals and the lead colposcopists were then contacted and permission sought to visit. A protocol for the visit was prepared which included guidance on the assessment of the colposcopy service. This was sent to the clinicians and management prior to the visits. The response rate for participation in the process was 100%.

3.2 Pre-visit Questionnaire

A pre-visit questionnaire was developed based on a BSCCP template. The questionnaire was originally designed for use in the UK setting and was modified to suit the Irish environment. It enquired into both quantitative and qualitative aspects of the Irish colposcopy service. This questionnaire was sent to the lead colposcopist in each centre for completion by him/her or a named person in the clinic. Nineteen colposcopy service centres were identified. The response rate was 100%.

3.3 Clinic Visits

Each colposcopy centre was visited once over a 2 year period between 2003-2005. The ICSP QA team comprised a consultant gynaecologist specialising in colposcopy and the ICSP Quality Assurance Manager. The colposcopy staff and Hospital management met with the team on the day of the visit. The team provided an assessment of the colposcopy service in terms of staffing, equipment, facilities, external communication and hospital management. The quality of service provided was assessed and the team identified areas of good practice as well as opportunities for improvement. Verbal feedback was provided on the day of the visit to the colposcopy staff and Hospital management. A written report was provided by the ICSP QA team, for consensus agreement, to the Clinical team and Hospital management with recommendations for improvements to service delivery.
results

4.1 Location of colposcopy clinics
There were 19 hospitals throughout the country providing colposcopy services.

- Regional Maternity Hospital, Limerick
- Mayo General Hospital
- Adelaide, Meath and National Hospital, Dublin
- Monaghan General Hospital
- National Maternity Hospital, Dublin
- Sligo General Hospital
- Letterkenny General Hospital
- Coombe Women’s Hospital, Dublin
- Waterford Regional Hospital
- Portiuncula Hospital, Galway
- St Finbarr’s Hospital, Cork
- University Hospital Galway
- Wexford General Hospital
- Our Lady of Lourdes Hospital, Drogheda
- Mater/Rotunda Hospital, Dublin
- Tralee General Hospital
- Beaumont Hospital, Dublin
- South Tipperary General Hospital
- Midlands Regional Hospital, Mullingar

The colposcopy service was based in the Outpatient department in 13 centres. Two were based in the day surgery service and 4 sited the service only in the operating theatre.
4.2 Timing of visits

The centers were visited between March 2003 and February 2005. The pre-visit postal questionnaire was administered to each centre and completed by either the Colposcopist (10/19) or nurse (9/19).

4.3 Clinic Size and Staffing

The exact numbers of people seen in the clinics was difficult to ascertain, as many of the clinics did not have complete databases. However, it was clear that the numbers of new patients seen increased for all except 1 colposcopy clinic. There has been a 65% increase in the numbers of new patients seen annually between 2000 - 2003/2005.

All colposcopy services were consultant led and with a total of 33 colposcopists providing services. In one third of clinics, this consultant was the only colposcopist (Table 1). There were 12 nurses working full time in colposcopy clinics throughout the country with a further 20 providing sessions. One clinic did not have any nursing input.
There were 11 clerical staff providing full time administrative support to colposcopy clinics and a further 17 provided varying support in terms of writing reports or letters and booking appointments. Three clinics reported having no administrative support.

### 4.4 Clinic Infrastructure

The clinic environment was assessed in terms of facilities and equipment. 60% of clinics had a computerised system in place to ICSP specification and less than one third of these (31.6%) had image storage capability.

There was a dedicated private area with toilet and changing facilities in less than half of centres (47.4%). Only 8 centres rated their facilities as good, very good or excellent.

Resuscitation equipment was available in almost all centres with only 1 centre stating that they did not have any. Staffs in those centres with resuscitation equipment were trained in its use. Three quarters of centres had written emergency guidelines with which all the clinic staff were familiar.
Clinics reported having the following equipment in their clinics (Table 2)

Table 2  Clinic Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colposcope</td>
<td>100</td>
</tr>
<tr>
<td>Colposcopy couch</td>
<td>100</td>
</tr>
<tr>
<td>Colposcopy stool</td>
<td>68</td>
</tr>
<tr>
<td>ESU</td>
<td>90</td>
</tr>
<tr>
<td>Suction unit</td>
<td>68</td>
</tr>
<tr>
<td>Suction Speculae</td>
<td>79</td>
</tr>
<tr>
<td>Sponge forceps</td>
<td>84</td>
</tr>
<tr>
<td>E-C forceps</td>
<td>68</td>
</tr>
<tr>
<td>Cold coagulator</td>
<td>26</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>21</td>
</tr>
<tr>
<td>Other treatment units</td>
<td>21</td>
</tr>
<tr>
<td>Dental syringe</td>
<td>84</td>
</tr>
<tr>
<td>Auto clave unit</td>
<td>53</td>
</tr>
<tr>
<td>Cleaning equipment</td>
<td>58</td>
</tr>
<tr>
<td>Disposable equipment</td>
<td>68</td>
</tr>
</tbody>
</table>

4.5  Information and Communication

84% of all women referred to the clinic receive a personal invitation and information leaflet prior to their visit. Almost two thirds of clinics use a standard pro-forma to record patient histories.

Consent is sought in all colposcopy clinics prior to procedures being undertaken; verbal consent is obtained in 84% of clinics, 2 clinics get written consent and one gets both written and verbal consent. However, there is no record kept of verbal consent.

Verbal or written information is given to every woman before a smear is taken in 90% of clinics. 95% of clinics provide verbal or written information for women prior to having a colposcopy performed. Only 1 clinic provides information in a format suitable for ethnic groups. In the event of a woman likely to have treatment at the visit, three quarters of clinics inform her prior to the visit.

Only 7 colposcopy clinics have regular meetings with cytology and histology services.
4.6 Audit

Almost two thirds of clinics did not undertake audit at the time of this review. Of those who undertook audit, the negative or normal cytology rate following treatment was greater than 90% in all clinics (range 90-100%).

Colposcopy/ cytology/ histology correlation was reported as being high in those clinics where audit was undertaken but exact correlation figures were unavailable.

There is no clerical backup for reports in four clinics and no clerical backup for letters in 5 clinics. The waiting time for reports and letters varied from 1-2 weeks but up to 8 weeks in 1 clinic.

4.7 Continuing Medical Education

Only 20% of clinics reported that they had access to some form of continuing medical education. This mainly included the Internet, library or journals. Staff from 2 clinics reported attending BSCCP training programmes and 4 attended multi-disciplinary meetings.

4.8 Follow up

Failsafe procedures are available in almost two-thirds of clinics to ensure that patients are followed up and results or non-attendances acted upon. These are available for a range of options including prevention of loss to follow up. There is some form of procedure in place in 69% of clinics. Of those that had some procedure in place the methods used are outlined in table 3.

<table>
<thead>
<tr>
<th>DNA policy</th>
<th>Patient &amp; Appt given before leave clinic</th>
<th>Follow up by nurse</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent loss to follow up</td>
<td>31%</td>
<td>46%</td>
<td>7%</td>
</tr>
</tbody>
</table>

There are failsafe procedures in place to identify women who are awaiting results in two thirds of clinics. These include monthly audit, which is undertaken in 11% of clinics. The nurse or consultants follows up the patients in 21% of clinics and 11% use their computer or clinic books to identify these women.

Half of colposcopy clinics have failsafe procedures in place to identify women who do not have an agreed management plan in place;
- one third use a computer system
- a quarter are followed by the nurse
- the remainder use some other method.

One fifth of clinics have a system in place to identify women who, some 30 days after their most recent appointment date, do not yet have a smear or biopsy result reported. Methods include the use of clinic books/ computer and follow up by the nurse or consultant.
Only 3 colposcopy clinics have a system in place to identify women who, some 30 days after their most recent appointment date, do not yet have a new appointment or management plan and methods include the use of clinic books/computer and follow up by nurse or consultant.

Two clinics have a system in place to identify women who, some 30 days after their most recent appointment date, have not yet been sent a letter about follow up.

4.9 Failsafe links with the laboratories

Seven colposcopy clinics (37%) reported having failsafe links between their clinic and the cytology/histology laboratories. A variety of methods were used and these are outlined in table 4. Some centres used more than 1 method.

*Table 4 Failsafe links with cytology/histology laboratories and colposcopy clinics*

<table>
<thead>
<tr>
<th>Failsafe method</th>
<th>n=7</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/ specimen books</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Ongoing audit</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>Charts seen by consultant</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>Training sessions and meetings</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>71</td>
</tr>
</tbody>
</table>
4.10 Written protocols

Clinics were asked if they had written protocols in place for a range of different procedures. Only 1 clinic did not respond to this question and the percentage with written protocols, whether in draft form or final, is outlined in table 5.

*Table 5 Percentage of Colposcopy Clinics with Written Protocols*

<table>
<thead>
<tr>
<th>Written protocol</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to the colposcopy clinic</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Clinic scheduling</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>Colposcopy guidelines or management guidelines</td>
<td>61</td>
<td>11</td>
</tr>
<tr>
<td>Emergency guidelines</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Glandular smears</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Abnormal smear during pregnancy</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>The menopause</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>Suspected invasion</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>Follow up</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>Discharge from colposcopy service</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>Communications</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Documentation</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Counselling and consent</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Management of default</td>
<td>56</td>
<td>10</td>
</tr>
<tr>
<td>Failsafe</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>Audit</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>
4.11  Waiting times for first appointment

The waiting times for first appointment at the colposcopy clinic for a range of different diagnoses was documented and is outlined in table 6. The ICSP provides a national statistical return form on which this information should be recorded and returned.

Table 6  Waiting times for first appointment by diagnosis

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>Inadequate</th>
<th>BNA Squamous</th>
<th>Mild dyskaryosis</th>
<th>Moderate dyskaryosis</th>
<th>Severe dyskaryosis</th>
<th>Invasive ca</th>
<th>BNA glandular</th>
<th>? Glandular neoplasia</th>
<th>Clinical indication urgent/ non-urgent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1=2 weeks</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>11</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>&gt;2=4 weeks</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>&gt;4= 8 weeks</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&gt;8=12 weeks</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&gt;12 weeks</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total n=</td>
<td>15</td>
<td>15</td>
<td>18</td>
<td>18</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>11</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>% Clinics achieving QA target</td>
<td>39%</td>
<td>28%</td>
<td>78%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.12  Waiting time targets

The waiting time for first appointment was documented for a number of conditions. These were compared to findings recorded in the 2001 report when the baseline review was undertaken. The BSCCP has set a Quality Assurance (QA) waiting time target of 4 weeks or less for patients with severe dyskaryosis. The percentage of clinics achieving this target has improved between 2000 and the 2003-2005 period by 10% and is now 78%.

QA target 4 weeks or less

![Figure 2  Waiting times for appointment for patients with severe dyskaryosis](image-url)
The waiting time QA target for patients with moderate dyskaryosis is four weeks or less. This has disimproved in eight of the clinics reporting since 2001 (Figure 3). Only 28% of clinics were achieving the QA target set by the BSCCP.

*Figure 3* Waiting times for appointment for patients with moderate dyskaryosis

![Figure 3 Waiting times for appointment for patients with moderate dyskaryosis](image)

The waiting time target for patients with mild dyskaryosis is 8 weeks or less and currently 39% of clinics reporting are achieving this target. This compares with 62% in 2000 (figure 4).

*Figure 4* Waiting times for appointment for patients with mild dyskaryosis

![Figure 4 Waiting times for appointment for patients with mild dyskaryosis](image)

**QA target 4 weeks or less**

The waiting time target for patients with mild dyskaryosis is 8 weeks or less and currently 39% of clinics reporting are achieving this target. This compares with 62% in 2000 (figure 4).

**QA target 8 weeks or less**

4.13 *Waiting times for treatment and information concerning default visits*

The waiting time target for all cases is set at less than 8 weeks – 61% of clinics reached this target.

The BSCCP accepted target for default at first visit is <=15%. Over three quarters (13/17) of clinics achieved this target while just over half (53%) achieved the target of <=15% for default at follow up visits.
4.14 Diagnostic parameters

The BSCCP has set target’s for certain diagnostic parameters within the colposcopy service. Data was available from 18 of the colposcopy clinics. Table 7 outlines the targets set for different diagnostic categories and the percentage of clinics that achieved these.

* This question was unclear for respondents and this outcome should be treated with caution

Targets have also been set in relation to certain treatment options for women attending colposcopy services and table 8 outlines the percentage of clinics meeting these targets. Data was available from 17 of the colposcopy clinics.

---

### Table 7 Percentage of clinics that met targets for diagnostic parameters

<table>
<thead>
<tr>
<th>Diagnostic category</th>
<th>Target</th>
<th>Percentage who met target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy from women with mod/ severe smears</td>
<td>&gt;=90%</td>
<td>78</td>
</tr>
<tr>
<td>Biopsy from women with persistent mild/borderline smears within 2 years of first abnormal smear</td>
<td>&gt;=90%</td>
<td>72</td>
</tr>
<tr>
<td>Biopsies adequate for histological assessment</td>
<td>&gt;=90%</td>
<td>83</td>
</tr>
<tr>
<td>Record of visibility of squamo-columnar junction; presence or absence of lesion; opinion of nature of lesion and need for treatment</td>
<td>&gt;=95%</td>
<td>89</td>
</tr>
<tr>
<td>Evidence of CIN on histology in women treated</td>
<td>&gt;=90%</td>
<td>89</td>
</tr>
<tr>
<td>Colposcopist’s accuracy in predicting high grade lesions</td>
<td>&gt;=70%</td>
<td>95</td>
</tr>
<tr>
<td>Histological diagnosis established before destructive therapy</td>
<td>100%</td>
<td>61*</td>
</tr>
</tbody>
</table>

* This question was unclear for respondents and this outcome should be treated with caution

### Table 8 Percentage of clinics that met targets for certain treatment categories

<table>
<thead>
<tr>
<th>Treatment category</th>
<th>Target</th>
<th>Percentage who met target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of women treated as outpatients under local analgesia</td>
<td>&gt;=80%</td>
<td>76</td>
</tr>
<tr>
<td>CIN in histology if treated at first visit</td>
<td>&gt;=90%</td>
<td>82</td>
</tr>
<tr>
<td>Treatment completed in less than 10 minutes from start of treatment</td>
<td>&gt;=85%</td>
<td>82</td>
</tr>
<tr>
<td>Primary haemorrhage requiring an additional haemostatic technique</td>
<td>&lt;=5%</td>
<td>94</td>
</tr>
<tr>
<td>Admitted as in-patient due to treatment complication</td>
<td>&lt;=2%</td>
<td>82</td>
</tr>
</tbody>
</table>
4.15 Overall Assessment of Clinics

The ICSP QA team visited each centre once over a 2 year period as part of the review process. Each centre was reviewed in terms of staffing, equipment, facilities, external communication and hospital management. The centres were then assessed using the following scales and findings are outlined in table 9.

Excellence: This element of the service in question is at the leading edge of service development. This service defines the standard that other service providers follow.

Very good: This element of the service in question is being provided to an exceptionally high standard. The standards requirements are being exceeded.

Good: This element of the service in question is being provided in a competent, complete and successful manner. The standards requirements are being met.

Opportunity for improvement: This element of the service in question is being provided in a manner, which does not fully meet the standard

Strong opportunity for improvement: This element of the service in question is not being provided in a competent, complete, successful manner or in some extreme cases may not be provided for at all. The standards requirements are not being met.

Reference: Quality Assurance Visit Guidance Document

Table 9 Colposcopy Clinics Assessment

<table>
<thead>
<tr>
<th></th>
<th>Excellence</th>
<th>Very Good</th>
<th>Good</th>
<th>Opportunity for improvement</th>
<th>Strong opportunity for improvement</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>2</td>
<td>3</td>
<td>11</td>
<td>3</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Equipment</td>
<td>10</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>External communications</td>
<td>1</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Hospital management</td>
<td>18</td>
<td>1</td>
<td>1</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>17</td>
<td>42</td>
<td>28</td>
<td>7</td>
<td>95</td>
</tr>
</tbody>
</table>
Other quality standards were reviewed as per the guidance document prepared and agreed by the ICSP Quality Assurance team at the outset. The following was noted:

### 4.15.1 Cervical Intraepithelial Neoplasia Clinical-Pathological Conference (CIN CPC) Meetings
Only 7 colposcopy clinics hold CIN/CPC meetings.

### 4.15.2 Treatments under General Anaesthetic
Four of the 19 clinics provided treatment only under general anaesthetic at the time of the visit.

### 4.15.3 Computer Systems
Almost two-thirds (12/19) colposcopy clinics had a computer system in the clinic. However, only 2 were operational at the time of the clinic visit.

### 4.16 Overall Quality of Service

The QA team provided an overall assessment of the quality of service provided in each colposcopy clinic and found that there are serious challenges that need to be addressed in 40% of clinics (table 10).

<table>
<thead>
<tr>
<th>Standard</th>
<th>Number of clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entirely satisfactory</td>
<td>0</td>
</tr>
<tr>
<td>Minor issues identified</td>
<td>6</td>
</tr>
<tr>
<td>Moderate issues identified</td>
<td>5</td>
</tr>
<tr>
<td>Serious challenges identified</td>
<td>8</td>
</tr>
</tbody>
</table>

The QA team provided verbal feedback to the staff and management of each centre on the day of the visit and subsequently provided a written report where the quality of the service provided was detailed. The report identified areas of good performance as well as areas for improvement and included a list of recommendations to assist in improving service delivery.
5.1 Introduction

This is the second report on colposcopy services in Ireland; the first was published in 2001. It provides valuable information on the quality and quantity of service provided in this country and helps provide data on the burden of cervical pathology in women. Both quantitative and qualitative data was gathered, the former based on a template produced by the BSCCP. Each centre was visited by an ICSP QA team and information collected on the quality of service provided. This aspect of the review provided an opportunity for the visiting team to meet with both staff and hospital management, to identify areas of good practice, discuss gaps in the colposcopy service provided and agree recommendations for improvement.

The QA visits were carried out over a period of almost 2 years and there have been some changes in service provision in the meantime based on the feedback provided by the team.

5.2 Level of Service

There were 19 centres providing colposcopy services in the Republic of Ireland. The numbers of new patients seen annually in clinics has increased significantly (65%) between 2000 and 2003-2005 periods. Clinics reported seeing a total of 7,507 new patients annually in 2003-2005 periods. These are generally estimates, as the majority of clinics either do not have computers or the computer is not fully operational. No information is available on the age profile of patients seen and thus the referral rates may be higher in younger and older age groups than previously predicted. A demand for services model, outlined in the 2001 report, was based on an anticipated referral rate of 3%, however experience gained by the first phase of the ICSP, operational in the Mid-Western Area of the HSE since October 2000, indicates that the referral rate may be nearer to 5%. The increased volume of patient referrals has implications for service planning, particularly with extension of the programme.

5.3 Staffing

Consultant staff
Staffing levels continue to be inadequate in many centres. One third of centres have only 1 consultant colposcopist.

A possible solution is taking on the current developments in nursing, such as the training of Advanced Nurse Practitioners in colposcopy that will be able to diagnose, treat and discharge patients in colposcopy clinics. As of May 2005 there are 2 such nurses in training in the Republic of Ireland.

Nursing staff
Not all clinics have a clinical nurse manager (CNMII) to take responsibility for running the clinics and to be the interface between the woman and the clinical team. This is a key requirement for all clinics.
While the number of nurses in clinics has increased since 2000, there are still not enough and particularly of dedicated nurses with colposcopy training. The training and recruitment of Clinical Nurse Specialists (CNS) in colposcopy is necessary to improve service delivery. Options for providing staff training must be addressed.

Colposcopy nurse-led smear clinics are now coming on stream. Much of the clinical staffing issue may be addressed through development within the current complement of hospital staff.

**Administration staff**
Lack of dedicated administrative support is a cause for concern with 4 centres having no clerical support and many other centres having to seek help from a general pool of clerical staff. This lack of dedicated clerical staff has implications for effective communications, patient safety and seamless service provision. It is an additional barrier to the implementation of training in the dedicated colposcopy computer systems.

### 5.4 Infrastructure

There are many improvements noted, particularly, in relation to the clinic facilities. Inadequate computerisation of clinics continues to be a cause for concern. While many clinics now have a computer, they are not fully operational. Resources and training must be addressed to ensure accurate inputting and updating of data. At the last review, toilet and changing facilities were identified as needing attention. Currently, half of all centres have a dedicated changing and toilet area. This compares with previous findings.

All clinics now have resuscitation equipment compared with only two thirds in 2000. Furthermore, staffs in all clinics except one are trained in its use. There has been a dramatic improvement in the amount and quality of equipment now provided in the clinics.

### 5.5 Information and Communication

Consent is sought in all clinics and this is usually verbal. This is not recorded. Over 80% of women receive information prior to visiting the clinic and over 90% before a procedure – smear or colposcopy.

Audit is essential to the provision of a quality service but is currently not undertaken in two-thirds of clinics and less than half of the centres have regular meeting with cytology or histology services. Regular CIN CPC meetings are essential to ensuring adequate case reviews, but are only held in a minority of centres.

Two-thirds of clinics have some form of failsafe procedure in place to ensure patients are followed up. These relate to non-attendance at first visit through to those women who some 30 days after their most recent appointment do not have an appointment or management plan in place. The audit process needs to address follow up of patients as a priority. Failsafe links with the histology/cytology laboratories are also inadequate with only 37% of clinics reporting that they have a process in place.

Over half of the clinics do not have a full set of written protocols in place. 61% have written colposcopy guidelines and management guidelines.
5.6 Targets

The BSCCP has set targets for waiting time for patients with a range of diagnoses. This review indicates that more clinics are now achieving some of the targets, 78% achieved the target of 4 weeks or less for patients with severe dyskaryosis. Many clinics have shown improvement on the findings from the 2001 review but there remains cause for concern, as there are still significant numbers of centres where waiting times are too long. This may be due to insufficient resources to provide for increased referrals to these centres.

The waiting time target for all cases to be seen within 8 weeks, is achieved by 61% of clinics.

Targets set for a range of diagnostic and treatment parameters are not met by any clinic but are over 75% in most. This information provides baseline data and ongoing audit is needed to monitor the quality of the service provided.

The visits to the centres confirmed many of the findings of the quantitative survey. Staffing and facilities need to be addressed while the standard of equipment is very good in the majority of clinics.

5.7 Quality of Service

The ICSP QA team identified issues that needed to be addressed in the majority of clinics. These included staffing numbers, facilities, treatment only under General Anaesthetic, lack of CIN CPC meetings and computerisation. Individual issues were documented for each centre recommendations agreed with the staff and management of the centres. Lack of facilities for Continuing Medical Education within colposcopy is also an issue with many centres not having access to Internet, library or journals.

All clinicians and hospital management were willing to be linked with the ICSP. However, there are challenges that must be addressed for the service as a whole to be ready for extension of the ICSP.
6.1 Conclusions

There were 19 colposcopy clinics providing a service in Ireland. This is the second report of colposcopy services. The process followed in developing this report included both a quantitative survey and a QA visit to each centre to review the service and meet with staff to provide feedback after the visit.

The major conclusion for this report is that the 18 centres providing a colposcopy service across the country demonstrate a very wide variation of service delivery to women. Some clinics are very well established in terms of structures, staffing, facilities, computerisation and adherence to quality guidelines, while other clinics are challenged to provide their current service. The 2001 report concluded that all of the established 18 clinics were required to support the national extension of the ICSP however the pace of development of these clinics has not been uniform and some of the clinics are not ready to take on the requirements of a national cervical screening programme.

All clinicians and managers in the hospitals expressed willingness to link with the ICSP.

There has been a 65% increase in the numbers of new patients seen annually in clinics since 2000. A total of 7,507 new patients were seen annually in the period 2003-2005. The increased throughput of patients will have implications for the service to cope with predicted increases based on programme extension and population increases.

All colposcopy clinics are consultant led. One third of clinics have only 1 consultant colposcopist. Staffing levels are inadequate in the majority of centres, particularly, dedicated nursing and administrative staff. New staffing grades and training must be considered particularly for nursing staff.

More centres are now computerised than previously but the full potential of this equipment has not been reached. Many of the new computers are at the installation phase.

Resuscitation and training has improved with all centres now having appropriate equipment and staff trained in almost all.

The type and timing of providing written information for patients has improved, as has the practice of getting consent for procedures. However, this remains verbal in many instances with a small minority obtaining written consent. Verbal consent is not documented.

Failsafe procedures with clinics are inadequate with many clinics not having any procedure in place to follow up non-attenders for appointments. In those clinics where there are procedures in place, these vary and are often dependent on 1 person.

Overall, written protocols are in place in less than half of clinics. For some procedures, just over a quarter of clinics have their protocols written.
Overall waiting time targets set by the BSCCP have improved compared with the findings of the 2001 review. However, some clinics are still not achieving these targets. Twenty two percent of clinics have not achieved the less than 4 weeks waiting time for patients with severe dyskaryosis. Waiting times for patients with mild dyskaryosis were found to be much longer than in 2000. Reasons for this must be considered and increased referral rates may be responsible.

Targets set for diagnostic and treatment parameters are high but some centres show a need for improvement.

Facilities such as toilet and changing facilities remain inadequate and have not improved since 2000.

The QA team visits to centres were very well received. Each centre received feedback about areas of good practice and recommendations to improve the quality of service provision.

Hospital management need to ensure that these recommendations are reflected in their service planning process.

These reports provide good baseline data on the quality of colposcopy service provision and will facilitate ongoing review.
6.2 Recommendations

This review of colposcopy services indicates that many aspects of the service have improved since the first review in 2001. However, the pace of development of these clinics has not been uniform across the country and some of the clinics are not ready to take on the requirements of a national cervical screening programme. The review also shows that the increased demand and through-put of patients will continue to challenge service provision now and into the future.

1. A meeting should be held at the earliest possible opportunity between all the concerned parties within the Health Service Executive and the Department of Health and Children, to provide a national development plan for colposcopy clinics in response to the findings and recommendations contained within this report.

2. The capacity of the current colposcopy service needs to be reviewed by the Health Service Executive National Hospitals Office senior management. The review should take into account the number of patients requiring the service based on information provided in this report.

3. Staffing must be addressed. Additional consultant staff are required, especially in the clinics identified as having only one consultant available. An alternative here may be the deployment of more Advanced Nursing Practitioners to the colposcopy service. Each clinic must be supported by:
   - A dedicated CNM2 nurse to manage the clinic
   - Dedicated clerical support.

Career development in nursing staff is a positive development for the service and must be encouraged and resourced.

4. All colposcopy clinics should adhere to BSCCP standards. Structures should be put in place to allow review or revision of the quality standards by the ICSP Quality Assurance Committee. This committee should include representation from the Professional Bodies, other key stakeholders.

5. Guidelines should be developed nationally for all processes and procedures associated with colposcopy services. A national colposcopy group should be established. Representation on this group should include colposcopist and nursing staff. This report will help inform the development of these guidelines.

6. Standardised information leaflets, pro forma for history taking and consent forms should be produced nationally.

7. National meetings should be held regularly to allow information sharing and all staff should be facilitated and encouraged to attend as part of their Continuing Medical Development. The ICSP in conjunction with the local representative of the BSCCP should facilitate these meetings.
8. A regional network structure should be established based around the 4 regions in the Health Service Executive. This structure will facilitate improved communications and support for Clinicians in terms of:
   • CIN CPC meetings
   • QA activities
   • IT support
   • Training.

9. Regular CIN CPC meetings must take place in each region to facilitate and encourage exchange of information and would provide a platform through which virtual imagery could be used to improve patient care.

10. The regional Quality Assurance structure will help advise and support colposcopy service development.

11. Data collection and management must be addressed to ensure that a quality service is provided. This must include funding computerisation and the system must include digital imaging capture. Staff training and recruitment must be included in resources needed. These databases should be linked to the ICSP to ensure collation of data nationally. Colposcopy clinics should use the national statistical return form that has been developed by the ICSP.

12. Colposcopy should be an outpatient service.

13. Each colposcopy clinic should develop and support the audit process.

14. Adequate and appropriate changing and toilet facilities must be provided in all clinics.

15. This review of service should be repeated regularly and used to identify service improvements.

16. The ICSP QA team should provide follow up visits to those centres where serious challenges were identified. They should support the implementation of the recommendations provided in the feedback report to each centre.

chapter 6
There are currently 18 colposcopy clinics in the Republic of Ireland. A number of the recommendations made in this report and, particularly, resulting from the individual visits to colposcopy clinics by the QA team have been implemented and include:

- One centre has closed
- Funding for computerisation has been provided through the ICSP
- Standardised information leaflets have been developed for all colposcopy clinics
- National Colposcopy Information Technology meetings have commenced. Two have been held to date - November 19th 2004 and April 6th 2005
- This group will identify IT training needs
- Colposcopy nurse-led smear taking clinics have been established in HSE Mid-Western Area.

Clinicians and hospital management have indicated their willingness to link with the ICSP but it is imperative that senior management in the Health Service Executive support the recommendations made in this report.
The help of a number of people has to be acknowledged in the production of this report.

Prof. Walter Prendiville has given generously of his time and expertise in undertaking much of the work associated with this report.

Dr. Grainne Flannelly is the Irish representative on the BSCCP and has been a welcome advisor to the Programme.

Mr. Jim Gallagher
Quality Assurance Manager, ICSP

Dr. Anne Sheahan,
Specialist Registrar in Public Health
Health Service Executive
Mid-Western Area

Dr. Kevin Kelleher
Director of Public Health
Health Service Executive
Mid-Western Area

Sr. Maureen Madden, CNM II
Limerick Colposcopy Clinic
Health Service Executive
Mid-Western Area

All the staff with their hospital management in the 19 colposcopy clinics that were visited in this process.
If you have any queries about the Cervical Screening Programme contact:

Information Line
1800 25 2 60 0

www.icsp.ie