A nurse practitioner led model of care for colposcopy services

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Background: Nurse Practitioner role

- Advanced education and clinical training with the ability to work independently and collaboratively within healthcare teams
- Utilise advanced nursing knowledge and skills with diagnostic reasoning to formulate a treatment plan and evaluate care
- Order and interpret diagnostic and laboratory tests and prescribe within their scope of practice
- Clinical leaders

(Nursing Council of NZ, 2017)

Background

- Nurse colposcopists / WHNP role has been an established role for 30 years internationally
- 2015 New model of care commenced development
- 2016 Nurse Practitioner clinical lead for colposcopy
- 2018 Employment of Nurse Practitioner intern

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Clinical component of the NP role

- Colposcopy – including management of vulval disease, diagnostic cervical / vaginal colposcopy, work up of cervical cancer cases
- Sexual and reproductive health: contraception, STI screening, menorrhagia, abnormal uterine bleeding, post menopausal bleeding, cervical screening, polypectomy, removal of IUDs
- Currently training to perform LLETZ procedures
- Multidisciplinary endometriosis service

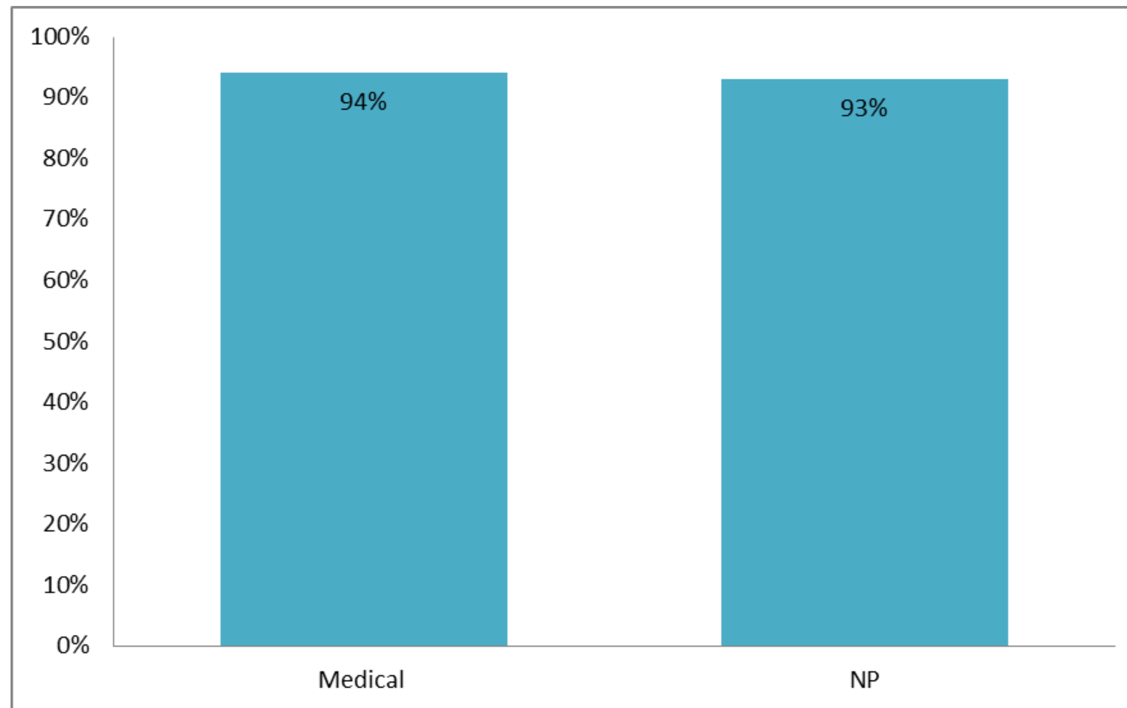
Role of the NP: Clinical Lead

- Clinical Leadership – chair MDM, team meetings, clinical advice, triaging referrals
- Education: Registrar / NP intern training; GP / practice nurse education
- Quality improvement / policy and practice development
- MOH reporting / clinical KPIs
- Management of a clinical database / annual report

Clinical effectiveness of the NP role:

Biopsy following HSIL cytology – CQUIP standard 2

95% of women with a HSIL cytology should have a biopsy



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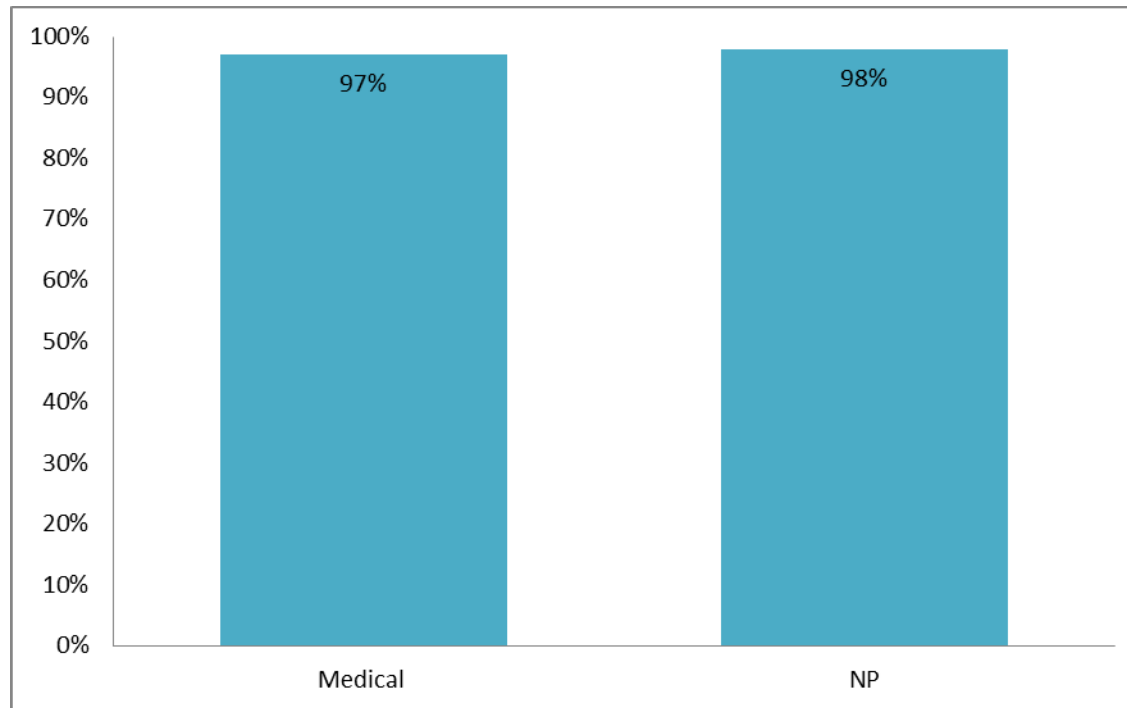
Clinical effectiveness of the NP role:

Biopsy adequacy – CQUIP standard 3

90% of biopsies should be adequate for examination



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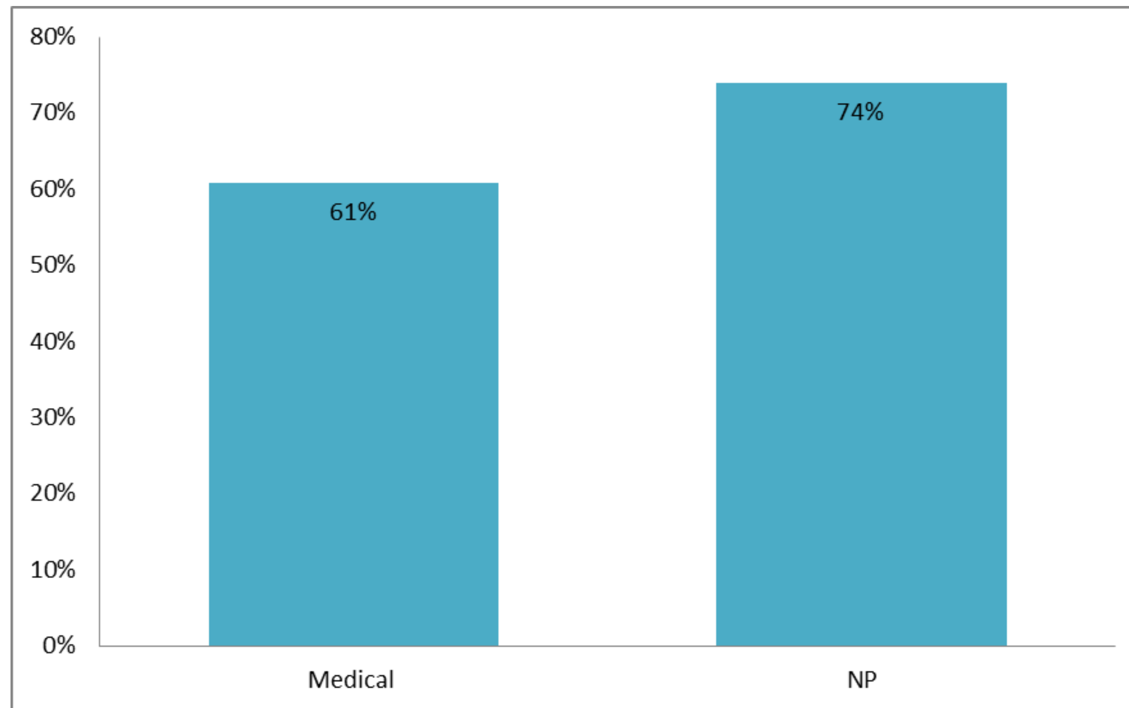
Clinical effectiveness of the NP role:

PPV HSIL disease – C-QUIP standard 4

65% PPV of HSIL disease



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Benefits of a NP led colposcopy service

- Clinically effective – cost effective model / high patient satisfaction
- Reduced cancelled clinics due to the flexibility to cover SMOs
- Focused approach to quality improvement / service delivery
  - Referral pathway for PCB
  - Laboratory utilisation project
  - Benchmarking project for colposcopists
- Freeing up SMO time for other clinical duties

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Cervical Cancer in the Pacific

Estimated age-standardized incidence and mortality rates (World) in 2018, cervix uteri, females, all ages

Papua New Guinea
Fiji
Solomon Islands
Guam
Vanuatu
France, New Caledonia
Samoa
French Polynesia
New Zealand
Australia

0 4.0 8.0 12 16 20 24 28

ASR (World) per 100 000

Incidence
Mortality

Data source:GLOBOCAN 2018
Graph production: Global Cancer Observatory (http://gco.iarc.fr/)
© International Agency for Research on Cancer 2018

International Agency for Research on Cancer
World Health Organization

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Cervical screening in the Pacific

NORTHERN MARIANA ISLANDS
GUAM
MARSHALL ISLANDS
PALAU (BELAU)
FEDERATED STATES OF MICRONESIA
NAURU
KIRIBATI
KIRIBATI
KIRIBATI
PAPUA NEW GUINEA*
SOLOMON ISLANDS
TUVALU
TOKELAU
WALLIS & FUTUNA
SAMOA
AMERICAN SAMOA
FIJI
VANUATU
NEW CALEDONIA
TONGA
NIUE
COOK ISLANDS
FRENCH POLYNESIA
PITCAIRN ISLANDS
PACIFIC OCEAN

* screening guideline for targeted exists but screening coverage <1%

Cervical cancer screening with a reported screening coverage ≥ 40%

Cervical cancer screening with a reported screening coverage ≤ 39%

Opportunistic or no cervical cancer screening

No data

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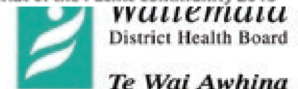
Obel et al. (2015) Asia Pac J Can Prev 16 (18)



Cervical Cancer prevention

- Primary strategy: HPV vaccination
- Secondary strategy: Cervical screening programme
  - Primary HPV screening / cytology
  - Diagnosis (VIA or colposcopy) / treatment
- Resources to maintain a organised cervical screening programme
  - Administration
  - Quality assurance
  - Funding
  - Staff training / on-going professional development

Strategies for cervical cancer prevention low resource settings

- WHO: HPV testing / cytology or VIA as screening
- ASCO: HPV primary screening recommend across all resource settings
- POC HPV testing / quick turn around 1-3 hours
- Ability to self sample
- Increased sensitivity compared to VIA / cytology as a screening tool

WHO (2014) Cervical Cancer Prevention; Jeronimo et al. (2017) J Glob Onc, 3(5)

Strategies for cancer prevention low resource settings

- HPV negative – can extend screening intervals
- One stop visit screening, VIA or colposcopy as a diagnostic tool and treatment – cryotherapy / heat coagulation / excision
- Nurse led!

Jeronimo et al. (2017) J Glob Onc, 3(5); Fong et al., (2014) Asian Pac J Cancer Prev 15(24)

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