

**UNDER THE HEALTH AND DISABILITY
SERVICES ACT 1993**

**IN THE MATTER OF THE MINISTERIAL
INQUIRY INTO THE UNDER-REPORTING
OF CERVICAL SMEAR ABNORMALITIES**

EVIDENCE OF JULIA MARY PETERS

HEALTH FUNDING AUTHORITY

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PART I – PROFESSIONAL QUALIFICATIONS AND EXPERIENCE

1. My name is Julia Mary Peters. I am a registered Medical Practitioner and Public Health Medicine Specialist.
2. I graduated with a Bachelor of Medicine in Surgery (MBCChB) from the University of Auckland School of Medicine in 1982.
3. I gained my initial clinical experience in 1983 and 1984 as a House Surgeon and then a Senior House Surgeon employed by the Wellington Hospital Board. This included six months as a Senior House Surgeon in obstetrics and gynaecology at Wellington Women's Hospital. I also obtained a post-graduate diploma in obstetrics from the University of Otago.
4. In January 1985 I left New Zealand to work in the Southern Highlands of Papua New Guinea as a volunteer for the provincial Government. During 1985 and 1986 I worked in Mendi Hospital. I had sole charge of the obstetrics and gynaecology ward and, like all the doctors there, participated in working in the accident and emergency ward and visiting outlying health centres. Later in 1986 I transferred to work first at Nipa Health Centre and then at Tari Hospital (both of these are within the Southern Highlands). I returned to New Zealand in October 1987.
5. For approximately 12 months after my return I was resident in Wellington and worked as a part-time locum general practitioner at the Tawa Medical Centre. In June 1988, my husband (who is also a doctor) and I purchased a general practice on Waiheke Island. I worked there until 1994. During that period I was involved in the establishment of a home birth service for

Waiheke Island women and built up a very busy practice with an emphasis on, but not exclusive to, women and children.

6. In 1991 I attended general practice training programme weekly seminars in Auckland and passed the Part 1 examination for membership of the College of General Practitioners that same year. I obtained the second part of this qualification in late 1994 and was awarded membership of the Royal New Zealand College of General Practitioners. I sold my general practice during 1994.
7. In late 1993 I was also accepted as a registrar within the Public Health Medicine Training Programme. Part 1 of this Programme involves completion of a Master of Public Health degree. In 1994 I began this course of study at the University of Auckland. During that time I worked as a research assistant in the Injury Prevention Research Centre at the University. I was awarded the Master of Public Health degree with Honours in 1997.
8. In June 1996 I took up a 12-month public health medicine registrar position at the Public Health Protection Service of Auckland Healthcare. In June 1997 I then commenced a six-month registrar position with the Transitional Health Authority in Auckland as a public health medicine registrar.
9. I sat and passed the Part 2 examination of the Australasian Faculty of Public Health Medicine in November 1997, becoming a Fellow of the College. I was admitted to the Vocational Registrar of Specialists of the Medical Council of New Zealand in 1998.
10. I took up a one-year senior registrar position with the Transitional Health Authority in December 1997. I worked both in the public

health team and the then community team. In August 1998 I obtained a permanent position as a public health physician in the Health Funding Authority. That position was in the Public Health Change Management Team of the HFA Public Health Operating Group. This team was in the process of being formed and had responsibility for the national management and co-ordination of both the national breast and national cervical screening programmes. My role initially was to work on the implementation of BreastScreen Aotearoa (the national breast screening programme).

11. In November 1998 I then took up the position of manager of the Public Health Change Management Team.

PART II – DESCRIPTION OF THE NATIONAL CERVICAL SCREENING PROGRAMME (NCSP) WITHIN THE HEALTH FUNDING AUTHORITY SINCE 1998.

A – NCSP purchasing responsibilities of the Health Funding Authority at the time of its formation

12. The Health Funding Authority (HFA) is a Crown Entity with a Board and a Chief Executive Officer. It was formed on the 1st of January 1998 from the Transitional Health Authority (THA). The THA was an interim structure developed from the amalgamation of the four Regional Health Authorities in April 1997.
13. When the Health Funding Authority was formed, the 1997/98 Annual Funding Agreement between the Ministry of Health and the Transitional Health Authority was the basis by which the Health Funding Authority purchased services.
14. That Funding Agreement included a so-called “Evergreen Document” which stated the responsibilities of the Transitional Health Authority with respect to the NCSP as follows:
 - ‘2.12.12. The THA will purchase -
 - (a) cervical screening Services for Eligible Women; and
 - (b) health education and promotion Services relating to cervical cancer and screening; and
 - (c) maintenance and operation of the national cervical screening register.

2.12.13 The national cervical screening programme is to be

consistent with the National Cervical Screening Programme Policy 1996 and the Health Act 1956 Section 74A.'

I understand that other witnesses have produced the 1996 NCSP Policy document referred to. Section 74A of the Health Act 1956 is set out in Appendix Three of the policy document.

15. The 1998/99 Funding Agreement between the Health Funding Authority and the Ministry of Health (commencing in 1 July 1998) stated in section 9.5 that:
 - '(a) the HFA will purchase a national cervical cancer screening programme for eligible women, who are aged 20-70 years.
 - (b) the national cervical screening programme is based on the National Cervical Screening Programme Policy 1996 and the Health Act 1956 Section 74A.'
16. As at January 1 1998, the Health Funding Authority had contracts with various providers in order to meet these funding agreement obligations. This included contracts with regional co-ordination sites, health promotion providers, smear takers, laboratories and colposcopy services.
17. As I understand it, the principal roles and responsibilities of providers within the NSCP have remained relatively unchanged through the various changes to the health system since the Programme was implemented in 1990.
18. The National Cervical Screening Register (NCSR) has been described as the key management tool of the Programme and Section 74A of the Health Act describes, among other things, the legal responsibilities of smear-takers and laboratories with

respect to the NCSR (in Section 74A a cervical smear test refers to the taking of any cervical cytological or histological specimen).

19. The NCSR holds information on enrolled women's demographic details, their smear results, their histology results, smear-takers, health centres and laboratories. As a clinical management tool for the Programme it is used to produce a number of reports and letters which are described in paragraphs 24 and 25.
20. The NCSR also has the potential to facilitate programme monitoring. Currently, it is used to produce monitoring reports which smear-takers and laboratories can use to contribute to their internal quality assurance processes for example, quality of smear reports and laboratory reporting patterns reports. In addition, monthly enrolment and coverage statistics are produced and some statistical information is provided to the Ministry of Health via a three monthly sector information report. The NCSR is also the source of data for the Annual Statistical Report and has the potential to be used as an integral part of an on-going quality assurance process.
21. The NCSP is co-ordinated locally at 14 regional sites funded by the Health Funding Authority. This configuration is based on the old Area Health Board structure under which the Programme was implemented and the current regional boundaries are those of the former Area Health Board boundaries, with the exception of the Bay of Plenty site which was expanded to include Turangi. These co-ordination sites are almost all sited within Hospital and Health services.
22. These co-ordination sites are responsible for regional remote data entry onto the NCSR, generation and management of NCSR reports for their region, regional provider co-ordination, facilitation

of some low-cost smear-taking services and are a point of contact for women's queries. In all but two regions, co-ordination sites also have total responsibility for regional NCSP health education services. Within the Auckland region, health education for the NCSP is undertaken by three independent service providers (Maori, Pacific Island and general) and in Waikato, there is a separate independent contract for health education to Maori women.

23. Over 400,000 smear results are processed annually at the 14 co-ordination sites. However, there are significant variations in the volumes processed by individual sites. For example, the number of results processed varies from approximately 3,500 on the West Coast and 5,000 in Tairāwhiti to approximately 126,000 at the Auckland site. Over 50,000 smear results are processed annually at the Wellington and Canterbury sites respectively. In general terms processing of cytology results involves up-dating a woman's details on the NCSR in accordance with information provided on the NCSP enrolment form. Subsequently her smear result is attached to her details when it is received from the laboratory on electronic disc in Bethesda code. The result that is received from the laboratory will automatically ensure that a recall date is set and a woman's smear history up-dated. The NCSR is programmed according to the Bethesda coding standard 1998 and thus the Register will alert the regional register staff if the most recent result sets an inappropriate recall date according to the women's history on the NCSR. When this occurs, register staff must contact the laboratory and smear-taker to resolve the discrepancy and ensure the correct recall date is set. Once results are accurately attached, any letters that need to be sent out are generated. A similar process is involved in entering histology results into the NCSR but no result letters are sent to women.

24. The regional co-ordination sites send letters out to women who:
 - (a) have had their first smear result entered on the NCSR, to welcome them to the Programme and advise them of that smear result
 - (b) are overdue for their smear (smear-takers being responsible for the initial recall at the time the smear is due)
 - (c) have an abnormal smear result
 - (d) are no longer on the active recall part of the NCSR e.g. they are over 70 years and have a normal screening history; or have had a total hysterectomy with normal a cervical histology result and a normal screening history. The purpose of these letters is to advise women that they no longer need to have regular smears
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25. The regional co-ordination sites also send reports out to health professionals and organisations providing services to women who are enrolled in the NCSP. My understanding is that these include:
 - (a) recall reports for General Practices and other smear-takers. All General Practices/smear-takers receive lists of women who are overdue for their smear and recall reports from the NCSR are available to assist with routine smear-taker based recall systems
 - (b) smear histories of women who have had a smear sent to a laboratory for reading. Histories are sent to the relevant laboratory on request
 - (c) reports to local smear-takers on the quality of the smears taken. This report provides information on the proportion of smears satisfactory for reading, the number of smears the smear-taker has taken have taken, and her/his smear-taking patterns compared with the regional average.

- (d) a number of reports which are designed to ensure that women with abnormal smears are referred to a specialist and receive treatment
- (e) cyto-histological reports are sent to laboratories at their request. However, I am advised that these reports only include instances where the histology has been read at a different laboratory to that at which the initial smear was read
- (f) the laboratory reporting patterns report that is generated and sent to laboratories twice a year. This report is generated at the central register but distributed by the regional co-ordination/register sites. It provides laboratories with feedback regarding the timeliness of their reporting to the NCSR, the volume of smears they have read and their reporting patterns compared with the national average.

26. The regional co-ordination sites, while having links with other providers such as laboratories, colposcopy services and smear takers, do not have any contractual responsibility for these other providers in the Programme. The contractual relationships are between each provider and the Health Funding Authority. I understand that since the commencement of the NCSP the National Co-ordinator has met regularly with the regional co-ordinators (initially this was quarterly, from 1998 onwards twice yearly). The agenda for these meetings is broad; co-ordinators submit agenda items on processes and policy issues around which resolution or clarification is needed, and the meeting is a forum to share ideas and concerns. These regular meetings continue.
27. Call and recall services are undertaken by smear-takers within their own practices with the NCSR providing a back-up service as previously described.

28. Enrolment in the NCSR, and thus the NCSP, occurs when a woman has a smear taken. At this point the woman should be informed about the NCSP and its purpose and advised that a copy of her smear result will be forwarded to the NCSR unless she objects. It should be noted that the way that Section 74A is written means that every time a woman has a smear taken from her cervix, or a histological biopsy taken, she must be advised that her result will be entered onto the NCSR unless she objects. Further, Section 74A of the Health Act applies to the cytology results of women of all ages although the NCSP is targeted at women aged 20-69 years inclusive.
29. Within New Zealand there are approximately 6,000 smear-takers. A majority of these are general practitioners, nurses and gynaecologists. I understand that there is a very small number of lay smear-takers, not more than 6. Apart from women who have a community services card, smear-taking services are not funded by the health service and women can expect to pay a normal consultation fee when a smear is taken. Throughout the country, some free or low cost smear taking services are provided. Prior to a smear or biopsy being taken it is expected that the smear-taker will explain the clinical procedure, the importance of having regular smear tests, the purpose of the NCSP and NCSR and determine whether a woman wishes to have her results forwarded to the NCSR.
30. My understanding is that 27 laboratories currently provide smear-reading services (cytology and histology) to the Programme. This included both public and private laboratories. Laboratories are required by Section 74A of the Health Act 1956 to forward the results for any woman who has not opted off the NCSR to the regional register site for entry onto the NCSR. The attached list and explanatory notes show the complexity of the situation

JMP/HFA/0001. I understand that in a small number of cases, results are sent to the NCSR from a laboratory which has sub-contracted the actual reading to another laboratory, for example in the case of slides prepared using liquid-based technology.

31. As part of the NCSP, colposcopy services are provided by gynaecology or women's health services within HHS's. Some women attend private gynaecologists for assessment and diagnosis following an abnormal smear result. Again, unless a woman objects, the cytological and histological laboratory results are forwarded to the NCSR. Section 74A of the Health Act 1956 also applies to private gynaecologists, although the Health Funding Authority does not have a contractual relationship with them. (However, it should be noted that ongoing monitoring of healthcare providers with whom a funder has no contractual relationship might be difficult to achieve.)

32. The purpose of colposcopy is to make a diagnosis usually on the basis of an abnormal smear result. It should be noted that a woman should be referred for immediate colposcopy regardless of her smear result should she have symptoms or signs that could indicate cervical cancer or if visual inspection of her cervix indicates that cancer could be present.

B – Restructuring of the Health Funding Authority

33. After the HFA was officially established, a process known as Transformation 98 (T98) was implemented to develop a new structure and outline the roles and responsibilities of the different groups within the new organisation.
34. The purpose of T98 was to create a single national funding agency to replace the four separate organisational structures that were in place as a result of the amalgamation of the Regional Health Authorities into a single organisation. This was to reduce unnecessary administrative costs and replication of effort; plan for the future health and disability needs of the country within a broader framework; clarify the funder's role and accountability and improve national consistency in quality and access.
35. The T98 process took several months and created five operating groups within the Health Funding Authority: Personal Health, Public Health, Maori Health, Mental Health and Disability Support Services.
36. Three Corporate Groups were also formed with responsibility for maintaining the HFA infrastructure including financial systems, strategic planning at a corporate level, servicing the Operating Groups, and carrying out other statutory functions of the HFA.
37. Each Operating Group and Corporate Group has a General Manager who reports to the Chief Executive Officer. The Chief Executive Officer reports to the chairperson of the HFA Board.
38. The Executive Management Team (EMT) of the HFA includes the CEO, the General Manager of each of the Operating Groups, the Chief Financial Officer and the General Managers of Corporate Services and Corporate Strategy.

39. In general, each Operating Group has a similar structure, although there is some inter-group variability. The basic structure includes four locality teams, situated in Auckland, Hamilton, Wellington and Christchurch or Dunedin. These teams are responsible for developing regional plans and purchasing services within their localities. There is also a change management team, service strategy team and support staff for the General Manager.
40. The Maori Health Operating Group has been charged with its own particular funding and contracting roles as well as developing an organisational capacity to address Maori Health disparities and issues.
41. The official launch of the new structure for the Health Funding Authority was 1st of October 1998. A diagram of the new structure is produced **JMP/HFA/0002**.

C – Transfer of responsibility for national co-ordination and management of the NCSP and the NCSR to the Health Funding Authority

42. At the time of the formation of the Health Funding Authority, the responsibility for national co-ordination and management of the NCSP and the NCSR was still with the Ministry of Health.
43. My understanding is that the decision to transfer the national co-ordination and management of the NCSP was made by Cabinet subsequent to it receiving a report from a Steering Group established to consider sector changes after the establishment of the 1996 Coalition Government. The Steering Group considered the relative roles of the Health Funding Authority and the Ministry

of Health and this led to a decision to separate strategic policy functions and operational policy functions, and resulted in a number of transfers. In addition it was thought that aligning the national co-ordination role in the same organisation as the funding role would strengthen national co-ordination. The transfer was also expected to alleviate some of the fragmentation that had occurred in the Programme in the past.

44. On 11 May 1998, formal responsibility for national co-ordination and management of the NCSP and the NCSR was transferred from the Ministry of Health to the Health Funding Authority.
45. Funding of \$545,000 associated with these arrangements had been credited to the HFA from 1 March 1998. Staff and assets had physically transferred to the Wellington office of the Health Funding Authority in April 1998. This difference in timing was due to some delays in having the formal transfer documents agreed between the Ministry of Health and the Health Funding Authority, particularly as the documents also covered the transfer of other public health services such as the production of health education materials.
46. The \$545,000 covered the three direct staff salaries, indirect staff costs such as travel and accommodation for visiting sites and attendance at national co-ordination meetings, operating costs for the Cervical Screening Advisory Committee (CSAC) and the production of a newsletter, operational costs of the NCSR, and depreciation on the NCSR.
47. The transfer documentation included a formal appointment of the HFA to maintain the NCSR and also four Deeds of Transfer. I produce a copy of the formal appointment document **JMP/HFA/0003**. Three of the Deeds related to the staff who were

transferred. The staff were Diana (Di) Valentine Best, Sandra (Sandie) Mary Matcham and Philip Graham Saysell. In their Deeds of Transfer the staff were transferred on the same terms and conditions that applied between themselves and the Ministry. They were also to be employed by the HFA in substantially the same capacity in which they were employed immediately before the date of transfer under the Deed. However, the staff also acknowledged that, as employees of the HFA, they would be subject to the T98 review that was underway. The Transfer Deed for Di Best is produced by way of example **JMP/HFA/0004**.

48. A separate deed was entitled “Transfer of the Function of Maintaining the National Cervical Screening Register and of National Co-ordination of the Cervical Screening Programme, Including Transfer of Assets” **JMP/HFA/0005**.
49. In this deed the HFA agreed to maintain the NCSR for the purposes of section 74A of the Health Act 1956.
50. A draft letter from Karen Poutasi, Director-General of Health to Phil Pryke, CEO of the HFA outlining the key decisions reached between the HFA and the Ministry of Health was drafted jointly by the Ministry of Health and the Health Funding Authority.
51. In summary, this letter recorded agreement about the following areas:
 - (a) when the HFA would assume operational responsibility for the service
 - (b) that the HFA would employ the three staff employed by the Ministry on their current terms and conditions. It was acknowledged that all staff would be subject to the HFA’s current review of all staff positions

- (c) that the HFA, Ministry of Health and staff would sign contracts transferring the staff and the register and responsibilities for national co-ordination
- (d) the appointment of a Maori advisor with responsibility for screening programmes
- (e) the fact that the Ministry of Health was to pass any year to date under spent funding to the HFA and other budget issues such as charges for data lines associated with the NCSR
- (f) the fact that the Ministry had in its planning an evaluation of the cervical screening operations with one off funding of \$200,000.00 and that the funding for the evaluation would be maintained in the Ministry until agreement was made as to who would manage this evaluation.
- (g) assistance with the preparation of the first statistical report following the physical transfer of the function.

- 51.** Changes to this draft version of the letter were sent back to the Ministry of Health from the HFA. The HFA never received a final version of this letter. A copy of the draft letter marked up with the HFA changes is produced **JMP/HFA/0006**.

- 52.** The Ministry of Health maintained its role of providing policy advice to the Minister of Health on the NCSP and for monitoring the Health Funding Authority with respect to the NCSP. The Ministry of Health also retained responsibility for servicing the National Kaitiaki Group which is a group appointed by the Minister of Health to consider and approve applications for the release of Maori women's data from the NCSR according to The Health (Cervical Screening (Kaitiaki)) Regulations 1995.

- 53.** Two items of correspondence between the Ministry of Health and the HFA in September 1998 further clarifies the situation regarding the planned evaluation and copies of these are

provided **JMP/HFA/0007**. My understanding is that the Ministry of Health had commissioned an evaluation plan with 13 parts prior to the transfer of responsibility for national co-ordination of the Programme. The September letters outline agreement between the Ministry of Health and the HFA that the Ministry would have responsibility for conducting two components of the original plan. In addition it was stated that the primary concern of the HFA was to establish ongoing quality mechanisms including continuous monitoring and evaluation of the Programme, including key indicators. It was also noted that as no specific budget had been allocated to the HFA to carry out the full evaluation plan, the HFA was unlikely to be able to meet expectations that may have been raised by the production of such a comprehensive plan.

54. After the transfer, Di Best was employed by the HFA as the National Co-ordinator of the NCSP. She initially reported to the National Director of Public Health within the HFA.

55. At the time of transfer the HFA received Di Best's Ministry of Health job description and Di Best, the national co-ordinator, provided a 'job explanation' and a detailed work plan until the 30th of June 1998. The job explanation detailed the activities of the National Co-ordinator as including responsibility for co-ordination and liaison (for example liaising with regional sites and professional colleges); producing Programme materials (e.g. health education materials and newsletters), convening and servicing various groups (e.g. Cervical Screening Advisory Committee and regional co-ordinators meetings) and monitoring/auditing and evaluation of the Programme. The job description, job explanation and work-plan are provided **JMP/HFA/0008**.

56. This final activity was described as:

“monitoring regionally produced health promotion and health education information for accuracy and consistency of message; colposcopy treatment and post treatment colposcopy waiting times; annual statistical report; annual Maori statistical report; monitoring enrolments on National Cervical Screening Register; facilitating the review of cervical screening recommendations and management of abnormal smear results; regional register performance; and monitoring laboratory performance.”

57. I understand from the staff who transferred from the Ministry of Health, that monitoring laboratory performance focused on monitoring the timeliness of reporting of cytology and histology results by laboratories and whether reporting was occurring in line with the policy. This focused on, for example, whether individual laboratories were reporting histology to the NCSR in an electronic form within the timeframes stated in the 1996 Ministry of Health Policy document.
58. Sandie Matcham was employed by the HFA as the Senior Advisor and Co-ordinator for the NCSR. The purpose of the position as outlined in the Ministry of Health job description was to effectively co-ordinate the NCSR so that its objectives are achieved to the highest standard within agreed resources. This was to involve:
- (a) providing an overview of the requirements of the NCSR and its impact on NCSP and the impact of NCSP policy on the NCSR
 - (b) ensuring the national co-ordinator is aware of potential issues regarding the NCSR
 - (c) assisting the national co-ordinator to assess policy issues which involve the NCSR

- (d) assisting the national co-ordinator to set priorities regarding the NCSR
 - (e) assisting NCSP staff to deal with queries regarding the NCSR
 - (f) advising on NCSR enhancements
59. At the time of the transfer, Sandie Matcham provided a 'job explanation' and detailed work plan until the 30th of June 1998. Her responsibilities included management of the information system providing the NCSR; co-ordination and liaison with health sector providers, staff and project management. She also shared responsibility with Philip Saysell for database and systems administration, technical support and the help desk function.
60. Philip Saysell was employed as an Systems Analyst and Programmer. His job description describes the purpose of his position as to perform programming tasks for the NCSR and to provide Programme documentation for the NCSR. On transfer to the HFA, Sandie Matcham and Philip Saysell reported jointly to the National Director of Public Health and the then National Director of Information Management.

D – Interim Structure of the NCSP within the HFA

61. At the time of transfer of the national cervical screening staff from the Ministry of Health an interim structure for the Public Health team had been implemented by the then National Director of Public Health, Bette Kill, after discussion with the then CEO, Phil Pryke.
62. The interim structure included a National Prevention team. This team was to be responsible for developing the strategic direction for all the screening programmes. Team members included public health managers from the four Regional Health Authorities as well

as local public health teams based in the Auckland, Hamilton, Wellington and Dunedin offices who were responsible for purchasing local health promotion and local register services. The national cervical screening co-ordinator reported directly to the National Director of Public Health. The two NCSR staff reported jointly to the National Director of Public Health and the Director of Information Management. A diagram of this interim structure is provided **JMP/HFA/0009**.

63. My understanding from reading the file, and talking to the personnel involved, was that the implementation of the interim structure for the management of the screening programmes was in response to several issues. A decision was made by the then CEO and the National Director of Public Health within the HFA to align the two screening programmes i.e. the NCSP and BreastScreen Aotearoa within the organisation. This was in order to ensure that the skills of the experienced staff would be available to both programmes and there could be transfer of skills between the two programmes. This also allowed the creation of a position for a dedicated Maori Screening Co-ordinator for both cervical and breast screening. There had been some concern that this position would be lost at the time of the transfer.
64. While it was originally envisaged that this team might also assume responsibility for the proposed Hepatitis B screening Programme this responsibility was later transferred to the Personal Health Operating Group following a government decision to change the Programme from being a population-based screening programme, to one in which specific sub-populations were targeted for screening.
65. Staff were seconded from other positions in the organisation to form the National Prevention team until the T98 process

determined the final structure of the organisation. Dr Bernadette Mullin who was the Public Health Manager for the Auckland office of the Transitional Health Authority was seconded as the interim Manager of the National Prevention team. She is a Public Health Physician with a PhD in epidemiology and had some experience in purchasing the regional co-ordination functions of the NCSP and had been involved in the early planning for the national breast screening programme.

66. Staff within the National Prevention team linked in with the National Cervical Screening Co-ordinator, particularly with respect to strategic direction for the Programme. However the National Cervical Screening Co-ordinator continued to have operational responsibility for national co-ordination until the T98 restructuring was implemented. I understand that this occurred around July 1998 when Dr Bernadette Mullin was appointed in the interim position of Manager of the Public Health Change Management Team, a position she held until November when I took up the position. There is an overlap period during November 1998.
67. The National Prevention team and later the Public Health Change Management Team (as the team was known after the completion of T98) was located in the Auckland office of the Health Funding Authority. This was because the National Director of Public Health and CEO had identified the work programme for this team as being a key performance objective for the organisation. They wished to have the team co-located in the same office as the National Director of Public Health (Bette Kill), as she expected to have hands-on and daily involvement with her staff.
68. The T98 process assigned responsibility for national co-ordination of the NCSP to the Public Health Operating Group Change Management Team. Change Management Teams were formed

within the HFA because the organisation recognised the importance of good change management and that adequate resources must be applied to drive health sector change effectively. I produce a newsletter that contains a diagram of the Public Health Operating Group structure **JMP/HFA/0010**. The managers of those teams were described as senior project managers within the new structure.

69. Both the national breast screening programme (BreastScreen Aotearoa) and the NCSP were to be managed by the Public Health Change Management Team. This was because Bette Kill recognised that both national programmes required adequate and dedicated staff and resources. Under the Regional Health Authorities and the Transitional Health Authority there had already been significant delays to the implementation of BreastScreen Aotearoa. It was anticipated that following the transfer of responsibility for the national management of the NCSP from the Ministry of Health to the HFA, a review of the national activities for the Programme would be required. In some ways the title “Change Management Team” is something of a misnomer given the roles and responsibilities which the team assumed. The title implies that the Team’s only role is that of managing change when that in fact is not the case. Although change management has been a significant part of our work for both screening programmes, the team also has responsibility for national co-ordination and management, operational policy development, monitoring and public health co-ordination for both programmes.
70. I understand there was a need to enhance the skill mix of the team and ensure that there was a critical mass of staff. Rather than relying on a single national co-ordinator for the NCSP, a Manager, two screening co-ordinators (one Maori and one non

Maori), two FTE project officer/analysts, and a half-time support co-ordinator were appointed to the Public Health Change Management team between July 1998 and December 1998 with responsibilities for managing both the cervical and breast screening programmes.

71. In addition, CEO approval was obtained to appoint a public health co-ordinator for health promotion aspects of both programmes on a fixed term contract.
72. From the 1st of July 1998 the major focus was on recruiting permanent staff for the team. Di Best, the national co-ordinator had transferred over from the Ministry of Health on a fixed term contract that expired in December 1998. She decided not to apply for the permanent staff position in the Auckland office of the HFA but was offered a twelve-month part-time consultancy position based in the Wellington office. This was to ensure that there was some continuity of staff and work programmes for the Programme. Her role was, in particular, to brief the newly appointed co-ordinators and undertake some operational policy development for the NCSP.
73. With the change from a single National Co-ordinator to a team approach, the responsibility for national co-ordination and management of the NCSP now lies with me as the Manager of the team, rather than with the National Co-ordinator as it had done in the past.
74. The T98 process also assigned responsibility for maintaining the NCSR to the Information Management (IM) Team within the Corporate Services section of the Health Funding Authority. Steve Mayo-Smith is the General Manager of IM. He reports to Sally Campbell who is the General Manager of Corporate Services. As

well as maintaining and supporting the NCSR, the IM team also has responsibility for the planning, implementation, maintenance, and support of the HFA-wide IM and telecommunications infrastructure. Until recently, the two NCSR staff, Sandie Matcham and Philip Saysell, remained in their positions within the IM team in Wellington. However, on Monday 13 March 2000 they and the NCSR transferred to my team, to be part of the wider Public Health Operating Group. They are still situated in the Wellington office of the HFA. This is part of a process of national alignment of all elements of the NCSP, a process that will be covered in more detail further on in my brief. The work of the two NCSR staff is addressed in paragraph 78.

E – Summary of current roles and responsibilities for the NCSP within the HFA

75. Within the Health Funding Authority, two operating groups have predominant roles and responsibilities for the NCSP. These are the Public Health Operating Group and the Personal Health Operating Group.
76. The Change Management Team within the Public Health Operating Group is responsible for national co-ordination of providers and for the management, policy development (including operational policy, quality standards and strategic policy), and monitoring and evaluation of the NCSP. This Team is also responsible for developing national public health strategies and health education materials and for purchasing national activities as required (for example, media recruitment campaigns and external monitoring requirements).
77. The Team is also responsible for information management issues in relation to the Programme including maintenance of all aspects of the NCSR, data management, data collection, reports, and approval of data releases.
78. The NCSR staff have a number of roles and responsibilities. These include:
 - (a) management of the functionality of the hardware and software of the NCSR computer system
 - (b) production of monthly enrolment and coverage figures for the Programme, and the biannual laboratory reporting patterns report
 - (c) facilitating data releases for the annual NCSP statistical report and for other organisations that have data releases approved

by the Manager of the Public Health Change Management Team or the Kaitiaki Group

(d) provision of a helpdesk service for the 14 co-ordination/register sites previously referred to

(e) liaison with healthcare providers as required

79. The Public Health Change Management Team also services the Advisory Group for Population-Based Screening Programmes (PBSP) to the HFA. This group was established to replace the Cervical Screening Advisory Committee and the Breast Cancer Screening Advisory Group. The Advisory Group for PBSP reports to the General Manager of the Public Health Operating Group of the HFA. I produce a copy of the Terms of Reference for the Advisory Group for PBSP and a list of group members **JMP/HFA/0011** and confirmed minutes from Advisory Group meetings held between December 1998 and March 2000 **JMP/HFA/0012**. The role of this Advisory Group is to advise on strategic policy issues, issues of cultural and consumer importance, to advise on evaluation and monitoring of the Programmes, and to provide specific expertise to complement that of the Public Health Change Management Team.
80. I have a leadership responsibility for the Programme within the HFA.
81. The total FTE allocation for the team is now 10.5 people (including a Public Health Medicine Registrar) employed by the HFA and in addition to this a number of contractors also provide specialised services and work on specific projects.
82. Locality teams within the Public Health Operating Group are responsible for purchasing regional co-ordination services (in the same 14 regions based on the previous Area Health Board. The

roles and responsibilities of these providers have previously been described in paragraphs 21 to 26.

83. The Locality teams of the Personal Health Operating Group purchase smear-taking (mostly as part of GMS subsidies or capitated contracts for primary care), smear-reading services from community and hospital laboratories and colposcopy and treatment services from hospitals, for the NCSP.
84. The Change Management team of the Personal Health Operating Group is responsible for the development of laboratory, and primary care purchasing strategies that impact or have an interface with the NCSP.
85. The Quality and Audit team of the Service Strategy team of the Personal Health Operating Group is responsible for the review and / or audit activities in relation to laboratory services in general. This team is the team that has responsibility for the investigation into the Gisborne laboratory. Evidence by Tracy Mellor covers the detail of the Gisborne investigation.

PART III – ANALYSIS OF THE NCSP FOLLOWING TRANSFER FROM THE MOH

A – Principles of population based screening programmes

86. Population based screening programmes aim to reduce the incidence and mortality of disease (in this case, cervical cancer) by routinely screening an entire defined population at regular intervals. The screening test aims to detect the disease or its precursors at a very early stage, enabling early diagnosis and treatment when it is likely to be most successful. It is generally recognised that a disease, or condition, must fulfill certain criteria to make it suitable for a population-based screening programme.
87. It is generally accepted in the medical literature that the criteria which a disease should fulfill include:
- (a) The disease or condition should be important
 - (b) The natural history of the disease should be understood
 - (c) The prevalence of the disease should be known
 - (d) Facilities for diagnosis and treatment should be available
 - (e) There should be a suitable test which enables the disease or precursors of the disease to be detected when it is asymptomatic
 - (f) The test should be simple, acceptable, accurate, inexpensive, reliable, sensitive and specific
 - (g) Early detection and treatment should have a positive impact on survival
88. Population-based screening programmes specifically target and invite an asymptomatic population (in this case women) to be tested for the probable presence or absence of disease or the

pre-cursors of a disease. If the test is positive for an individual, further tests are required to confirm the presence or absence of the disease or its pre-cursor. The initiative is that of the health sector and there is the potential for both benefit and harm to individuals who participate. For this reason there is an ethical responsibility on the health sector to ensure that overall the benefits of screening outweigh the risks. To ensure this, the screening services provided must be of very high quality, and diagnostic and treatment services must also be of very high quality and provided in a timely fashion. In addition, the eligible population needs to be informed of both the benefits and risks of screening so individuals are able to make an informed decision regarding participation.

89. The success of screening programmes in reducing the incidence and mortality from a particular condition depends upon high levels of enrolment and coverage and the highest quality screening and follow-up services. In addition, the Programme must be properly organised and should have focused co-ordination of all its constituent parts (EUROGIN – WHO International joint meeting – General statements and guidelines – 1997).
90. The WHO has promulgated guidelines that describe the key organisational requirements of an effective cervical screening programme including:
 - (a) A central office or individual responsible for planning, co-ordinating and monitoring and evaluating the Programme
 - (b) Computer based information systems
 - (c) Extensive coverage of the eligible population
 - (d) Quality control for both smearing and smear reading
 - (e) Measures to ensure that women with abnormal smears are followed up and treated.

B – HFA Internal Review of NCSP data

92. As mentioned previously, one of the most important features in ensuring the success of an organised screening programme is achieving high levels of enrolment and coverage among the eligible population. The term coverage means the proportion of eligible women who are enrolled and have had a screening test in a defined period of time. Although there is evidence to suggest that enrolment and coverage in some sub-populations of women is low (as I will go on to describe later in my evidence), in general the NCSP has been very successful in enrolling women. The latest monthly statistics from the NCSR show enrolment rates of 91% and 5 year coverage of 85% **JMP/HFA/0013**. These rates are an indication of the commitment of those who have worked in the Programme over the past decade.
91. After the transfer of responsibility for national co-ordination and management of the NCSP, the National Prevention team, and later the Public Health Change Management Team, commenced a review of some aspects of the NCSP using data that were readily available from the NCSR. Dr Robyn Whittaker, a Public Health Medicine Registrar with the Team at that time, took primary responsibility for this work.
92. The main aims of the review were to provide initial planning information about the workload and coverage of the Programme, and to identify areas in which the Public Health Change Management Team needed to focus its attention and effort. The review also examined information regarding Maori and Pacific women's participation in the Programme. At that stage there had been no recent statistical report for Maori women and the last Annual Statistical Report analysed data for all women until the

end of 1995. The review was commenced prior to the establishment of the National Public Health Change Management Team.

93. The key findings from the review covered a number of NCSP areas including:
- (a) workload in terms of the number of smears processed annually and the number of new enrolments
 - (b) the proportion of smears taken on women outside the recommended age group and the recommended interval
 - (c) the proportion of eligible women who have ever been enrolled
 - (d) and coverage at three years.

The term coverage in this context refers to the proportion of eligible women in the population who have had one or more smears recorded on the NCSR in the last 3 years.

94. Data from the NCSR for the years 1994 to 1997 were analysed for all women, Maori women and Pacific women (with approval from the Kaitiaki and Pacific Women's Data Management Group). This time period was chosen because Section 74A of the Health Act had not come into effect until 1994. Prior to this there was a much smaller proportion of women enrolled on the NCSR and they were probably not representative of the population.

95. Although approvals for data extraction and analysis were obtained in mid 1998, the data were not available until November 1998. The Kaitiaki Group consented to the release of data where the women are identified as Maori on the basis that a group of Maori women were appointed to oversee the analysis and writing of recommendations. The Public Health Change Management Team then initiated a process to obtain nominations to the oversight group. The group finally selected was called "The

Working Group for the Evaluation of Maori Women's Data" and consisted of :

- Jo Barnaby, an NCSP regional co-ordinator and a health educator from the Bay of Plenty
- Hazel McNicholl, a smear-taker and health educator from Hawkes Bay
- Carmen Timu-Parata, a Maori nurse's representative
- Druis Barrett, a consumer and President of the Maori Women's Welfare League
- Dr Sue Crengle, a Maori medical practitioner representing Maori Doctors, and researcher from the Department of Maori and Pacific Health at Auckland University
- Connie Hassan, a consumer who had linkages with the National Breast Screening Programme.

Georgina Martin, the National Maori Screening Co-ordinator, facilitated this group. The terms of reference for the group are provided for your reference **JMP/HFA/0014**.

- 96.** The results of these analyses were incorporated into a report the first full draft of which was completed in March 1999. The Kaitiaki Group objected to the way some of the data had been presented, despite the oversight by the working group. Further consultation occurred with the Kaitiaki group to resolve these issues and to agree a distribution list for the report. This has taken some time and the report has only recently been finalised.
- 97.** Dr Whittaker's report is produced **JMP/HFA/0015**. It contains a number of key results, some of which are detailed below.
- 98.** The number of smears processed annually had increased from 371,329 in 1994 to 408,803 in 1997 and is likely to continue increasing primarily due to population increases.

99. The proportion of women who had ever been enrolled in the Programme at the end of 1997 was 77% or 86% once adjusted for hysterectomy. The proportion of Maori women who were enrolled at the end of 1997 was 56% or 61% (once adjusted for hysterectomy). Enrolments for Pacific women were 61% or 66% adjusted.
100. The proportion of eligible women who had had a smear result entered on the NCSR within the past three years was 65% or 73% when adjusted for hysterectomy rates. The coverage rates for Maori women were 43% or 47% adjusted. Coverage for Pacific women was 44% or 48% adjusted.
101. Enrolment and coverage rates were lower in older women, in the Auckland region, for Maori women and for Pacific women. However, concern was expressed that the rates for Maori and Pacific women may not be accurate as a result of misclassification of ethnicity at the time of enrolment.
102. Recommendations were made for routine monitoring, for further evaluation and for policy review.
103. More specifically, these included the need to;
 - (a) Ensure funding decisions took account of the increasing workload of the Programme
 - (b) Explore strategies to reduce the number of smears taken outside the screening recommendations
 - (c) Improve strategies for increasing screening in under-screened groups, in particular in older women and Maori and Pacific women
 - (d) Improve aspects of data collection and management, for example the collection of ethnicity information and the methods by which hysterectomy rates are calculated

- (e) Improve routine Programme monitoring
- (f) Further evaluate the Programme to investigate some of the disparities in screening and coverage rates and to determine reasons for screening occurring outside the recommended guidelines.

104. This report was commissioned primarily as an internal planning document and has been used as a source of information to support planning for the NCSP.

C – Framework for population based screening programmes

105. In addition to this internal review, the Public Health Change Management Team developed a Framework for Population Based Screening Programmes. A final draft of this document is produced **JMP/HFA/0016**. As mentioned earlier, the T98 review had confirmed the decision to form one team with responsibilities for both the national cervical and breast screening programmes. However there were several important differences between the two national programmes. The purpose of the Framework was to provide a basis for the development of some consistency between the two programmes where this was rational.

106. The Framework outlines a broad strategic direction for both programmes based on the principles of population based screening programmes, the WHO recommendations, HFA funding principles, consistency with the Crown Statement of Objectives, consistency with the HFA National Strategic Plan for Maori and a focus on a women centred approach. The document summarises the current situation, provides a broad direction and poses a number of questions to facilitate planning in each of the following key areas:

- Public health and health promotion services

- Screening and diagnostic services
- Treatment services
- Primary healthcare services
- Information systems
- Quality assurance
- Policy development
- Monitoring and evaluation
- National co-ordination and management

D – Co-ordination meetings with providers

107. In addition to this internal analysis, opportunities were taken at routine meetings of regional co-ordinators to seek feedback with respect to the Programme.

108. The opportunity to provide this feedback occurred at a regular regional co-ordinators meeting in February 1999. This was their first meeting with the new National Screening Co-ordinator and the new Maori Screening Co-ordinator. This meeting included a facilitated session, run by one of the Public Health Change Management Team, which focused on eliciting co-ordinators views on strengths, weaknesses, and priorities for improvement to the Programme. Their views were recorded on a whiteboard and copies of the white-board print-outs are provided **JMP/HFA/0017**. Some of the issues the regional programme co-ordinators felt needed to be addressed included:

- (a) Ensuring other providers (labs and smear takers) complied with legislation and policy
- (b) National standards for all smear takers and laboratories
- (c) Monitoring and enforcement of these standards
- (d) Data on NCSR not complete or 100% accurate due to lab forms not being completed and women being automatically “opted off” without their consent

- (e) Lack of control over short interval rescreening
- (f) Need for up to date statistical information
- (g) Funding issues
- (h) Fragmentation of NCSP in HFA and regionally
- (i) Improving linkages with BreastScreen Aotearoa – Co-ordinators felt that this was a new programme which could benefit from the experiences from the NCSP

109. In addition a hui was held in February 1999 with Kaimahi, Maori women involved in the NCSP. Kaimahi had for some years had an annual hui that had been subsidised by the Ministry of Health. With the transfer of the national roles to the HFA, Kaimahi had strongly indicated that they wanted that annual meeting to continue. Bette Kill agreed to fund a hui in February 1999. It was held in Auckland over a 2-3 day period and was attended by approximately 30 Maori women, members of the Public Health Change Management Team and the General Manager of Public Health. One of the Maori Screening Co-ordinator's aims for the hui was to set up better communication networks with Maori women. However, there were a number of recommendations that came out of the hui. These included:

- (a) That a Maori supervisor be appointed in each region to support the work of Maori smear takers
- (b) That standards for smear takers take into account Maori circumstances
- (c) That educator training be provided
- (d) That a stronger emphasis on the concept of whanau ora be incorporated in the Programme (that is an holistic approach focussing on the well-being of the entire family and not its constituent parts) and that funding for integrated programmes be promoted
- (e) That a national Kaimahi forum is essential.

E – Conclusions regarding the status of the NCSP

110. As a result of the above analyses, I and the rest of the Change Management Team were concerned with a number of aspects of the NCSP including:
- (a) Under enrolment of some key sub-populations. The Programme has been successful in increasing choices for women and in enrolling and screening a large number of women but some groups remained under-screened, particularly Maori, Pacific and older women.
 - (b) There was a lack of detailed, mandatory operational policies and quality standards in place to ensure women were provided with a consistent, high quality service within the Programme.
 - (c) There was an absence of sufficient ongoing monitoring and evaluation linked to quality improvement processes.
 - (d) There were and are divided roles and responsibilities within the HFA; at the time, these were divided between the Public Health Operating Group, the Personal Health Operating Group and the IM Team. Although the overall responsibility lay with the Public Health Change Management team, a majority of the NCSP is funded through mainstream contracts managed by the Personal Health Operating Group. This is in direct contrast to BreastScreen Aotearoa where the entire Programme is funded by the Public Health Operating Group and all service provision is co-ordinated and provided by six lead providers. While it is acknowledged that this Programme is new and relatively untested, it does appear that this model allows for clearer lines of communication, control, accountability and responsibility
 - (e) We perceived structural problems outside of the HFA. The provider base had come about more through historical involvement in providing screening and treatment services,

rather than through a process of active structural planning focusing on the issues of quality and reasonable access for women

- (f) We had concerns about the efficiencies and effectiveness of maintaining a large number of data entry sites for the NCSR. In addition we were concerned as well about the relative roles and responsibilities of the national team and the regional co-ordination teams, and how the regional co-ordination role could be effectively maintained when no contractual relationship existed between regional Programme co-ordinators and the other providers of the Programme such as primary care providers and laboratories.

112. Clearly there were a large number of issues to be considered but it was decided that priority should go to:

- (a) Developing and documenting detailed operational policy and quality standards which would become mandatory to ensure consistent high quality services are provided to women
- (b) Setting up more effective on-going monitoring and evaluation mechanisms so that standards and other processes are monitored on a regular basis
- (c) Ensuring national consistency across all operations of the Programme
- (d) Improving the quality and accuracy of information to women e.g. the consent process, public health messages and resources
- (e) Structural planning for the future of the Programme

113. A decision was made, however, that any restructuring proposal should follow on from dealing with the priorities identified above.

114. At about this time, the 29 March 1999 to be exact, the situation in Gisborne came to the attention of the Public Health Change

Management Team via a letter from Stuart Grieve Q.C. The national team was concerned that there did not seem to be an established process in place to enable this type of information to be brought to its attention.

PART IV – CURRENT WORK PROGRAMME

A – Overview

115. In May 1999 the EMT of the HFA conducted its annual internal prioritisation process for project funding.
116. The Public Health Change Management team wrote and submitted a proposal to the EMT to secure funding for priority tasks described above **JMP/HFA/0018**. This document summarised the preliminary analyses the team had undertaken and outlined the initial and on-going budget required.
117. The EMT of the HFA considered all the proposals and granted \$1.4 million to the Public Health Change Management Team. This funding commenced on July 1 1999 and is available for one year. The funding included \$250,000 for capital expenditure on the NCSR, which was managed by the IM team to upgrade the hardware of the NCSR, and \$1.15 million for project related tasks.
118. This additional funding was announced by Bette Kill, General Manager of the Public Health Operating Group by way of a media release on 14 May 1999 **JMP/HFA/0019**.
119. The work programme for the Public Health Change Management Team in the NCSP since July 1999 has been split into three key areas. These have included:
- the NCSP Project
 - the Strategic Project
 - other operational tasks

120. The NCSP project was initiated to manage the implementation of the one-off tasks requiring attention and a majority of the \$1.15 million allocated has been dedicated to this initiative. Latterly the NCSP Strategic Project has commenced and a portion of the \$1.15 million has been allocated to support this work programme. Further project work for the Programme, including continuation of the strategic project, will be required in 2000/2001 and budgets for this are being prepared. A project methodology was deemed the most appropriate way to ensure that both initiatives would have a dedicated workforce and budget with a defined start and end point and key milestones.

121. In addition, there have been on-going operational tasks that the team have been involved in which have also been important to the on-going development of the NCSP.

B – NCSP Project

122. The Cervical Screening Project (the Project) has been set up to undertake some of the necessary developmental work to improve areas of the NCSP which need strengthening. These improvements are designed to ensure the Programme has the same safety mechanisms as international programmes and BreastScreen Aotearoa. The development work includes:

- (a) developing national documents explicitly stating standardised quality practices and operational policies for key service components and mandating these where possible
- (b) establishing national monitoring and evaluation mechanisms
- (c) improving information for women and implementing a national public health/health promotion plan including training for educators and development of appropriate resources
- (d) updating the information system i.e. the NCSR, so that it is able to meet the requirements of the above enhancements.

123. The Project has been organised into four sub-projects with appointed sub-project managers:

- quality standards and policy
- evaluation and monitoring
- public health
- information management.

124. 6 FTE people including operational and contracted staff are carrying out this Project. In addition a few components of the Project have been contracted out to other organisations to complete. For example the Women's Health Action Trust has completed a review of cervical screening resources as part of the public health sub-project. There is a Project Manager, regular Project Team meetings are held and Project up-dates are provided to me as team manager.

(i) – Policy and Quality Sub-project

125. The need for this sub-project was established in 1998 and early 1999. At that time it was ascertained that:

- (a) There was not a clearly documented comprehensive set of national quality standards for the Programme.
- (b) The operational policy for the Programme was written in a number of documents over time but these documents were not clear about the level of policy versus the level of information contained in them and to which providers the policy applied.
- (c) In some instances local policy decisions had been made rather than establishing national operational policy creating a lack of national consistency.

126. The purpose of the Operational Policy and Quality Standards sub project is to develop policies and standards for the NCSP, to

support those working within the Programme in providing quality practices for women, and to provide a standard against which their practice can be measured.

127. The operational policies and quality standards will cover all aspects of the screening pathway including :

- Public Health/Health promotion
- Enrolment of women
- Smear taking services
- Laboratory services
- Colposcopy services
- Programme co-ordination
- Referral for treatment

128. The first draft of the Policy and Quality Standards has been written and internally reviewed by relevant HFA staff. I produce a copy of the draft document **JMP/HFA/0020**. This document includes Chapter 7 that describes standards for laboratory services that carry out work for the Programme. The document was sent out to over 200 stakeholders who have a key interest in the NCSP on 19 November 1999 for their comment and feedback. It has subsequently been more widely distributed. The project team and I are aware that this first draft is an important first step towards mandated policy and quality standards for the NCSP. However, we are aware that a significant amount of work is still required to successfully complete the work and implement the standards.

129. Consultation meetings and hui around the country, involving providers and consumers are taking place in February, March and April 2000. In addition, further analytical work is being undertaken to further refine the document and ensure the policies and standards are robust and, as far as possible, evidence-

based. The document will then be redrafted in accordance with the feedback received and further analytical work. A second draft will then be distributed for further consultation. It is expected that an Interim Operational and Policy Document will be completed by 30 June 2000 for review in one year.

130. The document defines the Programme and the screening pathway and provides information about informed consent procedures and screening and referral recommendations.
131. The document also contains policy and quality standards specific to each discipline (including health promotion, smear takers, laboratories and colposcopy services) and covers areas such as training and continuing education requirements, quality assurance practices, interface with the NCSR etc.
132. For example, so far, the chapter on laboratories, among other things, outlines standards for the qualifications and ongoing education of pathologists and other cytotechnologists, smear volume requirements for all screeners, standards for re-screening and reporting to other professionals and the NCSR, and accreditation and on-going quality assurance processes.
133. Implementation of these standards involves their incorporation in contracts with all Providers who provide services to the NCSP and with whom the HFA has a financial relationship. Once incorporated in the contracts with Providers, implementation and compliance with the standards will be expected. Where no financial relationship exists e.g. where the woman pays a full consultation fee for a cervical smear or attends a private gynaecologist for colposcopy, the standards will not be able to be enforced. Again, this is in contrast to the Breast Screening Programme that is fully funded and only available to eligible

women through providers who have a contractual relationship with the funder. Quality standards are mandated in contracts and all Programme providers can be monitored and audited against them. Laboratory standards within the NCSP should be able to be mandated as all smear-reading services are publicly funded. Various steps have been undertaken to ensure that where possible the standards (and a requirement to participate in Programme monitoring) are incorporated in provider contracts. A memorandum to the GM of Personal Health, David Moore was sent by myself and my manager, Dr Don Matheson on 20 January 2000 **JMP/HFA/0021** seeking his support for this process. Further to this a briefing paper to the EMT **JMP/HFA/0022** on contracting issues for the NCSP supported the inclusion of appropriate clauses in provider contracts. The EMT meeting of 14 February supported the recommendations of the paper.

(ii) – Evaluation and Monitoring Sub-project

134. This sub-project has been set up to develop and implement a plan for ongoing monitoring and evaluation of the NCSP.
135. Continuous monitoring and analysis of Programme performance with information feedback to Programme funders, Programme providers, policy makers and consumers is required to monitor the success of the NCSP as well as ensuring quality practices and national consistency are maintained and that continuous improvement of the Programme occurs. This is necessary to ensure that the overall benefits of the screening programme are greater than the attendant risks and that the Programme remains a cost-effective use of health resources. Monitoring and evaluation needs to include consideration of process measures, such as Programme efficiency as well as outcome measures, such as interval cancer rates or overall mortality rates.

137. A high level draft evaluation plan has been developed to:
- (a) Provide a brief background about evaluation and monitoring and previous NCSP activities in this area
 - (b) Outline the roles and responsibilities for different levels of evaluation and monitoring within the sector and the NCSP
 - (c) Outline a set of draft national indicators for evaluation and monitoring of the NCSP and where possible show the current status of the New Zealand Programme against these indicators
 - (d) Describe the linkage between these indicators and the development of operational policies and quality processes
 - (e) Outline other current and proposed evaluation and monitoring activities

I produce a copy of the draft plan and indicators **JMP/HFA/0023**.

138. This plan also puts forward the option of developing an Independent Monitoring Group and asks for feedback on the potential establishment and make-up of this group.

139. The national indicators put forward in this draft plan include overall programme indicators such as enrolment and coverage rates, incidence and mortality rates and programme sensitivity.

140. In addition there are specific laboratory, colposcopy and smear-taker indicators.

141. The draft proposed laboratory indicators include community laboratory smear reporting, turn around times, unsatisfactory smear reporting, accuracy of cytology reports predicting High-Grade Squamous Cell Intraepithelial Lesions (HSIL) and accuracy of negative cytology reports. These indicators have been developed from a review of the international evidence.

142. A first round of consultation on the draft high level evaluation plan has been undertaken with stakeholders and evaluation experts. The feedback has been collated and an expert multi-disciplinary group is being established to consider the feedback and other technical issues so that the national indicator set can be further developed.
143. The next step in the process will be to develop detailed data definitions for the confirmed national indicators and to co-ordinate with the IM sub-project to ensure that the data can be collected by the NCSP.
144. Almost unanimous support for establishing an independent monitoring group has been apparent from the consultation process. Therefore work has commenced to establish such a group. An ROI (Registration of Interest) has been developed and sent to organisations and individuals who may be interested in forming a multi-disciplinary monitoring group and undertaking this work **JMP/HFA/0024**. Responses from prospective providers of this service are due with the HFA by 7 April 2000 after which a preferred provider will be confirmed. It is envisaged that this group will have a role in the confirmation of the indicators and targets and finalisation of the detailed data definitions.
145. Other issues under consideration for the next phase (2000/2001) of this sub- project will include:
- (a) The role of audit of providers performance against these standards
 - (b) The role the Programme has in the audit of women who develop cervical cancer within New Zealand
 - (c) Development of a national minimum data set for colposcopy

(iii) - Public Health Sub-project

146. Within the NCSP, recruitment and health promotion strategies need to be appropriate for all eligible women, but in particular for those women identified as being under-screened, for example Maori, Pacific and older women. The strategies employed also need to meet the needs of other women who may also be under-screened for example, women from minority ethnic groups, lesbian women and women with disabilities.
147. It is important that the NCSP delivers consistent, accurate information to women throughout the country so that they are informed about the benefits and risks of cervical screening and are able to make an informed decision about participating in the Programme.
148. The Programme also requires a recognisable identity, nationally consistent health education resources, nationally consistent training of health educators and overall national co-ordination of these functions.
149. My team considered that, in view of the results of our analyses and the fact that the Programme had been operating for almost ten years, it was appropriate to undertake a comprehensive review of all the public health components of the Programme.
150. To achieve this the Public Health sub-project was established with the following objectives:
- (a) To co-ordinate all National Health Promotion/Public Health activities within the Programme including the production of new national resources and the implementation of national training.

- (b) To align NCSP National Health Promotion/Public Health activities to similar activities in BreastScreen Aotearoa where appropriate
- (c) To ensure that the National Health Promotion/Public Health activities incorporate appropriate Maori and Pacific Island processes

151. Public health and health promotion service components of NCSP are currently delivered and co-ordinated through the 14 regional co-ordination sites nationally. Each register site has a Programme Co-ordinator. In the Auckland and upper Waikato regions however, independent providers, including Maori and Pacific Islands providers, also deliver services. The focus is on locally delivered services through a mixture of education sessions and promotional activities. Health promotion strategies have been determined locally with some national co-ordination, for example the provision of some national resources and an annual awareness campaign.

152. When the project commenced, there was a lack of current information available regarding the extent and range of health promotion activity among providers nationally. Therefore a review process has been undertaken to provide information on which to base a revised NCSP national public health plan, through which the objectives of the sub-project will be met.

153. The review has three components

- (a) Consumer - A collation of consumer resources currently available and a literature review of information for consumers. A first draft of this review is available JMP/HFA/0025.
- (b) National Public Health Co-ordination - A review of health promotion strategies and educator resources. There are Maori, and non-Maori components to this review, including a specific Pacific section. A Maori researcher has undertaken

the Maori component. This work is currently being compiled and will be finalised by the end of May 2000.

(c) Barriers - A literature review of the barriers to screening and strategies to overcome those barriers. This report is complete **JMP/HFA/0026**.

152. When all the review reports are complete at the end of May 2000 the results and recommendations will be analysed. This information will be used in the development of a national public health/health promotion plan for the NCSP. In addition to this, a working group will be formed to provide initial input into the development of the plan. Consultation on this plan will be carried out with internal and external stakeholders and consumers.
153. The plan will outline the national public health strategies and activities for the NCSP including the resources to be produced nationally and a training schedule.
154. We will then begin the process of producing new resources as outlined in the plan.
155. A national training event is being planned and will occur in June 2000. On-going regional training will be detailed in the plan.
156. The work that has been undertaken to provide the NCSP with a new nationally consistent identity will be complete by the end of April 2000. This will achieve the following:
 - A signal that the NCSP is a national programme
 - A recognisable link between all NCSP providers
 - Continuity of design
 - An opportunity for “brand recognition” by women in the priority group

- A vehicle to link national public health and recruitment activities with regional activities
157. A combined NCSP and BreastScreen Aotearoa website is being developed and will go on-line before the end of the year.
158. On-going evaluation of the public health aspects of the NCSP will be outlined in the plan.

(iv) - Information Management Sub-project

- 159.** The purpose of the IM sub-project is to align the NCSR and associated information processes and mechanisms to support the quality, monitoring and evaluation requirements of the NCSP.
160. The objectives of this sub-project are:
- (a) To document the information and data requirements as required by the quality, monitoring and evaluation workstreams
 - (b) To modify the existing NCSP information systems, policies, processes, procedures and associated mechanisms to deliver the specified information requirements in a robust and reliable manner.
 - (c) To ensure that the data collection, handling and management processes required to support the information requirements are implemented by the relevant NCSP stakeholders.
161. As I have described previously, the NCSR is the information system that provides Programme and management information for the NCSP. This is a centralised database with online, real-time links to the 14 Regional Co-ordination sites around New Zealand. The NCSR maintains data relating to women who have received a cervical smear and not objected to their result being forwarded for inclusion on it. Data entry to the NCSR is managed

by the 14 regional sites, and is predominantly based on data received from smear-takers and the laboratories that under-take smear-reading.

162. The IM sub project has completed the initial work, which is to gather information on the existing IM environment to enable the impact of changes to be assessed and to identify any areas for further work. The completed activities include:
- (a) The development of a generic process map of the main activities and information flows in the existing NCSP process
 - (b) A high level review to identify how regional co-ordination sites manage NCSR information and to identify any IM related concerns raised by site staff or other stakeholders
163. Analysis of the quality and evaluation and monitoring workstream information requirements is due to commence in March 2000.

C – Strategic Project

(i) - Background

164. As I outlined in paragraph 113 it was initially decided that work related to structural planning for the NCSP would not be a first priority for the Public Health Change Management Team. However, a number of events have occurred that have meant that the timetable for this work has had to be brought forward. These events include:
- (a) The current health sector restructuring which necessitates consideration of the placement and future of many health programmes including population based screening programmes.
 - (b) A developing consensus amongst relevant staff within the Personal and Public Health Operating Groups in the HFA that

the existing division of roles and responsibilities made it very difficult to manage and plan for the NCSP in total.

165. The division of roles and responsibilities for the NCSP within the HFA has been the subject of concern from important external stakeholders, including Professor David Skegg (in a radio interview on National Radio on May 14, 1999), Sandra Coney (in the Woman's Health Action website) and Dr Brian Cox (in a letter to the HFA on May 3, 1999). I produce a copy of the letter from Dr Cox **JMP/HFA/0027**. The Advisory Group for PBSP wrote to the CEO of the HFA on 11 August 1999 requesting that on the basis of the divided roles and responsibilities within the HFA that it report directly to the CEO as the person with ultimate responsibility for the Programme. I understand that this request to change the Advisory Group's level of reporting was discussed by the EMT at a meeting on 9 September 1999 and it was decided that due to the fact that primary responsibility for population based screening programmes resides with Public Health that the request be declined. The Advisory Group was advised of this in a letter. I produce a copy of both letters **JMP/HFA/0028**. However, in view of the resolution that the primary responsibility for screening programmes was with Public Health, the EMT also recommended that the General Manager of Public Health should both develop formal processes to ensure that the goals of the NCSP were met within the HFA, and explore the possible transfer of budgetary responsibility for the Programme to the Public Health Operating Group. To facilitate internal management, a Memorandum of Understanding (MOU) between relevant Operating Groups was developed to facilitate the development and operation of the NCSP within the HFA, and consideration of transfer issues commenced. I produce a copy of the MOU **JMP/HFA/0029**.

166. The health sector restructuring, as well as continuing concern regarding the division of roles and responsibilities within the HFA, has resulted in my team commencing a strategic options project, the nature of which has evolved over the past few months. Initially, because of the proximity of the election we concentrated on determining future options for national co-ordination. More recently we have formalised our approach to unbundling the Programme from mainstream contracts and bringing almost all elements of the NCSP under one national team as well as examining options for the future structure of the Programme.
167. Formal endorsement of the process to align all the functions of the NCSP i.e. funding, the NCSR, national co-ordination and monitoring, policy development and monitoring and evaluation has come from the CEO of the HFA and been endorsed by the HFA Board. A briefing paper, signed off by the HFA CEO is produced **JMP/HFA/0030**.

(ii) - Options for National Co-ordination

168. Work to consider the strategic options for the screening programmes in alternative health environments commenced in November 1999 and an internal draft paper, treated as a final draft, was written by my team to document these options **JMP/HFA/0031**. This was an internal options paper and did not achieve any official status. We believed it was important, with a forthcoming election that could have consequences for the structure of the health system, that there was an internal consideration of the alternatives for the national and funding activities for the screening programmes (including both breast and cervical). We considered that in some of the previous restructuring the potential impact on the breast and cervical screening programmes had been inadequately considered.

169. The original paper considered the advantages and disadvantages of each of the following options:

- (a) Status quo – with one national agency (HFA) carrying out co-ordination and funding role for both Programmes across multiple teams
- (b) Status quo – with one national agency (HFA) but aligning all funding and contract negotiation in the same team as national co-ordination for both Programmes
- (c) Ministry of Health – with one team within the Ministry being responsible for national co-ordination and funding for both Programmes
- (d) Other National Agency – with a separate entity being responsible for national co-ordination and funding for both Programmes
- (e) National co-ordination in central agency (Ministry or separate entity) but devolved funding via multiple district health boards or managed care organisations
- (f) Devolved co-ordination and funding via multiple district health boards or managed care organisations.

170. The subsequent election of a Labour-led coalition, which has stated its policy of disbanding the HFA and incorporating its functions into the Ministry of Health and 22 District Health Boards which have yet to be formed, resulted in further analysis of the funding and structural options within the new environment and these were documented in a further paper which is also produced **JMP/HFA/0032**.

171. Further work has been undertaken to determine the most appropriate option for national management of the screening programmes and this has been outlined in a paper submitted to the steering group over-seeing the health reforms and

considered, and I understand agreed to in principle, at its meeting on Friday 10 March **JMP/HFA/0033**.

(iii) - Unbundling and financial modelling sub-project

172. This sub-project has recently commenced and has the task of planning for the transfer of the responsibility (including funding) for all aspects of the NCSP, with the exception of a majority of smear-taking services, to the Public Health Change Management Team. A sub-project team has been appointed and a project plan and associated budget is being drawn up.
173. Thus far, this process has resulted in bringing the operation of the NCSR back into my team within the Public Health Operating Group. Subsequent phases will involve identifying and unbundling the funding for the various aspects of the NCSP from mainstream HHS and community laboratory contracts so that these services can be purchased separately on behalf of the Programme by the National Public Health Change Management Team within the Public Health Operating Group. Transfer of responsibility for these services should occur by the end of this calendar year. Those involved in contracting with these providers have been requested not to enter into any contractual arrangements beyond 30 June 2001.
174. Alongside this unbundling sub-project a financial modelling exercise will be undertaken to determine the adequacy of current funding for the Programme. The financial model will be based on the population of eligible women, the recommendations for frequency of screening, the incidence of pre-cancerous abnormalities, and the predicted number of women who require colposcopy and treatment in any one year. In any public health Programme, in which individuals are encouraged to participate, it essential that adequate provision is made for assessment and treatment.

(iv) - Structural Planning Sub-project

175. Finally, the third sub-project being undertaken relates to the current provider structure of the Programme. Again a sub-project team has been established and a project plan developed with associated timeframes and budget requirements.

176. It is possible that the existing provider structure for the Programme is not as integrated or cost-effective as possible. The aim of this sub-project is to examine possible alternative structural options that would be cost-effective for the country, provide reasonable access for women, as well as enabling a very high quality, integrated and culturally appropriate service to be offered. This is a further reason for requesting those currently contracting for services for the NCSP within the HFA, not to enter into any arrangements which extend beyond 30 June 2001.

D – Other Operational Tasks

177. As well as the project tasks outlined above there have been a number of other tasks that the Public Health Change Management team has been involved in since May 1999.

(i) - UK visit

178. In June 1999 I, along with an analyst from the team, visited the United Kingdom (UK) screening programmes for the purpose of making international contacts and understanding how the UK programmes were structured and operated. Face to face meetings were held with 12 people in four parts of the country including the National Co-ordinator of the screening programmes in the UK, the Chairperson of the Screening Advisory Committee, the Laboratory accreditation agency, a laboratory manager, a

Health Authority Screening Commissioner and a Regional Quality Assurance Director.

179. A report has been written outlining what we learned about the key structure and operation of the UK screening programmes **JMP/HFA/0034**. In addition, significant documentation was collected and has been added to the library of resources used by the Public Health Change Management team.
180. Key findings from this visit as they relate to the NCSP include the following:
- (a) the UK cervical screening programme is co-ordinated nationally by a co-ordinator and her team who also have responsibility for the breast screening programme in the UK
 - (b) The UK CSP is split into 8 regions, each with a Regional Director of Public Health who has ultimate responsibility for the cervical screening programme in their area. The structure of the UK Programme is provided in the report.
 - (c) Each region has a Quality Assurance Director with responsibility for ensuring services in their area are monitored. They are responsible for co-ordinating the quality assurance teams (made up of relevant health professionals) in their area and for the collection of relevant data by the regional quality assurance reference centre team
 - (d) There are national standards and targets that are reported on annually by region, health authority and laboratory.
 - (e) Each region has taken a slightly different approach to quality assurance and they are in continual development. While some collect and report on data from providers and provide assistance to those requiring it, others have started making visits to laboratories and checking internal quality assurance processes and testing screeners. This is in addition to mandatory accreditation of laboratories.

(f) Local health authorities fund services and facilitate local multidisciplinary meetings between providers in their area.

181. I understand that these quality monitoring structures were implemented in 1997/98 as a result of an inquiry into a cervical screening failure at Kent and Canterbury Hospital and a breast screening failure at Exeter. The report into the Exeter breast screening failure highlighted changes required to the quality assurance system and my colleague and I were informed that they were subsequently implemented for cervical screening also.

(ii) - Draft data release policy

182. The Public Health Change Management Team within the HFA began drafting a policy for the release of information from the breast and cervical screening programme national databases and the NCSR in August 1999. This was undertaken in response to an apparent lack of a clear written policy for releasing information from these databases.

183. The lack of clear guidelines became apparent following two specific requests for information. Both requests related to the release of identifiable data from the NCSR about all registered women in the first case and about specific women in the second.

184. A draft document, including a flow diagram, has been produced and is undergoing further development **JMP/HFA/0035**. This initial draft took into consideration existing HFA practices, examined legislation which impacted on the release of information and sought comment from a variety of HFA internal sources.

185. This first draft was sent to the HFA Public Health Screening Advisory Group for advice and recommendation.
186. Alongside this process there was a wider recognition within the HFA that confidential information within the HFA needed to be managed more effectively. A project group was formed which sought to explore issues around the Management of Confidential Information and consult with the community on this. This project has sought further legal clarification on Acts that relate to Health Information and Privacy and obtained NZHIS documentation for data release. This broader examination has influenced the thinking and process of the draft policy on the release of information.
187. Following the presentation of documentation and discussion within the wider HFA group for Management of Confidential Information, the initial flow diagram was drafted that attempts to map out the possible range of information requests. It then states the process/es to be followed under those circumstances. A working diagram has been drafted. Once complete, tested against existing requests and modified as necessary, it will be included in the policy document under development as part of the quality and policy sub-project as outlined above. In addition, forms to assist and standardise information request processes may need to be produced.
188. The timeframe for the completion of this policy is determined by the timeframe for the quality and policy document. Data release policy will need to be completed for the final documentation scheduled to be produced in June 2000.

(iii) - Annual Statistical Report

189. The 'NCSP Annual Statistical Report' provides national statistics on key indicators and background information on the screening programme. This information is vital in assessing the quality and effectiveness of a screening programme.
190. The first NCSP statistical report was produced in 1993 and included data to May 1992. Two subsequent reports produced in 1995 and 1998 included data to June 1994 and December 1995 respectively. These reports were all produced by the Ministry of Health and provided data on all New Zealand women with no ethnic breakdown. In 1999 the Ministry of Health produced a further report including analysis of Maori women's data to 31 December 1995.
191. With the responsibility for the NCSP moving from the Ministry of Health to the HFA, it became necessary for the HFA to plan Annual Statistical reports for the 1996, 1997, and 1998 calendar years to bring data up to date. This planning occurred during 1999.
192. The first three Annual Statistical reports all followed a similar format. My team reviewed this format and it was agreed that several improvements could be made to the way analyses were undertaken and presented.
- (a) A review of annual reports from the British and Australian Programmes, and a review of literature was undertaken to assist in planning a new format for the Annual Statistical Report.
 - (b) Additional consideration was given to the most efficient manner to present data for the three outstanding calendar years (1996-98).
 - (c) In contrast to previous reports, the HFA Annual Statistical Report aims to include data for both Maori and Pacific women (the latter has not been previously undertaken in any reports).

Applications were therefore made to the National Kaitiaki Group and the Pacific Women's Data Management Group for access to Maori and Pacific women's data respectively. Both of these applications were approved.

- (d) A draft plan for the format of the Annual Statistical Report was prepared and circulated within the HFA and to the Advisory group for comment **JMP/HFA/0036**.
- (e) A substantial amount of time was spent planning the extract of data from the NCSR for the Annual Statistical Report.
- (f) Data have been obtained from the National Cancer Registry for inclusion in the report.
- (g) Updated population estimates by ethnicity and region are required for calculation of rates; these have been obtained from Statistics New Zealand.

193. Data has now been extracted from the NCSR for the Annual Statistical Report, and analyses are underway. These analyses are also being written up in the new report format.

194. The current Annual Statistical Report involves considerably more work than previous reports. It includes data for three calendar years as opposed to the usual one. It will also have three substantial results sections, one for the total population of New Zealand women accessing the screening Programme, one devoted to Maori women, and a third section including data on Pacific women.

195. Work on the report will be ongoing over the next few months. The first draft of the Annual Report is planned for mid-April 2000, at which point it will be distributed for consultation and review. This feedback will also be important to planning of the Annual Report for 1999 data.

196. The report will include, among other things, information on enrolment and screening frequency, cytology and histology results and incidence and mortality rates.

(iv) - Legal issues involved in auditing cervical cancers

197. One of the processes being proposed to contribute to monitoring the NCSP is the investigation and auditing of all cases of cervical cancer. This would involve accessing the records and history of all women and there are both privacy and medico-legal implications of this.

198. In order to clarify the position on these issues, the HFA is working with Elizabeth Longworth, Barrister and Solicitor and this work continues.

(v)- Letter to laboratories

199. On October 21st 1999 a letter was sent to all laboratories from me, as the Manager of the Public Health Change Management team **JMP/HFA/0037**. The purpose of the letter was to re-examine laboratory responsibilities to the NCSP which are defined in legislation and government policy and to address a number of other issues that were seen to be important.

200. I understand that throughout the history of the NCSP concerns about the compliance and consistency of the data received by the Programme from laboratories has been discussed at a variety of meetings. It was seen to be timely to revisit both the legislative and policy responsibilities of laboratories to the Programme, and reporting responsibilities of laboratories participating in the Programme. The accuracy of the information supplied by the

Register is vital for the ongoing success of the Programme, alongside the quality of service provision.

201. A generic letter was sent to all laboratories outlining the following legislative responsibilities and current government policy:
- The Cancer Registry Act 1993 and Regulations 1994
 - Section 74A of the Health Act, 1956
 - NCSP Policy, 1996.
202. A number of other issues were also regarded as important and addressed in the letter.
203. Information was collected from the NCSR and the regional co-ordination sites identifying any reporting issues that were specific to a laboratory. These issues were addressed in a laboratory specific letter that was attached to the generic letter that was sent to all laboratories. Fifteen laboratories received a specific letter identifying issues related to their laboratory. Some of the specific issues included:
- (a) A small number of laboratories had not forwarded any histology results to the Register for a considerable period of time.
 - (b) The laboratories had sent histology results to the Register in hard copy only when the laboratory should send these to the Register in electronic format within 20 working days of receipt of the specimen.
 - (c) A concern about the timeframe for some laboratories in relation to the redelivery timeframe for any miscellaneous forms or results.
 - (d) The inappropriate use of the B2B13 Bethesda code.
204. A member of my team has followed up these laboratory-specific letters with a personal phone call to the head pathologist within

each laboratory where specific problems were identified. All laboratories contacted have been receptive to the issues raised in the letter. If the issues have not already been resolved each laboratory has undertaken to address the issues raised in the letter. To ensure that these issues are resolved and a strong working relationship is developed with the laboratories, one member of my team will continue to liaise with the laboratories on a regular basis.

(vi) - New technologies

205. At its meeting on the 1 September 1999, the Advisory Group for PBSP agreed that one of the key issues it wanted to be addressed was the issue of new technologies in cervical screening. My understanding of their reasons for wanting this issue addressed is that the group was concerned that there had been no comprehensive New Zealand analysis on the effectiveness and cost effectiveness of new technologies that are available to prepare and read cervical cytology. One consequence of this was that there was no information available to women or smear-takers from the NCSP that covered these issues.

206. To this end, New Zealand Health Technology Assessment (NZHTA) has been commissioned by the HFA to conduct a systematic review of the effectiveness and cost effectiveness of cervical screening devices, including new technologies. As a first step, NZHTA conducted a literature search and provided the HFA with the literature collected on the subject. The HFA has subsequently commissioned NZHTA to conduct a more detailed review that will include estimates of sensitivity and specificity, estimates of additional cases detected and health care costs of the new technologies. NZHTA has provided the HFA with a protocol that outlines the review process in more detail

JMP/HFA/0038. Component A of the protocol has been approved, and Component B has been discussed with the Advisory Group and it has recommended that this component be deferred until further information becomes available.

207. It will be obvious from the above that this brief ends while a significant amount of work is still in progress for the NCSP. This evidence brings up to date events to 13 March 2000.