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National Cervical Screening Program Data Dictionary

Version 1.2

AIHW

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Contents

Terminology

The change in primary screening test for the National Cervical Screening Program (NCSP) from a Pap test to an HPV test with partial genotyping and reflex LBC triage has led to the introduction of new terminology and new concepts. Key terms and concepts are defined.

Cervical screening: This term describes the process of screening for the prevention of cervical cancer. The term 'HPV screening' should not be used.

Cervical Screening Test (CST): The agreed term to describe the screening test of the renewed NCSP, which is an HPV test with partial genotyping and a reflex LBC test if this is indicated by the result of the HPV test.

Co-test: This term indicates that an HPV test and LBC are both performed on the sample, irrespective of the result of the HPV test.

Follow-up episode: Is a term that encompasses a follow-up HPV test and an LBC if this is required.

HPV: This term is used to indicate oncogenic HPV, which are the types of HPV associated with cervical cancer.

HPV test: Performed as part of the screening round to test for the presence of oncogenic HPV types; this is defined as either a screening HPV test when it is part of the screening episode, or a follow-up HPV test if it is performed 12 months or 24 months after the screening episode (this is also sometimes referred to as a repeat HPV test). An HPV test is also performed to test for the presence of oncogenic HPV types as part of a **co-test**.

HPV test result: An HPV test result will be reported as detected or not detected in line with molecular testing terminology (where detection levels are based on a set threshold) rather than HPV positive or HPV negative. The high-level HPV test result groupings are:

- HPV 16/18 detected
- Oncogenic HPV (not 16/18) detected
- Oncogenic HPV not detected
- Unsatisfactory (test cannot be performed due to technical reasons).

Negative co-test: A single cervical sample for which oncogenic HPV is not detected and LBC is reported negative.

If more than one sample is collected and tested on the same day, none of these samples can have oncogenic HPV or a cytological abnormality detected.

Negative HPV is defined as an HPV test result of 'oncogenic HPV not detected'.

Negative cytology is defined as a cytology test result where the squamous cell component is '*S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes*' and there is no endocervical (glandular) abnormality.

That is, a cytology test where the squamous cell component is '*S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes*', and the endocervical (glandular) component is '*E0 No endocervical component*', '*E1 Endocervical component present. No abnormality or only reactive changes*', '*EU Due to the unsatisfactory nature of the cytology specimen, no assessment has been made*', or '*E- Not applicable: vault smear/previous hysterectomy*').

Reflex test: LBC test following an HPV test that detected oncogenic HPV.

Risk of significant cervical abnormality: There are three risk classifications:

- participants who are classified at **low risk** will be invited to re-screen in five years.
- participants who are classified at **intermediate risk** will be invited to have a follow-up HPV test in 12 months, and then a second follow-up HPV test in another 12 months if they remain at intermediate risk (at which time they move to either low risk or higher risk depending on test results).
- participants classified at **higher risk** will be referred directly to colposcopy for further investigation.

Screening episode: Is a term that encompasses a primary screening HPV test and a reflex LBC if this is required. Is also referred to as a primary screening episode in this document.

Screening round: Covers the entire screening pathway for a participant from their primary HPV test through to a final screening outcome; a screening round is only completed when a participant returns to routine 5 yearly screening, or has either a cervical abnormality detected that requires treatment or a diagnosis of cervical cancer.

Self-collected sample: A vaginal sample taken by a participant. This sample can only be used for an HPV test (a sample needs to be collected by a practitioner if the HPV test result indicates that an LBC test is required to ascertain risk of of significant cervical abnormality).

1 Introduction

1.1 National Cervical Screening Program

The National Cervical Screening Program (NCSP) is a highly successful public health initiative in Australia, halving cervical cancer incidence and mortality since it was introduced in 1991. This has been achieved through organised, population-based cervical screening to detect precancerous changes to cervical cells, allowing treatment before any progression to cervical cancer, thereby preventing this disease. Until December 2017, cervical screening involved 2-yearly Pap tests, which was supported by high-quality cervical cytology through pathology laboratories, and by state and territory cervical cytology registers, that supported appropriate recommendations for clinical management, and provided a safety net to people who participated in cervical screening by sending reminders about screening and follow-up.

Improvements in technology, a greater understanding of the role of human papillomavirus (HPV) in the development of cervical cancer, and the introduction of an HPV vaccine that is administered to girls and boys under the National Immunisation Program, led to the NCSP being reviewed and 'renewed', to ensure that the NCSP continued to provide Australians with safe and effective cervical screening.

As a result of this process, on 1 December 2017, a renewed NCSP was introduced that included a change from 2-yearly Pap tests for the target age group 20–69 to 5-yearly Cervical Screening Tests (CST) for the target age group 25–74. A CST is a human papillomavirus (HPV) test, followed by a liquid-based cytology (LBC) test if oncogenic (cancer-causing) HPV is found.

A further change was the collection of cervical screening data by the National Cancer Screening Register (NCSR), which is now the sole source of cervical screening data, and as such has taken over responsibility for sending reminders about screening and follow-up.

1.2 Development of the National Cervical Screening Program data dictionary

The development of the first data dictionary for the NCSP started when NCSP program managers and data managers saw the implementation of *Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities* (NHMRC 2005) as an opportunity to standardise data collections across jurisdictions through the development of a national cervical screening data dictionary.

The then-called *Standardised cervical screening data dictionary* was originally developed as three sub-sets; the first sub-set comprised data items related to demographic information for program participants, practitioners, and laboratories as well as cytology and HPV testing results, and was published on the Department of Health (Health) website in April 2007. The second sub-set comprised data items for procedures for obtaining histology specimens and reporting of histology codes. The third sub-set was developed concurrently with the incorporation of the three sub-sets into a single document and comprised definitions and algorithms for the performance indicators reported nationally in the annual monitoring report for the NCSP, *Cervical Screening in Australia*.

At an NCSP program managers meeting held in June 2008, it was decided that the dictionary should be further developed into a comprehensive document, comprising *Essential*, *Desirable* and *Aspirational* data elements to support the NCSP as a whole. The original

dictionary was expanded into the *National cervical cancer prevention data dictionary* in July 2008, with the final data dictionary published in 2014.

This data dictionary promoted and supported national consistency in state and territory data collection and national reporting by the Australian Institute of Health and Welfare (AIHW) for the NCSP until 30 November 2017.

Work on a new data dictionary commenced in 2015, soon after the onset of the renewal process for the NCSP, as it was seen as a key document to support data collection and reporting for the renewed program. The *National Cervical Screening Program data dictionary version 1.0* was developed by the AIHW with the assistance of state and territory cervical screening programs, and the National Cervical Screening data dictionary working group, with additional input into specific elements of the data dictionary provided by the NCSP Quality and Safety Monitoring Committee, the Colposcopy Working Group convened to progress the collection and reporting of colposcopy data in the renewed NCSP, and cervical screening experts Professor Ian Hammond, Professor Marion Saville, Professor Julia Brotherton, Professor David Roder and Professor Dorota Gertig.

Following a lengthy development process alongside other key documents, including the clinical management guidelines, quality framework, a form for the collection of colposcopy data, and NPAAC standards for pathology laboratories reporting cervical screening tests, the *National Cervical Screening Program data dictionary version 1.0* was endorsed by the Standing Committee on Screening in February 2017 and published on 25 May 2017.

While the early development of this data dictionary was key to the successful implementation of the renewed NCSP on 1 December 2017, because the data dictionary predated the renewed NCSP, it was recognised that the data dictionary would need to be reviewed and updated periodically in the future to ensure it continues to align with and support data and reporting for the renewed NCSP.

The *National Cervical Screening Program data dictionary version 1.1* was the result of the first process to revise and update the data dictionary in line with the renewed NCSP. This update included a major review of all data items with requisite changes made to data items to reflect the renewed NCSP and the data collected by the NCSR. This update of the data dictionary also reflected a change to the screening pathway for intermediate risk participants, effective from 1 February 2021, which meant that intermediate risk participants could remain at this risk level for 24 months instead of 12 months. This update again occurred with the assistance of state and territory cervical screening programs through the National Cervical Screening Program data dictionary working group and the NCSP Program Management Committee (PMC). The *National Cervical Screening Program data dictionary version 1.1* was endorsed by the NCSP PMC on 5 May 2022 and released by the AIHW on 10 May 2022.

This current *National Cervical Screening Program data dictionary version 1.2* is the result of the second process to revise and update the data dictionary in line with the renewed NCSP, specifically to incorporate changes following the 1 July 2022 expansion of the eligibility criteria for self-collection of vaginal samples to include all participants, rather than only those who are under-screened or never screened. This update was undertaken with the assistance of state and territory cervical screening programs through the National Cervical Screening Program data dictionary working group, the NCSP PMC, and the Department of Health and Aged Care.

Endorsement of changes to Performance Indicators in the *National Cervical Screening Program data dictionary version 1.2* was provided by the NCSP Quality and Safety Monitoring Committee on 18 May 2023.

The *National Cervical Screening Program data dictionary version 1.2* was endorsed by the NCSP PMC on 26 May 2023.

The *National Cervical Screening Program data dictionary version 1.2* was endorsed by the Department of Heath and Aged Care on 26 May 2023, following NCSP PMC endorsement.

The *National Cervical Screening Program data dictionary version 1.2* was released by the AIHW on 30 May 2023. It supersedes the *National Cervical Screening Program data dictionary version 1.1*.

1.3 Role of the National Cervical Screening Program data dictionary

The *National Cervical Screening Program data dictionary* is a key document that has been developed to support AIHW monitoring and reporting for the renewed NCSP, although it has been recognised that this document will support the renewed NCSP and its operation more broadly, including ensuring consistency in data collection and reporting between the AIHW and the state and territory cervical screening programs.

As the primary purpose of this data dictionary is to support monitoring and reporting by the AIHW for the renewed NCSP, only key data items required for this purpose, along with selected others considered important to support the renewed NCSP more broadly are included in this data dictionary.

Many more data items exist in the NCSR that are either not provided to the AIHW or do not support AIHW reporting and are therefore not included in this data dictionary.

2 Summary of updates to the National Cervical Screening Program data dictionary

This chapter summarises the updates made to this current *National Cervical Screening Program data dictionary version 1.2* compared to *version 1.1*.

Terminology

Where appropriate, the term ‘people’ has been replaced with the term ‘participants’ or ‘invitees’ when referring to cervical screening data. Participants and invitees may include women, transgender men, intersex people, and non-binary people.

The term ‘females’ is used for cancer, mortality, and population data, as these data are based on sex recorded at birth. However, it should be noted that some people may not identify with this term.

Eligibility for self-collection

Eligibility to self-collect a sample for HPV testing has changed.

Up until 30 June 2022, only people aged 30 or over who had never participated in cervical screening or were 2 or more years overdue for cervical screening, and who declined a practitioner-collected sample, were eligible to self-collect a vaginal sample for HPV testing.

On 1 July 2022, these eligibility criteria were removed, allowing all participants to self-collect their sample for HPV testing.

This means that anyone who is eligible for cervical screening (people with a cervix aged 25–74 years who have ever been sexually active) is now also eligible for self-collection, and should be offered the choice of HPV testing on a self-collected vaginal sample or on a clinician-collected sample.

Data items

New and revised data items are detailed in Table 2.1 and Table 2.2.

Table 2.1: New data items

Data item (version 1.2)	Definition	Reason for addition
J5 Primary screening episode participant risk of significant cervical abnormality	Primary screening episode risk of significant cervical abnormality of a participant.	Capturing the primary screening episode participant risk which is highly relevant to changes to the intermediate risk screening pathway.
J11 First follow-up episode participant risk of significant cervical abnormality	First follow-up episode risk of significant cervical abnormality of a participant.	Capturing the first follow-up episode participant risk which is highly relevant to changes to the intermediate risk screening pathway.
J13 Second follow-up episode commencement date	The date the second follow-up episode commenced.	New data item specific to the second follow-up episode.
J14 Second follow-up episode completion date	The date the second follow-up episode was completed.	New data item specific to the second follow-up episode.

(continued)

Table 2.1: New data items (continued)

Data item (version 1.2)	Definition	Reason for addition
J15 Second follow-up episode result	The second follow-up episode result is a combination of an HPV test and an LBC test (where this is performed), where the HPV test is a repeat HPV test performed 12 months after the first follow-up episode.	New data item specific to the second follow-up episode.
J16 Second follow-up episode test risk of significant cervical abnormality	Risk of significant cervical abnormality determined from a second follow-up episode result, comprised of a primary HPV test with partial genotyping and LBC triage.	New data item specific to the second follow-up episode.
J17 Second follow-up episode participant risk of significant cervical abnormality	Second follow-up episode risk of significant cervical abnormality of a participant.	New data item specific to the second follow-up episode.
J18 Second follow-up episode recommendation	The appropriate management based on the second follow-up episode risk of significant cervical abnormality of a participant.	New data item specific to the second follow-up episode.

Table 2.2: Revised data items

Data item		Reason for change
Version 1.2	**Version 1.1**	
A1 Participant identifier	A1 Participant identifier	Guide for use restricted to cervical screening invitees and participants.
B1 Family name	B1 Family name	Collection methods and Comments updated.
B2 Given name	B2 Given name	Collection methods and Comments updated.
B3 Other given names	B3 Other given names	Collection methods and Comments updated.
B5 Sex	B5 Sex	Data item updated to reflect changes made between the candidate and the final METEOR identifier 741686.
B6 Gender	B6 Gender	Data item updated to reflect changes made between the candidate and the final METEOR identifier 741842.
B7 Indigenous status	B7 Indigenous status	Definition changed from ‘Whether a person identifies as being of Aboriginal and/or Torres Strait Islander descent’ to ‘Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin’.
B10 CALD status	B10 CALD status	Guide for use expanded to include additional background.
D1 HPV vaccination clinical completion status	D1 HPV vaccination clinical completion status	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.
D2 HPV vaccination clinical completion date	D2 HPV vaccination clinical completion date	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.
D3 HPV vaccine dose date	D3 HPV vaccine dose date	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.
D4 HPV vaccination dose age	D4 HPV vaccination dose age	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.
D5 HPV vaccine implied dose number	D5 HPV vaccine implied dose number	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.
D6 HPV vaccine type	D6 HPV vaccine type	Comments expanded to describe change from 3-dose to 2-dose to single-dose HPV vaccination schedule.

(continued)

Table 2.2: Revised data items (continued)

Data item		Reason for change
Version 1.2	**Version 1.1**	
F1 Correspondence type	F1 Correspondence type	Correspondence types E1 Exit letter, F0 Follow up, and G0 deleted to limit to correspondence types to only invitations and reminders to screen and invitations and reminders to rescreen. Guide for use restricted to correspondence sent to invitees and participants.
I8 Cytology test result	I8 Cytology test result	Definition of 'Negative' changed from I5 = S1 and I6 = (E- or E0 or E1) to I5 = S1 and I6 = (EU or E- or E0 or E1). Definition of 'Any glandular abnormality' clarified by the addition of I5 = SU or S1 or S2 or S3 or S4 or S5 or S6 or S7 to the existing I6 = E2 or E3 or E4 or E5 or E6. Guide of use expanded to note that source of cytology test result categories is the clinical guidelines.
H3 HPV test specimen site	H3 HPV test specimen site	Comments added that self-collected samples should have an HPV test specimen site of B2 'Vaginal' rather than B1 'Cervical'.
H8 HPV test medium	H8 HPV test sample	Name changed to align with NCSR data dictionary.
J3 Primary screening episode result	J3 Primary screening episode result	Guide for use and Comments updated.
J4 Primary screening episode test risk of significant cervical abnormality	J4 Primary screening episode risk of significant cervical abnormality	Name and definition changed to reflect that this is the risk of significant cervical abnormality based on test results alone.
J6 Primary screening episode recommendation	J5 Primary screening episode recommendation	Numbering change. Definition changed to reflect that this is based on primary screening episode participant risk.
J7 First follow-up episode commencement date	J6 Follow-up episode commencement date	Name and numbering change. Guide for use updated to be specific to first follow-up episode. Comments note change to screening pathway for intermediate risk participants.
J8 First follow-up episode completion date	J7 Follow-up episode completion date	Name and numbering change. Guide for use updated to be specific to first follow-up episode. Comments note change to screening pathway for intermediate risk participants.
J9 First follow-up episode result	J8 Follow-up episode result	Name and numbering change. Guide for use updated to be specific to first follow-up episode. Comments note change to screening pathway for intermediate risk participants
J10 First follow-up episode test risk of significant cervical abnormality	J9 Follow-up episode risk of significant cervical abnormality	Name and numbering change. Guide for use updated to be specific to first follow-up episode. Name and definition changed to reflect that this is the risk of significant cervical abnormality based on test results alone. Guide for use updated to note that test risk is not adjusted for participants who were overdue for screening by at least 2 years prior to their intermediate risk screening episode, are Aboriginal and/or Torres Strait Islander, or are aged 50 or older when assigning a test risk of significant cervical abnormality. Comments note change to screening pathway for intermediate risk participants.
J12 First follow-up episode recommendation	J10 Follow-up episode recommendation	Name and numbering change. Guide for use updated to be specific to first follow-up episode. Definition changed to reflect that this is based on follow-up episode participant risk. Comments note change to screening pathway for intermediate risk participants.
M11 Test of cure completion flag	M11 Test of cure completion flag	Definition of cytology component of a negative co-test changed from S1 and (E0 or E1) to S1 and (E0 or E1 or EU or E-).
M12 Test of cure completion date	M12 Test of cure completion date	Definition of cytology component of a negative co-test changed from S1 and (E0 or E1) to S1 and (E0 or E1 or EU or E-).

Performance indicators

Revised performance indicators are detailed in Table 2.3.

Table 2.3: Revised performance indicators

Performance indicator	Outline of change
Indicator 1 Participation	No substantive change. Definition wording updated to 'eligible females' to clarify that only females with a cervix are included in the denominator. Participation specifications updated to clarify primary screening and follow-up HPV tests for the numerator. Coverage specifications added. 'People' changed to 'participants'.
Indicator 2 Response to invitation	No substantive change. Definition wording updated. Specifications updated to clarify correspondence types for the denominator and primary screening HPV tests for the numerator. 'People' changed to 'invitees'.
Indicator 3 Rescreening	Rescreening time frames for early, appropriate, and late adjusted. Appropriate rescreening split into two time frames to allow more detailed analysis of rescreening. Definition wording updated. Specifications updated to clarify primary screening HPV tests for the numerator and denominator. 'People' changed to 'participants'.
Indicator 4 Screening results	No substantive change. Definition wording updated. Specifications updated to clarify primary screening episodes for the numerator and denominator. 'People' changed to 'participants'.
Indicator 5 Correlation of screening results	No substantive change. Definition wording updated. Denominator updated to 'Primary screening episode results' to reflect correlation of results. Specifications updated to clarify primary screening episodes for the denominator. H5 HPV test result – oncogenic corrected to J3 Primary screening episode result. 'People' changed to 'participants'.
Indicator 6 Screening HPV test positivity	No substantive change. Definition wording updated to 'valid screening HPV tests' to clarify that only valid tests are included, and to 'oncogenic HPV' to clarify that only oncogenic HPV is included. Specifications updated to clarify valid primary screening HPV tests for the numerator and denominator. 'People' changed to 'participants'.
Indicator 7 Cervical cancer diagnosed after a low risk screening test result	No substantive change. Definition wording updated. Specifications updated to clarify primary screening HPV tests for the denominator. Rationale updated. 'People' changed to 'participants'.
Indicator 8 LBC test in self-collection participants positive for oncogenic HPV (not 16/18)	Indicator name changed from 'Self-collection participants positive for oncogenic HPV (not 16/18) who have an LBC test within 6 months'. Definition wording updated. Calculations and specifications updated to be measured within 3 months and within 6 months. Age group expanded from 30–74 to 25–74 to reflect removal of criteria for self-collection from 1 July 2022. Specifications updated to clarify primary screening HPV tests for the numerator and denominator. 'People' changed to 'participants'.
Indicator 9 Colposcopy in self-collection participants positive for oncogenic HPV 16/18	Indicator name changed from 'Self-collection participants positive for oncogenic HPV 16/18 who have a colposcopy within 6 months'. Definition wording updated. Calculations and specifications updated to be measured within 3 months and within 6 months. Age group expanded from 30–74 to 25–74 to reflect removal of criteria for self-collection from 1 July 2022. Specifications updated to clarify primary screening HPV tests for the numerator and denominator. 'People' changed to 'participants'.
Indicator 10 Adherence to recommendation for follow-up	Definition wording updated and split into (a) screening episodes and (b) follow-up episodes. Rationale updated to include both screening episodes and follow-up episodes. Second calculation added for follow-up episodes. Calculation for disaggregation of numerator removed. 'People' changed to 'participants'.
Indicator 11 Follow-up results	Definition wording updated. Rationale updated to include first follow-up episodes and second follow-up episodes. Second set of calculations added for second follow-up episodes. Addition of 'intermediate risk' to Numerator specifications to reflect current screening pathway in which participants can remain at intermediate risk at first follow-up HPV test. 'People' changed to 'participants'

(continued)

Table 2.3: Revised performance indicators (continued)

Performance indicator	Outline of change
Indicator 12 Colposcopy rate	Definition wording updated. Rationale wording updated to include both screening episodes and follow-up episodes. Calculation for follow-up episodes split into calculations for first follow-up episode result that indicates higher risk and second follow-up episode result that indicates higher risk. 'People' changed to 'participants'.
Indicator 13 Time to colposcopy	Definition wording updated. Rationale wording updated to include both screening episodes and follow-up episodes. Calculation for follow-up episodes split into calculations for first and second follow-up episode result that indicates higher risk. 'People' changed to 'participants'.
Indicator 14 Biopsy rate	No substantive change. Definition wording updated. 'People' changed to 'participants'.
Indicator 15 Yield of high-grade abnormalities on biopsy among participants who attend colposcopy with higher risk screening results	No substantive change. Definition wording updated to include both screening episodes and follow-up episodes. 'People' changed to 'participants'.
Indicator 16 Positive predictive value of colposcopy	No substantive change. Definition wording updated to include both screening episodes and follow-up episodes. 'People' changed to 'participants'.
Indicator 17a High-grade cervical abnormality detection rate	No substantive change. Denominator updated. 'People' changed to 'participants'.
Indicator 17b Cervical cancer detection rate	No substantive change. Definition wording updated. Denominator updated. 'People' changed to 'participants'.
Indicator 18 Cervical cancers diagnosed by time since last screen	No substantive change. Definition wording updated.
Indicator 19 Incidence of cervical cancer	No substantive change. Definition wording updated.
Indicator 20 Mortality from cervical cancer	No substantive change. Definition wording updated.

3 Data items

3.1 Data item specifications

The data items in the *National Cervical Screening Program data dictionary* are described and defined using a standard metadata format that is designed to ensure that each data item is clear, concise, unambiguous, comprehensive and provides sufficient information to ensure all those who collect, provide, analyse, and use the data understand its meaning.

The format is consistent with that of AIHW's Metadata Online Registry (METeOR), which would allow these items to be imported into METeOR in the future.

Identifying and definitional attributes

Identifying and definitional attributes include the name and definition of the data item, as well as its collection status within the NCSP. Collection status reflects the importance of the data item to the collection, and can be *Essential*, *Desirable* or *Aspirational*. There are also *Conditional* data items, whose inclusion depends on criteria for this data item being met. Essential data items are mandatory for collection; conditional data items may be mandatory, desirable, or aspirational.

Value domain attributes

Representation class refers to the form of the data item, such as identifier, text, date, or code. The data type refers to the type of symbol, character or other designation used to represent the data item (for example, string, date/time, number, text), and the format and character length describe how the value should appear for that data item.

Formats can be alphabetic character (denoted by the letter A), numeric (denoted by the letter N) alphanumeric (denoted by the letter X), or specific to dates (D for day, M for month, Y for year). Characters that are not in brackets denote a value that must be represented. Round brackets are used to indicate the number of repeats if a character is repeated more than 6 times in succession (X(9) indicates 9 alphanumeric characters). Square brackets are used to indicate that characters are optional in any ordered combination ([XXX] indicates 0, 1, 2 or 3 alphanumeric characters). Curly brackets are used to indicate that characters are entirely optional (X{XX} indicates 1 or 3 alphanumeric characters).

Value domain format examples

X(10) – No square/curly brackets, therefore exactly 10 alphanumeric characters must be entered.

{X(10)} – Curly brackets, therefore optional with fixed length. Either 0 or exactly 10 alphanumeric characters must be entered.

[X(10)] – Square brackets, therefore optional with variable length – either 0 or between 1 to 10 alphanumeric characters entered.

X[X(39)] – At least 1 alphanumeric character is required (an X is outside any square/curly brackets) and optionally supports an additional 0 to 39 alphanumeric characters, which means the maximum total length is 40 alphanumeric characters.

{N(10)[N]} – Curly brackets, therefore optional with fixed length. Either 0 or 10 numeric characters with a further optional single numeric character entered. This allows for 0, 10 or a maximum of 11 numeric characters.

{AAX[XXX]} – Curly brackets, therefore optional with fixed length. Either 0 or 2 alphabetic characters followed by a single alphanumeric character with a further optional 0 to 3 alphanumeric characters

allowed. This allows for 0, 3, 4, 5 or a maximum of 6 characters (2 alphabetic, and 4 alphanumeric). If only 3 characters are entered, then they must be 2 alphabetic followed by 1 alphanumeric.

See tables 3.1 and 3.2 for further examples of the use of codes and brackets.

Collection and usage attributes may be included to ensure that data are captured correctly and to aid in the correct interpretation of permissible values.

Data item attributes

This section of the data item may also include a guide for use, which takes the form of additional comments or advice on interpretation or application, and collection methods, which are comments and advice concerning the capture of data for a particular data item.

Additional information relates to source, reference documents, as well as an indication of whether this is a new data item, or whether it supersedes a data item in the previous data dictionary.

Table 3.1: Data item format – codes

Code	Definition	Description	Example
A	Alphabetic	Supports letter characters (including punctuation) only (that is, no numbers)	AAA = ABC not A1C
N	Numeric	Supports numeric digits only (that is, no alphabetic characters)	NNN = 123 not 1B3
X	Alphanumeric	Supports both alphabetic characters (including punctuation) and numeric digits	XXX = ABC or 123 or A1C or 1B3
D	Day	Date specific: day number within a month. Represented as DD in DDMMYYYY date format	23rd day of August 2013 23082013
M	Month	Date specific: month number within a year. Represented as MM in DDMMYYYY date format	8th month of 2013 23082013
Y	Year	Date specific: year number. Represented as YYYY in DDMMYYYY date format.	2013th year 23082013

Table 3.2: Data item format – use of brackets

Bracket type	Description	Example	Notes
No square or curly brackets	Characters must be entered in the format presented. *Note*: number in round brackets ( ) represents characters repeated 7 or more times in succession.	AAA	Exactly 3 alphabetic characters
		NN	Exactly 2 numeric characters
		X(8)	Exactly 8 alphanumeric characters
Curly brackets /braces { }	Characters are optional, but if entered, they are fixed in length and must match exactly the format presented.	{AAA}	0 or exactly 3 alphabetic characters
		{NN}	0 or exactly 2 numeric characters
		{X(8)}	0 or exactly 8 alphanumeric characters
Square brackets [ ]	Characters are optional, but if entered are variable in length up to the maximum length designated	[AAA]	Either 0, 1, 2 or 3 alphabetic characters
		[NN]	Either 0, 1 or 2 numeric characters
		[N(8)]	Either 0, 1, 2, 3, 4, 5, 6, 7 or 8 numeric characters

3.2 Structure of data items

The following table provides an overview of the data items in this version of the *National Cervical Screening Program data dictionary*. It also maps current data items to their previous number, where data items have been retained across the versions.

Data items are arranged into two main groups – Participant data items which either do not change or do not change very often, and screening pathway data items that will be added to a participant's record each time they screen. This is illustrated in Table 3.3.

Table 3.3: Data item structure

	Associated groups
Participant	Group A: Participant identifier data items
	Group B: Participant data items
	Group C: Participant status data items
	Group D: Participant vaccination status data items
	Group E: Participant demographic data items
Screening pathway	Group F: Correspondence data items
	Group G: Test type data item
	Group H: HPV test data items
	Group I: Cytology test data items
	Group J: Screening episode data items
	Group K: Colposcopy data items
	Group L: Histology test data items
	Group M: Treatment data items
	Group N: Provider data items
	Group O: Pathology laboratory data items
	Group P: Screening history data items

3.3 Summary of data items

The following table provides a summary of the data items in the data dictionary, arranged as 'Participant' data items and 'Screening pathway' data items. To aid in transition from the previous versions of the data dictionary, the number of each data item is shown alongside the number in the previous data dictionaries.

Table 3.4: Summary of data items

Participant		*Version 1.2*	*Version 1.1*	*Version 1.0*	*Pre-renewal*
Group A	***Participant identifier data items***				
	Participant identifier	A1	A1	A1	A1
	Previous participant identifier	A2	A2	A2	. .
	Medicare card number	A3	A3	A3	A2
	Individual healthcare identifier	A4	A4	A4	A3
Group B	***Participant data items***				
	Family name	B1	B1	B1	A4
	Given name	B2	B2	B2	A5
	Other given names	B3	B3	B3	. .
	Date of birth	B4	B4	B4	A7
	Sex	B5	B5	B5	. .
	Gender	B6	B6	. .	. .
	Indigenous status	B7	B7	B6	A8
	Main language other than English spoken at home	B8	B8	B8	A9
	Country of birth	B9	B9	B7	A10
	CALD status	B10	B10	B9	. .
Group C	***Participant status data items***				
	Defer flag	C1	C1	. .	. .
	Reason to defer screening	C2	C2	C2	. .
	Defer start date	C3	C3	C3	. .
	Defer end date	C4	C4	C4	. .
	Opt out flag	C5	C5	. .	. .
	Reason for opt out	C6	C6	. .	. .
	Opt out date	C7	C7	C5	. .
	Opt in date	C8	C8	C6	. .
	Hysterectomy flag	C9	C9	C7	A21
	Date of hysterectomy	C10	C10	C8	A22
	Death flag	C11	C11	C9	A24
	Date of death	C12	C12	C10	A25
	DES exposed	C13	C13	. .	. .
	Immunocompromised	C14	C14	. .	. .

(continued)

Table 3.4: Summary of data items (continued)

Group D	***Participant vaccination status data items***				
	HPV vaccination clinical completion status	D1	D1	D1	V2
	HPV vaccination clinical completion date	D2	D2	D2	V3
	HPV vaccine dose date	D3	D3	D3	V4
	HPV vaccine dose age	D4	D4	. .	. .
	HPV vaccine implied dose number	D5	D5	D4	V5
	HPV vaccine type	D6	D6	D5	V1
Group E	***Participant demographic data items***				
	Residential address	E1	E1	E1	A11
	Residential suburb/town/locality	E2	E2	E2	A12
	Residential alternative or other names for suburb/town/locality	E3	E3	E3	A13
	Residential Australian state/territory	E4	E4	E4	A14
	Residential Australian postcode	E5	E5	E5	A15
	Residential geocode – latitude	E6	E6	E6	. .
	Residential geocode – longitude	E7	E7	E7	. .
	Residential geocode – quality	E8	E8	E8	. .
	Residential SA1	E9	E9	E9	. .
Screening pathway		***Version 1.2***	***Version 1.1***	***Version 1.0***	***Pre-renewal***
Group F	***Correspondence data items***				
	Correspondence type	F1	F1	F1	. .
	Correspondence date	F2	F2	F2	. .
	Correspondence method	F3	F3	F3	. .
	Correspondence failure flag	F4	F4	F4	. .
	Correspondence failure date	F5	F5	F5	. .
	Correspondence failure type	F6	F6	F6	. .
Group G	***Test type data item***				
	Type of test	G1	G1	G1	T1
Group H	***HPV test data items***				
	HPV test date	H1	H1	H1	D2
	HPV test collection method	H2	H2	H2	. .
	HPV test specimen site	H3	H3	H3	. .
	Reason for HPV test	H4	H4	H4	. .
	HPV test result – oncogenic HPV	H5	H5	H5	D5
	HPV test result – secondary oncogenic HPV	H6	H6	. .	. .
	HPV test type	H7	H7	H8	D6
	HPV test medium	H8	H8	H9	. .

(continued)

Table 3.4: Summary of data items (continued)

Group H	***HPV test data items***				
	HPV test batch information – Control kit lot number	H9	H9	H10	. .
	HPV test batch information – Control kit expiry date	H10	H10	H11	. .
	HPV test batch information – Cellular (LBC) extraction kit lot number	H11	H11	H12	. .
	HPV test batch information – Cellular (LBC) extraction kit expiry date	H12	H12	H13	. .
	HPV test batch information – Nucleic acid extraction kit lot number	H13	H13	H14	. .
	HPV test batch information – Nucleic acid extraction kit expiry date	H14	H14	H15	. .
	HPV test batch information – Amplification kit lot number	H15	H15	H16	. .
	HPV test batch information – Amplification kit expiry date	H16	H16	H17	. .
	HPV test batch information – Detection kit lot number	H17	H17	H18	. .
	HPV test batch information – Detection kit expiry date	H18	H18	H19	. .
	HPV test batch information – Wash buffer lot number	H19	H19	H20	. .
	HPV test batch information – Wash buffer expiry date	H20	H20	H21	. .
Group I	***Cytology test data items***				
	Cytology test date	I1	I1	I1	C2
	Cytology test specimen type	I2	I2	I2	C4
	Cytology test specimen site	I3	I3	I3	C3
	Reason for cytology test	I4	I4	I4	. .
	Cytology test squamous cytology cell analysis	I5	I5	I5	C5
	Cytology test endocervical (glandular) cytology cell analysis	I6	I6	I6	C6
	Cytology test other/non-cervical cytology cell analysis	I7	I7	I7	C7
	Cytology test result	I8	I8	I8	C9
Group J	***Screening episode data items***				
	Primary screening episode commencement date	J1	J1	J1	. .
	Primary screening episode completion date	J2	J2	J2	. .
	Primary screening episode result	J3	J3	J3	. .
	Primary screening episode test risk of significant cervical abnormality	J4	J4	J4	. .
	Primary screening episode participant risk of significant cervical abnormality	J5	. .	. .	. .
	Primary screening episode recommendation	J6	J5	J5	. .
	First follow-up episode commencement date	J7	J6	J6	. .
	First follow-up episode completion date	J8	J7	J7	. .
	First follow-up episode result	J9	J8	J8	. .
	First follow-up episode test risk of significant cervical abnormality	J10	J9	J9	. .

(continued)

Table 3.4: Summary of data items (continued)

	First follow-up episode participant risk of significant cervical abnormality	J11	. .	. .	. .
	First follow-up episode recommendation	J12	J10	J10	. .
	Second follow-up episode commencement date	J13	. .	. .	. .
	Second follow-up episode completion date	J14	. .	. .	. .
	Second follow-up episode result	J15	. .	. .	. .
	Second follow-up episode risk of significant cervical abnormality	J16	. .	. .	. .
	Second follow-up episode participant of significant cervical abnormality	J17	. .	. .	. .
	Second follow-up episode recommendation	J18	. .	. .	. .
Group K	***Colposcopy data items***				
	Date of colposcopy episode	K1	K1	K2	. .
	Indication for colposcopy	K2	K2	K3	. .
	Indication for colposcopy – other indication free text	K3	K3	K4	. .
	General colposcopic assessment – adequacy	K4	K4	K5	. .
	General colposcopic assessment – transformation zone visibility	K5	K5	K6	. .
	Colposcopic impression – primary diagnosis	K6	K6	K7	. .
	Colposcopy impression – other finding free text	K7	K7	K8	. .
	Biopsy this episode	K8	K8	K9	. .
	Pregnant at time of colposcopy	K9	K9	K10	. .
	Colposcopy data source	K10	K10	. .	. .
Group L	***Histology test data items***				
	Histology test date	L1	L1	L1	H2
	Histology test specimen site	L2	L2	L2	H3
	Procedure used for obtaining specimen for histological analysis	L3	L3	L3	H4
	Squamous histology cell analysis	L4	L4	L4	H5
	Endocervical (glandular) histology cell analysis	L5	L5	L5	H6
	Other/non-cervical histology cell analysis	L6	L6	L6	. .
	Histology test result	L7	L7	L7	H9
	Histology report text	L8	L8	. .	. .
	Histology stain	L9	L9	L8	. .
	Histology stain result	L10	L10	L9	. .
	Histology data source	L11	L11	. .	. .
Group M	***Treatment data items***				
	Treatment this episode	M1	M1	M1	. .
	Treatment date	M2	M2	M2	. .
	Excision performed this episode	M3	M3	M3	. .

(continued)

Table 3.4: Summary of data items (continued)

	Modality/method used for excision	M4	M4	M4	. .
	Ablation performed this episode	M5	M5	M5	. .
	Hysterectomy	M6	M6	M6	. .
	Treatment anaesthetic type	M7	M7	M7	. .
	Location of service	M8	M8	M8	. .
	Eligible for test of cure flag	M9	M9	M9	. .
	Eligible for test of cure date	M10	M10	M10	. .
	Test of cure completion flag	M11	M11	M11	. .
	Test of cure completion date	M12	M12	M12	. .
Group N	***Provider data items***				
	Medicare provider number of provider requesting a test	N1	N1	N1	B1
	Healthcare provider identifier – individual (HPI-I) of provider requesting a test	N2	N2	N3	B2
	Healthcare provider identifier – organisation (HPI-O) of provider requesting a test	N3	N3	N2	B3
	Australian state/territory of provider requesting a test	N4	N4	N5	B10
	Australian postcode of provider requesting a test	N5	N5	N6	B11
	Medicare provider number of provider collecting a specimen	N6	N6	. .	. .
	Non-medical provider number of provider collecting a specimen	N7	N7	N7	B13
	Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen	N8	N8	N9	B14
	Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen	N9	N9	N8	B15
	Type of provider collecting a specimen	N10	N10	N10	B12
	Australian state/territory of provider collecting a specimen	N11	N11	. .	. .
	Australian postcode of provider collecting a specimen	N12	N12	. .	. .
Group O	***Pathology laboratory data items***				
	Pathology laboratory identifier	O1	O1	O1	L1
	Pathology laboratory name	O2	O2	O2	. .
	Pathology laboratory accession number/identifier	O3	O3	O3	C1
	Pathology laboratory Australian state/territory	O4	O4	. .	. .
	Pathology laboratory Australian postcode	O5	O5	. .	. .
Group P	***Screening history data items***				
	Previously screened flag	P1	P1	P1	. .
	Date of last screening test	P2	P2	P2	. .
	Last screening test type	P3	P3	P3	. .
	Number of days since last screening test	P4	P4	P4	. .

3.4 Data items

Group A: Participant identifier data items

A1 Participant identifier
A2 Previous participant identifier
A3 Medicare card number
A4 Individual healthcare identifier

A1 Participant identifier

Identifying and definitional attributes

Data item name	Participant identifier
Definition	Participant identifier unique within the National Cervical Screening Register.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Guide for use	This data item is used to uniquely identify cervical screening invitees and participants who exist on the National Cervical Screening Register
Collection methods	Assigned by the National Cervical Screening Register.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* A1 Client identifier

A2 Previous participant identifier

Identifying and definitional attributes

Data item name	Previous participant identifier
Definition	Participant identifier unique within the state or territory cervical screening register from which the record has been migrated to the National Cervical Screening Register.
Collection status	Conditional

Value domain attributes

Representation class	Identifier
Data type	String
Format	[X(20)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Guide for use	This data item only applies to participants who have been migrated from a state or territory cervical screening register to the National Cervical Screening Register. Therefore, it only applies to 'legacy participants' within the National Cervical Screening Register, and not to new participants within the National Cervical Screening Register.
Collection methods	When the National Cervical Screening Register migrated participants from a state or territory cervical screening register, it was important that the participant identifier as it appeared on that register was also migrated. There needed to be the capacity to collect more than one A2 for an individual in the National Cervical Screening Register, as there are participants who appeared on more than one state or territory cervical screening register that were migrated to a single A1 Participant identifier in the National Cervical Screening Register, either because a single record was sent by pathology laboratories to more than one state or territory cervical screening register, or because these participants resided in more than one state or territory over their screening history. This means that each individual on the National Cervical Screening Register will have zero, one, or many A2 fields, and all these possibilities needed to be able to be captured by the National Cervical Screening Register.

Comments	To prevent a situation whereby participants from different registers have the same identifier, and to avoid losing information about the state or territory from which the participant was migrated, the identifier and state or territory both need to be recorded. To do this, the source state or territory of the record (which is not necessarily the state or territory in which the participant resides) was used as a prefix to the previous participant identifier. For example, a participant identifier of 123456789 that was migrated from a New South Wales register became NSW123456789.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* A2 Previous client identifier

A3 Medicare card number

Identifying and definitional attributes

Data item name	Medicare card number
Definition	A numeric number on a medical card allocated by Medicare Australia for the purpose of identifying those people eligible for specific services.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(10)[N]}
Maximum character length	11

Data item attributes

Collection and usage attributes

Guide for use	Full Medicare number for an individual (that is, family number plus person (individual reference) number), or truncated Medicare number.
Comments	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person. Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* A3 Medicare card number

A4 Individual healthcare identifier

Identifying and definitional attributes

Data item name	Individual healthcare identifier
Definition	An individual healthcare identifier (IHI) is a unique 16-digit number allocated to each Australian resident and others seeking healthcare in Australia.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Data item attributes

Collection and usage attributes

Guide for use	An individual healthcare identifier (IHI) is allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs (DVA) treatment card, and others who seek healthcare in Australia.
Comment	As not all participants will have an IHI or be matched, this does not replace A1 Participant identifier.

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)
Reference documents	

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* A4 Individual healthcare identifier

Group B: Participant data items

B1 Family name
B2 Given name
B3 Other given names
B4 Date of birth
B5 Sex
B6 Gender
B7 Indigenous status
B8 Main language other than English spoken at home
B9 Country of birth
B10 CALD status

B1 Family name

Identifying and definitional attributes

Data item name	Family name
Definition	The text that represents the part of a name a person usually has in common with some other members of their family, as distinguished from their given names.
Collection status	Essential

Value domain attributes

Representation class	Text
Data type	String
Format	X[X(249)]
Maximum character length	250

Data item attributes

Collection and usage attributes

Guide for use	
Collection methods	A full history of names should be retained. Do not delete or overwrite a previous given name. Where a person uses multiple names, these should all be recorded to increase the ability to undertake data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* B1 Family name

B2 Given name

Identifying and definitional attributes

Data item name	Given name
Definition	The person's identifying name within the family group or by which the person is socially identified.
Collection status	Essential

Value domain attributes

Representation class	Text
Data type	String
Format	X[X(249)]
Maximum character length	250

Data item attributes

Collection and usage attributes

Guide for use	
Collection methods	A full history of names should be retained. Do not delete or overwrite a previous given name. Where a person uses multiple names, these should all be recorded to increase the ability to undertake data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* B2 Given name

B3 Other given names

Identifying and definitional attributes

Data item name	Other given names
Definition	The person's other identifying name(s) within the family group or by which the person is socially identified.
Collection status	Desirable

Value domain attributes

Representation class	Text
Data type	String
Format	[X(249)]
Maximum character length	250

Data item attributes

Collection and usage attributes

Guide for use	
Collection methods	A full history of names should be retained. Do not delete or overwrite a previous given name. Where a person uses multiple names, these should all be recorded to increase the ability to undertake data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* B3 Other given names

B4 Date of birth

Identifying and definitional attributes

Data item name	Date of birth
Definition	The date on which a person was born.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. If only the year and month is known, date of birth should be set to 01MMYYYY; if only the year is known, date of birth should be set to 0107YYYY.
Collection methods	Date of birth should be in the preferred representational layout DDMMYYYY.
Comments	If there is more than one date of birth, all should be recorded.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* B4 Date of birth

B5 Sex

Identifying and definitional attributes

Data item name	Sex
Definition	The sex of a person.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Male
	2	Female
	3	Another term
Supplementary values	9	Not stated/Inadequately described

Data item attributes

Collection and usage attributes

Guide for use

The terms sex and gender are interrelated, and are often used interchangeably, however they are distinct concepts:

- Sex is understood in relation to sex characteristics. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or in infancy.
- Gender is about social and cultural differences in identity, expression and experience.

While they are related concepts, caution should be exercised when comparing counts for sex with those for gender.

‘The preferred Australian Government approach is to collect and use gender information. Information regarding sex would ordinarily not be required and should only be collected where there is a legitimate need for that information and it is consistent with Australian Privacy Principle 3. (AGD 2015).

The permissible values are based on the Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021). The values are defined as follows:

CODE 1 Male

Persons whose sex at birth or infancy was recorded as male, or who reported their sex as male at the time of collection.

CODE 2 Female

Persons whose sex at birth or infancy was recorded as female, or who reported their sex as female at the time of collection.

CODE 3 Another term

Persons whose sex at birth or infancy was recorded as another term (not male or female), or who reported their sex as another term (not male or female) at the time of collection.

The value meaning of ‘Another term’ has been assigned to Code 3 for this value domain, which replaces ‘Other’ and ‘Intersex or indeterminate’. The third option recognises that across Australian jurisdictions and elsewhere there are a range of terms used.

CODE 9 Not stated/inadequately described

This supplementary value is used to code inadequately described responses and non-responses for sex. It is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Collection methods

This may be used to collect either sex recorded at birth or sex reported at the time of collection. This information should be specified in the Data Set Specific Information in order to provide transparency about which type of data was collected.

The Australian Bureau of Statistics (ABS) Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021) recommends that where data on sex is collected, the preferred question should relate to sex recorded at birth. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or infancy. This is an important indicator for statistical analysis in births and deaths, health statistics, calculating fertility rates and deriving counts for cis and trans populations.

A data collection may instead collect data on a person's sex at the time of collection, rather than their sex recorded at birth. However, there are advantages of sex recorded at birth as the sex question and further data that can be derived when using sex recorded at birth as the sex question.

Caution should be exercised when comparing counts for sex of a person recorded at birth and the sex of a person reported at the time of data collection, as a person's reported sex may change over the course of their lifetime. Also, as the terms sex and gender are often used interchangeably, a respondent might provide a gender response to a sex question.

Standard questions

Sex recorded at birth

The ABS recommends the following standard question structure:

What was [your/Person's name/their] sex recorded at birth? Please [tick/mark/select] one box.

[ ] Male

[ ] Female

[ ] Another term (please specify)

The following elements must be included:

- The words ‘sex recorded at birth’ in the question to clearly articulate the concept being collected
- Label the response options ‘Male’, ‘Female’, and ‘Another term (please specify)’
- A write-in facility is available when the ‘Another term (please specify)’ response option is selected
- Only one response is permitted
- If this question is interviewer administered, the question must always be asked as written and no assumptions made by the interviewer.

The following elements are recommended for inclusion:

- Use inclusive language (for example ‘they’ or ‘their’ rather than ‘he/she’ or ‘his/her’)
- If both sex and gender questions are included, ask the sex question first and note that a separate question on gender is also asked
- If both sex and gender questions are included, ask both on the same page if practical.

Sex reported at time of data collection

The ABS recommends the following standard question structure:

What is [your/Person's name/their] sex? Please [tick/mark/select] one box.

[ ] Male

[ ] Female

[ ] Another term (please specify)

The following elements must be included:

- The word ‘sex’ in the question to clearly articulate the concept being collected
- Label the response options ‘Male’, ‘Female’, and ‘Another term (please specify)’
- A write-in facility is available when the ‘Another term (please specify)’ response option is selected
- Only one response is permitted
- If this question is interviewer administered, the question must always be asked as written and no assumptions made by the interviewer.

The following elements are recommended for inclusion:

- Use inclusive language (for example ‘they’ or ‘their’ rather than ‘he/she’ or ‘his/her’)

- If both sex and gender questions are included, ask the sex question first and note that a separate question on gender is also asked in the survey
- If both sex and gender questions are included, ask both on the same page of the instrument if practical.

The Australian Government Guidelines on the Recognition of Sex and Gender recommend ‘departments and agencies should refrain from making assumptions about a person's sex and/or gender identity based on indicators such as their name, voice or appearance’ (AG 2015.)

The inclusion of the write-in facility for ‘Another term’ as a third response option recognises that there are a range of terms used to describe sex which is neither male nor female, and enhances data quality.

Comments

A person's sex is based upon their sex characteristics, such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or in infancy, a person's reported sex can change over the course of their lifetime and may differ from their sex recorded at birth.

Where this data element is used to record sex reported at the time of collection, the data may not be used to derive cis and trans counts through the 'two-step method'.

Source and reference attributes

Origin

Adapted from METeOR Data Element 741686.

Reference documents

Australian Bureau of Statistics 2021. Standard for sex, gender, variations of sex characteristics and sexual orientation variables. Canberra: ABS

Attorney-General's Department 2015. Australian Government Guidelines on the Recognition of Sex and Gender.

Relational attributes

Related metadata reference

Supersedes *National Cervical Screening Program data dictionary version 1.1* B5 Sex

B6 Gender

Identifying and definitional attributes

Data item name	Gender
Definition	How a person describes their gender.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Man, or boy, or male
	2	Woman, or girl, or female
	3	Non-binary
	4	Different term
	5	Prefer not to answer
Supplementary values	9	Not stated/Inadequately described

Data item attributes

Collection and usage attributes

Guide for use

Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, boy, woman, girl, or non-binary person. Non-binary is an umbrella term describing gender identities that are not exclusively male or female.

Gender includes the following concepts:

- Gender identity is about who a person feels themself to be
- Gender expression is the way a person expresses their gender. A person's gender expression may also vary depending on the context, for instance expressing different genders at work and home
- Gender experience describes a person's alignment with the sex recorded for them at birth, that is, a cis experience or a trans experience' (ABS 2021).

The terms sex and gender are interrelated and often used interchangeably; however, they are two distinct concepts:

- Sex is understood in relation to sex characteristics. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or infancy
- Gender is about social and cultural differences in identity, expression, and experience.

While they are two related concepts, caution should be exercised when comparing counts for sex with those for gender.

"The preferred Australian Government approach is to collect and use gender information. Information regarding sex would ordinarily not be required and should only be collected where there is a legitimate need for that information and it is consistent with Australian Privacy Principle 3." (AGD 2015) is the permissible values are based on the Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021). The values are defined as follows:

CODE 1 Man, or boy, or male

A person who describes their gender as man, or boy, or male.

CODE 2 Woman, or girl, or female

A person who describes their gender as woman, or girl, or female.

CODE 3 Non-binary

A person who describes their gender as non-binary.

CODE 4 Different term

A person who describes their gender as a term other than man/boy/male, woman/girl/female, or non-binary.

CODE 5 Prefer not to answer

A person who prefers not to respond on how they describe their gender.

CODE 9 Not stated or inadequately described.

This supplementary value is used to code inadequately described responses and non-responses for gender. It is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Collection methods

Standard Question Module

The following standard question module is based on that recommended in the Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021): How [do/does] [you/Person's name/they] describe [your/their] gender?

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

Please [tick/mark/select] one box:

[ ] Man, or boy, or male

[ ] Woman, or girl, or female

[ ] Non-binary

[ ] [I/They] use a different term (please specify)

[ ] Prefer not to answer

Mandatory elements

The following elements must be included:

- The word 'gender' in the question to clearly articulate the concept being collected
- Label the response options ‘Man, or boy, or male’, ‘Woman, or girl, or female’, ‘Non-binary’, ‘[I/they] use a different term (please specify)’, and ‘Prefer not to answer’
- A write-in facility is available when the ‘[I/they] use a different term (please specify)’ response option is selected
- Including a note to respondents that ‘Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents’
- Only one response is permitted
- If this question is interviewer administered, the question must always be asked as written and no assumptions made by the interviewer.

Recommended elements

The following elements are recommended for inclusion:

- Use inclusive language (for example ‘they’ or ‘their’ rather than ‘he/she’ or ‘his/her’)
- If both sex and gender questions are included, ask the sex question first and note that a separate question on gender is also asked
- If both sex and gender questions are included, ask both on the same page if practical.

The Australian Government Guidelines on the Recognition of Sex and Gender recommend ‘departments and agencies should refrain from making assumptions about a person's sex and/or gender identity based on indicators such as their name, voice or appearance’ (AG 2015).

The inclusion of the write-in facility for 'Different term' as a response option recognises that there are a range of terms used to describe gender which is neither male nor female, and enhances data quality. Where the "Different term" code has been selected for gender, the data element Person—gender, text X[X(99)] may be used to capture any further (optional) specification of gender descriptors.

Note: Where written responses for CODE 4 (T) 'Different term' indicate a variation of one of 'Man, or boy, or male', 'Woman, or girl, or female' or 'Non-binary', those responses may be coded to the associated label.

Comments

A person's gender may stay the same or can change over the course of their lifetime. The gender response option chosen will reflect a person's gender at that point in time. Some people may not identify with a specific gender or with the concept of gender at all.

Source and reference attributes

Origin	Adapted from METeOR Data Element 741842.
Reference documents	Australian Bureau of Statistics 2021. Standard for sex, gender, variations of sex characteristics and sexual orientation variables. Canberra: ABS Attorney-General's Department 2015. Australian Government Guidelines on the Recognition of Sex and Gender.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* B6 Gender

B7 Indigenous status

Identifying and definitional attributes

Data item name	Indigenous status
Definition	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
Supplementary values	9	Not stated/inadequately described

Data item attributes

Collection and usage attributes

Guide for use

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'Not stated/inadequately described' responses. The classification is as follows:

Indigenous Australians:

• Aboriginal but not Torres Strait Islander origin.

• Torres Strait Islander but not Aboriginal origin.

• Both Aboriginal and Torres Strait Islander origin.

Non-Indigenous Australians:

• Neither Aboriginal nor Torres Strait Islander origin.

Not stated/inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

• Primarily when importing data from other data collections that do not contain mappable data.

• Where the answer cannot be determined without clarification from the respondent (for example, 'No' and 'Yes, Aboriginal' are both selected).

• Where an answer was declined.

• Where the question was not able to be asked because the individual was unable to communicate or a person who knows the individual was not available.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

• If the respondent answers 'Yes, Aboriginal' and 'Yes, Torres Strait Islander', then their response should be coded to 'Yes, both Aboriginal and Torres Strait Islander origin'.

• If the respondent answers 'No' and one or more of the following:

- 'Yes, Aboriginal'
- 'Yes, Torres Strait Islander'
- 'Yes, both Aboriginal and Torres Strait Islander'

then the response should be coded to 'Not stated/inadequately described' if the response cannot be clarified with the respondent.

Collection methods

The following information provides advice on the recommended way to ask the Indigenous status question.

Self-enumerated collections

For self-enumerated collections (for example, self-completed questionnaires or forms), the following question is recommended:

Q1. [Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

• No

• Yes, Aboriginal

• Yes, Torres Strait Islander

If [you] [the person] [(name)] are of both Aboriginal and Torres Strait Islander origin, answer using both 'Yes' options.

This approach may be problematic in some data collections, for example when data are collected using screen based data capture systems. An additional response category of 'Yes, both Aboriginal and Torres Strait Islander' may be included if this better suits the data collection practices of the agency or establishment concerned.

If the Indigenous status question has not been completed on a returned form, this should be followed up and confirmed with the person.

Interviewer-conducted collections

For interviewer-conducted collections in which the Indigenous status of one person is collected, the following question set is recommended:

Q1. Are you of Aboriginal or Torres Strait Islander origin?

• Yes

• No (no more questions)

Q2. Are you of Aboriginal origin, Torres Strait Islander origin, or both?

• Aboriginal

• Torres Strait Islander

• Both Aboriginal and Torres Strait Islander

The first question is used to sequence out non-Indigenous Australians. The second question is used to determine the specific Aboriginal and/or Torres Strait Islander origin of the person. A benefit of this approach is that the interviewer is not required to prompt the respondent with response categories. The 'Both Aboriginal and Torres Strait Islander' response category can be included or excluded in interviewer conducted collections depending on which option best suits the data collection practices of the agency concerned. Including the additional response category ensures that respondents are aware of the option to identify as being of both Aboriginal and Torres Strait Islander origin.

Various articulations of the standard question are recommended to address the following circumstances:

Person is present and answers

This question wording is recommended where it is known that the person being interviewed is the subject:

Q1. Are you of Aboriginal or Torres Strait Islander origin?

Q2. Are you of Aboriginal origin, Torres Strait Islander origin, or both?

Person is not present and someone else who knows the person well answers

The following question wording is recommended when another member of the household answers for the person. Examples of such incidents include: parents answering for children, or relatives answering in hospital situations.

Q1. Is [the person] [(name)] of Aboriginal or Torres Strait Islander origin?

Q2. Is [the person] [(name)] of Aboriginal origin, Torres Strait Islander origin, or both?

Person is deceased and someone else answers on their behalf (for example, death information form)

In these circumstances a close relative or friend should answer. Only if a relative or friend is unavailable should the undertaker or other such person answer. The suggested question wording follows:

Q1. Was [the person] [(name)] of Aboriginal or Torres Strait Islander origin?

Q2. Was [the person] [(name)] of Aboriginal origin, Torres Strait Islander origin, or both?

Person is an infant and parents answer (for example perinatal information form)

In this circumstance it is recommended that parents are asked:

Q1. Is [the baby's] [(name)'s] mother of Aboriginal or Torres Strait Islander origin?

Q2. Is [the baby's] [(name)'s] mother of Aboriginal origin, Torres Strait Islander origin, or both?

and

Q1. Is [the baby's] [(name)'s] father of Aboriginal or Torres Strait Islander origin?

Q2. Is [the baby's] [(name)'s] father of Aboriginal origin, Torres Strait Islander origin, or both?

For interview conducted collections in which the Indigenous Status of more than one person is collected from a household representative, the following question set is recommended:

Q1. Is anyone who (usually lives here) (or) (is visiting here) of Aboriginal or Torres Strait Islander origin?

• Yes

• No

Q2. Who are they?

Question 3 is asked of each person identified as being of Aboriginal or Torres Strait Islander origin.

Q3. [Are you] [Is (name)] of Aboriginal origin, Torres Strait Islander origin, or both?

• Aboriginal

• Torres Strait Islander

• Both Aboriginal and Torres Strait Islander

The first question is used to sequence out households in which no Aboriginal and/or Torres Strait Islander people usually live (or are visiting). The second question is used to identify those usual residents (and visitors) of Aboriginal or Torres Strait Islander origin. This approach eliminates the need to repeatedly ask the Indigenous status question of each individual in a household when data are collected on a single household form. It is particularly advantageous when collecting from areas with a large proportion of households with non-Indigenous Australians.

For both self-enumerated collections and interviewer-conducted collections

The Indigenous status question can be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that the question be asked directly wherever possible.

When the subject person is not present, the person answering for them should be in a position to do so, that is, this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them.

The Indigenous status question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question may only be left unanswered in the following circumstances:

• Where the person declined to answer

• Where the question was not able to be asked because the individual was unable to communicate or a person who knows the individual was not available.

Comments	The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625. 'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'. There are three components to the Commonwealth definition: • descent; • self-identification; and • community acceptance. In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

Origin	Adapted from METeOR Data Element 602543.
Reference documents	Australian Bureau of Statistics 2014. Indigenous Status Standard Version 1.5, Canberra. (Cat. no. 1200.0.55.008). Australian Institute of Health and Welfare 2010. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. AIHW 29. Canberra: AIHW.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* B7 Indigenous status

B8 Main language other than English spoken at home

Identifying and definitional attributes

Data item name	Main language other than English spoken at home
Definition	The language reported by a person as the main language other than English spoken by that person in their home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	Number
Format	{N[NNN]}
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of languages which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow group level), identified by two-digit and three-digit codes. The most general level of the classification consists of broad groups of languages (the Broad group level) and is identified by one-digit codes. The classification includes Australian Indigenous languages and sign languages. For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is a Western Desert language. Language data may be output at the Broad group level, Narrow group level or the language level of the classification. Also, significant languages within a Narrow group can be presented separately with the remaining languages of the Narrow group aggregated. The same principle can be adopted to highlight significant Narrow groups within a Broad group
Collection methods	Where extensive data on main language other than English spoken at home is needed, one of the two questions below may be used: Alternative 1 *Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home? (If more than one language, indicate the language that is spoken most often.)*

No, (English only) []
Yes, Mandarin []
Yes, Italian []
Yes, Arabic []
Yes, Cantonese []
Yes, Greek []
Yes, Vietnamese []
Yes, Spanish []
Yes, Hindi []
Yes, Tagalog []
Yes, Other (please specify) _____

The above list includes languages based on their statistical frequency in Australia, based on data from the Census of Population and Housing.

Alternative 2

Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home?

No, English only []

Yes, Other - please specify _____

Where there is no requirement for detailed language data, the following question may be suitable:

Do you/Does the person/Does (name)/ Will (name of child under two years) speak a language other than English at home?

No, English only []

Yes, Other []

Comments

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the ABS.

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin

Adapted from METeOR Data Element 659402.

Reference documents

Australian Bureau of Statistics 2016a. Australian Standard Classification of Languages (ASCL) 2016. ABS cat. no.1267.0. Canberra: ABS.

Australian Bureau of Statistics 2016b. Language Standards 2016. ABS cat. no.1200.0.55.005. Canberra: ABS.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* B8 Main language other than English spoken at home

B9 Country of birth

Identifying and definitional attributes

Data item name	Country of birth
Definition	The country in which the person was born.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	Number
Format	{N[NNN]}
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	The Standard Australian Classification of Countries 2016 is a four-digit, three-level hierarchical structure specifying major group, minor group, and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.
Collection methods	Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category. Recommended questions are: *In which country were you/was the person/was (name) born?* *Australia* *Other (please specify) ...* or *In which country were you/was the person/was (name) born?* *Australia* *England* *New Zealand* *India* *Italy* *Vietnam* *Philippines* *South Africa* *Scotland*

	Malaysia *Other (please specify) ...*
	The option list for this question includes countries according to their statistical frequency in Australia, according to data from the Census of Population and Housing. Exceptions are made for countries such as 'United Kingdom' and 'China', as they are likely to reduce the level of detail that is possible to be coded to the Standard Australian Classification of Countries.

Source and reference attributes

Origin	Adapted from METeOR Data Element 659454.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* B9 Country of birth

B10 CALD status

Identifying and definitional attributes

Data item name	CALD status
Definition	An overall indication of CALD status.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	CALD
	2	Not CALD
	9	Not stated/inadequately described

Data item attributes

Collection and usage attributes

Guide for use

CALD is an Australian term that is used for people that are culturally and linguistically diverse. There are differences in how CALD is defined, but a common definition where country of birth and a language variable are collected is to include people born in countries other than those identified by the ABS as the main English-speaking countries (MESC) from which Australian receives a significant number of migrants and/or those who report that they speak a language other than English at home (AIHW 2022).

This aligns with the definition suggested following a review of CALD definitions as people born in non-English speaking countries, and/or who do not speak English at home, with Aboriginal and Torres Strait Islander people considered separately (Pham 2021).

For this definition, CALD status is derived from the two data items B9 ‘Country of birth’ and B8 ‘Main language other than English spoken at home’.

CALD is defined as:

- people born overseas in countries where English is not the main language spoken (people whose country of birth is not Australia and its external territories, New Zealand, the United Kingdom, Ireland, the United States of America, Canada, or South Africa—this selection of countries is based on the main countries from which Australia receives settlers who are likely to speak English).

and/or

- people born in Australia whose main language other than English spoken at home is not English (excluding Aboriginal languages).

Collection methods	CALD status is derived from the two data items B9 ‘Country of birth’ and B8 ‘Main language other than English spoken at home’.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* B10 CALD status

Group C: Participant status data items

C1 Defer flag
C2 Reason to defer screening
C3 Defer start date
C4 Defer end date
C5 Opt out flag
C6 Reason for opt out
C7 Opt out date
C8 Opt in date
C9 Hysterectomy flag
C10 Date of hysterectomy
C11 Death flag
C12 Date of death
C13 DES exposed
C14 Immunocompromised

C1 Defer flag

Identifying and definitional attributes

Data item name	Defer flag
Definition	An indication as to whether a participant has requested that their participation in cervical screening be deferred.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Defer screening

Data item attributes

Collection and usage attributes

Guide for use	Defer flag should be raised at such time as it is known that a participant has requested that their participation in cervical screening be deferred This flag is used to determine if a participant has deferred screening as at the current date.
Rules for use	If C3 Defer start date is not NULL and current date < C4 Defer end date, then C1 Defer flag should = 1.
Collection methods	This is a derived data item.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C1 Defer flag

C2 Reason to defer screening

Identifying and definitional attributes

Data item name	Reason to defer screening
Definition	The reason that a participant provides to the National Cancer Screening Register as to why they requested that their participation in cervical screening be deferred.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Medical advice to defer
	2	Living or travelling overseas
	3	Other

Data item attributes

Collection and usage attributes

Guide for use	The National Cancer Screening Register allows participants to defer future screening date and reminders in the National Cancer Screening Register for the National Cervical Screening Program. Three main reasons are provided as options for deferring cervical screening reminders. These are: ‘Medical advice to defer’; ‘Living or travelling overseas’; and ‘Other (please specify)’. As a participant may defer more than once, reason to defer screening needs to be able to be collected multiple times, with each linked to the defer start date.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C2 Reason to defer screening.

C3 Defer start date

Identifying and definitional attributes

Data item name	Defer start date
Definition	The date from which a participant has requested that their participation in cervical screening be deferred.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The collection of data for this data item is conditional on a participant requesting that their participation in cervical screening be deferred. The National Cancer Screening Register allows participants to defer future screening date and reminders in the National Cancer Screening Register for the National Cervical Screening Program. As a participant may defer more than once, defer start date needs to be able to be collected multiple times. While it is preferable that this be an accurate date, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
Collection methods	This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C3 Defer start date.

C4 Defer end date

Identifying and definitional attributes

Data item name	Defer end date
Definition	The date from which a participant requests their participation in cervical screening no longer be deferred.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The collection of data for this data item is conditional on a participant requesting that their participation in cervical screening be deferred. The National Cancer Screening Register allows participants to defer future screening date and reminders in the National Cancer Screening Register for the National Cervical Screening Program. As a participant may defer more than once, defer end date needs to be able to be collected multiple times. While it is preferable that this be an accurate date, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
Collection methods	This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C4 Defer end date.

C5 Opt out flag

Identifying and definitional attributes

Data item name	Opt out flag
Definition	An indication as to whether a participant has opted out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Opt out

Data item attributes

Collection and usage attributes

Guide for use	The National Cancer Screening Register allows participants to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program. This means that: • The participant will not be contacted or receive any future correspondence from the National Cancer Screening Register for the National Cervical Screening Program. • No further cervical screening information about the participant will be recorded on the National Cancer Screening Register. Opt out flag should be raised at such time as it is known that a participant has requested to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program. This flag is used to determine if a participant has opted out as at the current date.
Rules for use	If C7 Opt out date is not NULL and current date < C8 Opt in date, then C5 Opt out flag should = 1.
Collection methods	This is a derived data item.

Relational attributes

Related metadata reference	Supersedes National Cervical Screening Program data dictionary version 1.1 C5 Opt out flag

C6 Reason for opt out

Identifying and definitional attributes

Data item name	Reason for opt out
Definition	The reason that a participant provides to the National Cancer Screening Register for opting out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Not interested
	2	Privacy concerns
	3	Other

Data item attributes

Collection and usage attributes

Guide for use

The National Cancer Screening Register allows participants to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.

This means that:

- The participant will not be contacted or receive any future correspondence from the National Cancer Screening Register for the National Cervical Screening Program.
- No further cervical screening information about the participant will be recorded on the National Cancer Screening Register.

Three main reasons are provided as options for opting out. These are:

‘Not interested’;

‘Privacy concerns’; and

‘Other (please specify)’.

As a participant may opt out more than once, reason for opt out needs to be able to be collected multiple times, with each linked to the opt out date.

Relational attributes

Related metadata reference	Supersedes National Cervical Screening Program data dictionary version 1.1 C6 Reason for opt out

C7 Opt out date

Identifying and definitional attributes

Data item name	Opt out date
Definition	The date on which a participant opts out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use

The National Cancer Screening Register allows participants to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.

This means that:

- The participant will not be contacted or receive any future correspondence from the National Cancer Screening Register for the National Cervical Screening Program.
- No further cervical screening information about the participant will be recorded on the National Cancer Screening Register.

As a participant may opt out more than once, opt out date needs to be able to be collected multiple times.

While it is preferable that this be an accurate date the participant opts out of the National Cancer Screening Register, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.

Collection methods

This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C7 Opt out date.

C8 Opt in date

Identifying and definitional attributes

Data item name	Opt in date
Definition	The date on which a participant withdraws their request to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use

The National Cancer Screening Register allows participants to opt out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.

This means that:

- The participant will not be contacted or receive any future correspondence from the National Cancer Screening Register for the National Cervical Screening Program.
- No further cervical screening information about the participant will be recorded on the National Cancer Screening Register.

Participants are subsequently able to opt back into participation in the National Cancer Screening Register for the National Cervical Screening Program, by withdrawing their request to opt out.

As a participant may opt in more than once, opt in date needs to be able to be collected multiple times.

While it is preferable that this be an accurate date the participant opts back into the National Cancer Screening Register, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.

Collection methods

This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* C8 Opt in date.

C9 Hysterectomy flag

Identifying and definitional attributes

Data item name	Hysterectomy flag
Definition	An indication as to whether a participant has had a total hysterectomy (removal of uterus and cervix).
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Total hysterectomy

Data item attributes

Collection and usage attributes

Guide for use	Hysterectomy flag should be raised at such time as it is known that a participant has had a total hysterectomy.
Rules for use	If C10 ‘Date of hysterectomy’ is not NULL, C9 ‘Hysterectomy flag should be = 1.
Collection methods	While this can be communicated by the practitioner or participant procedure code for total hysterectomy should also trigger the hysterectomy flag.
Comments	Whether or not a participant who had had a total hysterectomy will require further follow-up within the National Cervical Screening Program should be according to clinical recommendations in the *National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding* (as per ‘Flowchart 13.1 Vaginal screening after total hysterectomy’) (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party).

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C9 Hysterectomy flag

C10 Date of hysterectomy

Identifying and definitional attributes

Data item name	Date of hysterectomy
Definition	The date a participant underwent a total hysterectomy (removal of uterus and cervix).
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The collection of data for this data item is conditional on a participant having had a total hysterectomy. While it is preferable that this be an accurate date of a reported total hysterectomy, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
Rules for use	If C9 'Hysterectomy flag' = 1, C10 'Date of hysterectomy' should not be NULL.
Collection methods	This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C10 Date of hysterectomy

C11 Death flag

Identifying and definitional attributes

Data item name	Death flag
Definition	An indication as to whether a participant is deceased.
Context	These data are essential to ensure that correspondence is not sent to deceased people to avoid potential distress for the participant's family or friends.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Deceased

Data item attributes

Collection and usage attributes

Guide for use	
Rules for use	If C12 ‘Date of death’ is not NULL, C11 ‘Death flag’ should be = 1.
Collection methods	Frequent linking to the National Death Index or similar source of identified deaths data.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C11 Death flag

C12 Date of death

Identifying and definitional attributes

Data item name	Date of death
Definition	The date of death of a participant.
Context	Required to prevent screening reminder letters or other correspondence being sent to deceased people.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	While it is preferable that this be an accurate date of death, part of the date may need to be estimated. If this date needs to be estimated, the following guide should be used; if only the year and month is known, date should be set to 01MMYYYY; if only the year is known, date should be set to 0107YYYY.
Rules for use	If C11 ‘Death flag’ = 1, C12 ‘Date of death’ should not be NULL.
Collection methods	This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, a date of 1 July 2015 should be recorded as 01072015 as specified in the representational layout.
Comments	Depending on how this information is collected, day or even month may not be known. The death flag should be used as soon as it is known that a participant has died, as it is important individuals who are deceased are not sent correspondence (this is more important than recording the day and month of death).

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C12 Date of death

C13 DES exposed

Identifying and definitional attributes

Data item name	DES exposed
Definition	An indication of whether a participant was exposed to diethylstilboestrol (DES) in utero
Context	People exposed to DES in utero are at increased risk of clear cell carcinoma of the vagina and cervix.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	DES exposed

Data item attributes

Collection and usage attributes

Guide for use	DES exposed should be coded to '1' at such time as it is known that a participant was exposed to DES in utero. The Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party) include recommendations specific for cervical screening in DES-exposed people. These recommendations are that people exposed to DES in utero should be offered an annual co-test and colposcopic examination of both the cervix and vagina indefinitely, and that people exposed to DES in utero who have a screen-detected abnormality should be managed by an experienced colposcopist. There is very little evidence on the risk of cervical cancer in daughters of those exposed to DES in utero. Therefore the Guidelines note that they should be screened with 5-yearly HPV testing unless they have concerns, in which case annual co-testing (similar to their DES-exposed mothers) could be offered by clinicians on an individual basis to provide reassurance.
Collection methods	A medical practitioner is likely to note that a person was exposed to DES in utero given the higher risk of cervical and vaginal cancer and the need for a different cervical screening process.
Comments	DES is a synthetic oestrogen that was prescribed predominantly in the first trimester of pregnancy from the1940s until the early 1970s. There is substantial evidence indicating that those exposed in utero to DES have a markedly increased risk of clear cell carcinoma of the vagina and cervix (IARC 2012).

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C13 DES exposed

C14 Immunocompromised

Identifying and definitional attributes

Data item name	Immunocompromised
Definition	An indication of whether a participant is immunocompromised
Context	People with HIV and solid organ transplant recipients have been defined as sufficiently immune-deficient to warrant more frequent screening and a lower threshold for colposcopy referral than the general population.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Immunocompromised due to HIV or solid organ transplant
	2	Immunocompromised due to other reason

Data item attributes

Collection and usage attributes

Guide for use

Immunocompromised should be coded to ‘1’ at such time as it is known that a participant is immunocompromised due to HIV or solid organ transplant.

Immunocompromised should be coded to ‘2’ at such time as it is known that a participant is immunocompromised due to other reasons (such as congenital immune deficiency, being treated with immunosuppressant therapy for autoimmune disease, or being treated for graft versus host disease).

The Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party) include recommendations specific for cervical screening in people with HIV and solid organ transplant recipients. These recommendations are that people that are immunocompromised due to HIV or solid organ transplant who have an HPV test in which oncogenic HPV types are not detected should be screened every 3 years with an HPV test, and those who have a positive oncogenic HPV (any type) test result should be referred for colposcopic assessment informed by the reflex LBC.

	People with congenital immune deficiency, being treated with immunosuppressant therapy for autoimmune disease, or being treated for graft versus host disease could also be considered for 3-yearly cervical screening.
Collection methods	A medical practitioner is likely to note that a person is immunocompromised and for what reason.
Comments	Refer to the many 'Practice point' entries for immunocompromised people in the Guidelines (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party) for further information.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* C14 Immunocompromised

Group D: Participant vaccination status data items

D1 HPV vaccination clinical completion status
D2 HPV vaccination clinical completion date
D3 HPV vaccine dose date
D4 HPV vaccination dose age
D5 HPV vaccine implied dose number
D6 HPV vaccine type

D1 HPV vaccination clinical completion status

Identifying and definitional attributes

Data item name	HPV vaccination clinical completion status
Definition	An indication as to whether a person is vaccinated against HPV
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	0	Unvaccinated
	1	Vaccinated – complete
	2	Vaccinated – incomplete
	3	Vaccinated – too close
	4	Vaccinated – no valid status

Data item attributes

Collection and usage attributes

Guide for use	Vaccination status is according to clinical completion status, which is derived from HPV vaccination data held by the Australian Immunisation Register based on an algorithm that considers number of doses and length of time between doses. 'Unvaccinated' refers to individuals who have never received a dose of HPV vaccine. 'Complete' refers to people who received a full course of HPV vaccine at adequate intervals. 'Incomplete' refers to people who received less than a full course of HPV vaccine. 'Too close' refers to people who received their HPV vaccine doses too close together, and as such their clinical status is uncertain. Definitions of 'complete', 'incomplete' and 'too close' are subject to change based on future research findings. 'No valid status' is to be used for people who have data items recorded for HPV vaccination but do not have a valid clinical completion status. These people should not be interpreted as 'unvaccinated', which is to be reserved for people who have never received a dose of HPV vaccine.
Comments	HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using

	Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9. While some of the permissible values for this data item do not apply to the more recent HPV vaccination schedule/s, they have been retained to allow the analysis and reporting of historical data. The National HPV Vaccination Program Register ceased on 31 December 2018; all HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D1 HPV vaccination clinical completion status

D2 HPV vaccination clinical completion date

Identifying and definitional attributes

Data item name	HPV vaccination clinical completion date
Definition	The date on which a person is considered completely vaccinated with HPV vaccine.
Collection status	Conditional (conditional for vaccinated people)

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	Record the date that a person received an HPV vaccine dose that changed their status to 'complete', according to their clinical completion status, as shown in D1 'HPV vaccination clinical completion status'. This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, 1 July 2007 should be recorded as 01072007 as specified in the representational layout.
Rules for use	If D1 'HPV vaccination clinical completion status' = 1 ('Complete'), D2 'HPV vaccination clinical completion date' should be populated. If D1 'HPV vaccination clinical completion status' NOT = 1 ('Complete') then D2 'HPV vaccination clinical completion date' should NOT be populated.
Comments	HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9. While some of the permissible values for this data item do not apply to the more recent HPV vaccination schedule/s, they have been retained to allow the analysis and reporting of historical data. The National HPV Vaccination Program Register ceased on 31 December 2018; all HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D2 HPV vaccination clinical completion date

D3 HPV vaccine dose date

Identifying and definitional attributes

Data item name	HPV vaccine dose date
Definition	The date on which a person received an HPV vaccine dose.
Collection status	Conditional (essential for vaccinated people)

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	Record the date of a person's vaccine dose. A separate date should be recorded for each dose a person receives. It is usual for each person to receive more than one dose – each dose received requires a D3 'HPV vaccine dose date'. Record date for ALL doses, not just implied doses. This data item should always be recorded as an 8-digit valid date comprising day, month, and year. Year should always be recorded in its full 4-digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example, 1 July 2007 should be recorded as 01072007 as specified in the representational layout. This data item will not be populated for unvaccinated people.
Comments	HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9. The National HPV Vaccination Program Register ceased on 31 December 2018; all HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D3 HPV vaccine dose date

D4 HPV vaccine dose age

Identifying and definitional attributes

Data item name	HPV vaccine dose age
Definition	The age at which a person received an HPV vaccine dose.
Collection status	Conditional (essential for vaccinated people)

Value domain attributes

Representation class	Code
Data type	Number
Format	[NNN]
Maximum character length	3

Data item attributes

Collection and usage attributes

Guide for use	Record a person's age at the time of a vaccine dose. A separate age should be recorded for each dose a person receives. It is usual for each person to receive more than one dose – each dose received requires a D4 'HPV vaccine dose age'. Record age for ALL doses, not just implied doses. Age should be determined by subtracting the person's date of birth from the date on which the dose was administered D3 'HPV vaccine dose date'. This data item will not be populated for unvaccinated people.
Comments	HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9. The National HPV Vaccination Program Register ceased on 31 December 2018; All HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D4 HPV vaccine dose age

D5 HPV vaccine implied dose number

Identifying and definitional attributes

Data item name	HPV vaccine implied dose number
Definition	The clinically valid dose number of HPV vaccine.
Collection status	Conditional (essential for vaccinated people)

Value domain attributes

Representation class	Code
Data type	Number
Format	[NN]
Maximum character length	2

Data item attributes

Collection and usage attributes

Guide for use

Implied dose number is the clinically valid dose number, and takes into account the length of time between doses. It uses the same algorithm used for D1 'HPV vaccination clinical completion status' to determine the number of clinically valid doses administered.

Implied dose number of 1 will be the same as the actual dose number, but may differ from actual dose number for subsequent doses. Implied dose number will also remain the same for any doses that are received after they are clinically completely vaccinated.

For example:

Actual dose number	Implied dose number
1	1
2	1
3	2
4	3
5	3

This data item will not be populated for unvaccinated people.

Comments

HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9.

While some of the permissible values for this data item do not apply to the more recent HPV vaccination schedule/s, they have been retained to allow the analysis and reporting of historical data.

	The National HPV Vaccination Program Register ceased on 31 December 2018; all HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D5 HPV vaccine implied dose number

D6 HPV vaccine type

Identifying and definitional attributes

Data item name	HPV vaccine type
Definition	The specific type of HPV vaccine administered at each dose.
Collection status	Conditional (essential for vaccinated people)

Value domain attributes

Representation class	Code	
Data type	String	
Format	{N[XX]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	1i	Gardasil®
	1ii	Gardasil®9
	2	Cervarix
	88	Generic
	99	Unknown

Data item attributes

Collection and usage attributes

Guide for use	Record the type of HPV vaccine administered for each dose. A separate HPV vaccine type should be recorded for each dose a person receives. It is usual for each person to receive more than one dose – each dose received requires a D6 'HPV vaccine type'. Record type for ALL actual doses, not just all implied doses. The permissible values reflect the types of HPV vaccine administered in Australia at the time of preparation. Further HPV vaccine types will be added to this document as required. 'Generic' should be used when the HPV vaccine type is known, but not one of 'Gardasil®', 'Gardasil®9' or 'Cervarix' (for example if the HPV vaccine was administered overseas). 'Unknown' should be used when the HPV vaccine type is not known. This data item will not be populated for unvaccinated people.
Comments	HPV vaccination has undergone two major changes since it was introduced in Australia in April 2007. HPV vaccination was originally a 3-dose schedule using Gardisil® (or Cervarix), which provides protection against HPV types 6, 11, 16, and 18. From January 2018, the three-dose schedule was replaced with a 2-dose schedule using Gardasil®9, which provides protection against HPV types 6, 11, 16, 18, 31, 33, 45, 52, and 58. Then from 6 February 2023, the two-dose schedule was replaced with a single-dose schedule using Gardasil®9.

	While some of the permissible values for this data item do not apply to the more recent HPV vaccination schedule/s, they have been retained to allow the analysis and reporting of historical data. The National HPV Vaccination Program Register ceased on 31 December 2018; all HPV vaccinations are now recorded on the Australian Immunisation Register.

Source and reference attributes

Origin	Australian Immunisation Register

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* D6 vaccine type

Group E: Participant demographic data items

Demographic analysis is performed on the address attributed to a related cervical test.

Participants may have differing addresses across multiple tests, all of which need to be captured, with the ability to identify a specific address for a given cervical test.

While it is preferable that demographic analyses are performed on place of residence, this may not be known, in which case an alternative address may be used. However, address data items are all specified as *residential* to reflect that this is the appropriate address for demographic analyses.

E1 Residential address
E2 Residential suburb/town/locality
E3 Residential alternative or other names for suburb/town/locality
E4 Residential Australian state/territory
E5 Residential Australian postcode
E6 Residential geocode – latitude
E7 Residential geocode – longitude
E8 Residential geocode – quality
E9 Residential SA1

E1 Residential address

Identifying and definitional attributes

Data item name	Residential address
Definition	The address where an invitee or participant usually resides.
Collection status	Essential

Value domain attributes

Representation class	Text
Data type	String
Format	X[X(179)]
Maximum character length	180

Data item attributes

Collection and usage attributes

Guide for use	Address is a composite of one or more standard address components that describes a low level of geographical/physical description of a location. Used in conjunction with the other high-level address components, that is, Suburb/town/locality, Postcode – Australian, Australian state/territory, and Country, forms a complete geographical/physical address of an invitee or participant. Residential or a postal (mailing) address should be provided for an invitee or participant.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* E1 Residential address

E2 Residential suburb/town/locality

Identifying and definitional attributes

Data item name	Residential suburb/town/locality
Definition	The suburb/town/locality where an invitee or participant usually resides.
Collection status	Essential

Value domain attributes

Representation class	Text
Data type	String
Format	A[A(49)]
Maximum character length	50

Data item attributes

Collection and usage attributes

Guide for use	Suburb/town/locality is the text that represents the full name of the locality contained within the specific address of an invitee or participant. The suburb/town/locality name may be a town, city, suburb, or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of person, organisation, or event. It can be a component of a street or postal address. If there is no data for this item, please refer to E3 ‘Residential alternative or other names for suburb/town/locality’ as this may contain an alternative name by which the locality can be known. Residential or a postal (mailing) address should be provided for an invitee or participant.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* E2 Residential suburb/town/locality

E3 Residential alternative or other names for suburb/town/locality

Identifying and definitional attributes

Data item name	Residential alternative or other names for suburb/town/locality
Definition	The alternative name or other name of the suburb/town/locality (for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where an invitee or participant usually resides.
Collection status	Conditional

Value domain attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data item attributes

Collection and usage attributes

Guide for use	The alternative name or other name of the suburb/town/locality is, for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name, that is contained within the specific address of an invitee or participant. The alternative or other name for a suburb/town/locality may be used instead of, or in addition to, the official or commonly used name of the locality.
Collection methods	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* E3 Residential alternative or other names for suburb/town/locality

E4 Residential Australian state/territory

Identifying and definitional attributes

Data item name	Residential Australian state/territory
Definition	The Australian state or territory in which an invitee or participant usually resides.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Text	
Format	AA[A]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data item attributes

Collection and usage attributes

Guide for use	This data item is important for national reporting by the Australian Institute of Health and Welfare. The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and territories in order of most populated to least populated. Residential or a postal (mailing) address should be provided for an invitee or participant.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* E4 Residential Australian state/territory

E5 Residential Australian postcode

Identifying and definitional attributes

Data item name	Residential Australian postcode
Definition	The code that represents a postal delivery area, aligned with locality, suburb, or place for the address where an invitee or participant usually resides.
Collection status	Essential

Value domain attributes

Representation class	Code
Data type	String
Format	NNNN
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	This data item is important for national reporting by the Australian Institute of Health and Welfare.
Comments	Must accept zero as the leading digit to accommodate all Australian postcodes. Australian Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* E5 Residential Australian postcode

E6 Residential geocode – latitude

Identifying and definitional attributes

Data item name	Residential geocode – latitude
Definition	Latitude of place of residence.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Geospatial
Format	{XN[N][.N(9)]}
Maximum character length	13

Data item attributes

Collection and usage attributes

Guide for use	The 'X' in the latitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number. Latitudes north of the equator are positive and shall be designated by use of the plus sign (+), latitudes south of the equator are negative and shall be designated by use of the minus sign (-). The equator shall be designated by use of the plus sign (+). The format XN[N][.N(9)] allows for 1- or 2-digit latitudes (that is, degree values) with the option of 0 to 9 decimal places (that is, decimal degree values). Usage examples: • +14.091360569 • +2 • –50.321

Source and reference attributes

Origin	Standards Australia 2006. AS 4590–2006 Interchange of client information. Sydney: Standards Australia.
Reference documents	

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* E6 Residential geocode – latitude

E7 Residential geocode – longitude

Identifying and definitional attributes

Data item name	Residential geocode – longitude
Definition	Longitude of place of residence.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Geospatial
Format	{XN[N][.N(9)]}
Maximum character length	13

Data item attributes

Collection and usage attributes

Guide for use	The 'X' in the longitude format symbolises the designator symbol '+' or '-' and should be placed prior to the first number. The designator symbol for longitudes east of Greenwich are positive and shall be designated by use of the plus sign (+), while longitudes west of Greenwich are negative and shall be designated by use of the minus sign (-). The Prime Meridian shall be designated by use of the plus sign (+). The 180th meridian shall be designated by use of the minus sign (-). The format XN[N][.N(9)] allows for 1-, 2- and 3-digit longitudes (that is, degrees) with the option of 0 to 9 decimal places (that is, decimal degrees). Usage examples: • +149.091360569 • +2 • –50.321

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* E7 Residential geocode – longitude

E8 Residential geocode – quality

Identifying and definitional attributes

Data item name	Residential geocode – quality
Definition	A measure of the quality of geocode for place of residence.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	Number
Format	{N}
Maximum character length	1

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* E8 Residential geocode – quality

E9 Residential SA1

Identifying and definitional attributes

Data item name	Residential SA1
Definition	SA1 of place of residence.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	String
Format	{N(11)}
Maximum character length	11

Data item attributes

Collection and usage attributes

Guide for use

SA1 coding structure:

SA1s are identified by an 11-digit fully hierarchical code. The SA1 identifier is a 2-digit code, assigned within an SA2. An SA1 code is only unique within a state/territory when it is preceded by the state/territory identifier.

For example:

State/territory	SA4	SA3	SA2	SA1
N	NN	NN	NNNN	NN

Comments

There are approximately 55,000 SA1s. In aggregate, they cover the whole of Australia without gaps or overlaps.

SA1 can be used in geospatial analyses to assign individuals to any geography that is larger than this, such as SA2, SA3, SA4, or to geographies of interest such as Primary Health Network (PHN).

Source and reference attributes

Origin	1270.0.55.001 – Australian Statistical Geography Standard (ASGS): Volume 1 – Main Structure and Greater Capital City Statistical Areas
Reference documents	

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* E9 Residential SA1

Group F: Correspondence data items

F1 Correspondence type
F2 Correspondence date
F3 Correspondence method
F4 Correspondence failure flag
F5 Correspondence failure date
F6 Correspondence failure type

F1 Correspondence type

Identifying and definitional attributes

Data item name	Correspondence type
Definition	An indication of the type of correspondence between the National Cancer Screening Register and an invitee or participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	A1	Screening invitation
	A2	Screening reminder
	B1	Screening invitation – self-collection eligible
	B2	Screening reminder – self-collection eligible
	C1	Rescreening invitation
	C2	Rescreening reminder
	D1	Rescreening invitation – self-collection eligible
	D2	Rescreening reminder – self-collection eligible

Data item attributes

Collection and usage attributes

Guide for use

There are many types of correspondence between the National Cancer Screening Register and a person. This data item is limited to correspondence related to invitations and reminders to screen and rescreen, and not the many other types of correspondence. This data item is further limited to correspondence sent to invitees and participants (excludes correspondence sent to providers).

Invitations and reminders to screen and rescreen are based on the 'business as usual' protocol of action for the National Cervical Screening Program. 'Screen' refers to a participant's first screen in the program; 'rescreen' refers to any screen that is not their first.

A1 & A2 applies to:

• Invitees turning 25 who have never screened before (or were screened prior to 24 years and 9 months);

• Invitees aged ≥ 25 to <30 who have been newly identified from Medicare enrolment data and who have not been sent an invitation previously; and

• Invitees aged ≥25 to <30 who have never previously had a Pap test.

	B1 & B2 applies to: • Invitees aged ≥30 to <75 who have been newly identified from Medicare enrolment data who have never screened and who have not been sent an invitation previously. C1 & C2 applies to: • Invitees aged ≥ 30 to <75 who have a screening history and are less than 2 years overdue for their next screening test. D1 & D2 applies to: • Invitees aged ≥ 30 to <75 who have a screening history and are 2 years or more overdue for their next screening test.
Comments	Although the eligibility criteria for self-collection were removed from 1 July 2022, invitations and reminders for 'self-collection eligible' invitees have been retained to support analysis of historical data.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F1 Correspondence type

F2 Correspondence date

Identifying and definitional attributes

Data item name	Correspondence date
Definition	The date on which the National Cancer Screening Register sent correspondence to an invitee or participant.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The date of correspondence is the date that the National Cancer Screening Register sent correspondence to an invitee or participant. This may not be the same date that the invitee or participant received the correspondence, as there can be a delay between the date a letter, email or SMS is sent by the National Cancer Screening Register and the date an invitee or participant receives this correspondence.
Comments	This data item relates only to correspondence sent from the National Cancer Screening Register to an invitee or participant as specified in F1 Correspondence type, and does not relate to other correspondence or to correspondence sent to a practitioner or other medical professional.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F2 Correspondence date

F3 Correspondence method

Identifying and definitional attributes

Data item name	Correspondence method
Definition	The method by which National Cancer Screening Register sent correspondence to an invitee or participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Mail
	2	SMS
	3	Email

Data item attributes

Collection and usage attributes

Guide for use	The method by which the correspondence was sent from the National Cancer Screening Register to an invitee or participant as specified in F1 Correspondence type. ‘Mail’ indicates a letter was sent. ‘SMS’ & ‘Email’ indicates that the correspondence was delivered via the portal, and either an SMS or email notification was sent, for example ‘You have received a letter from the NCSR. Please log onto the Portal to view this letter.’
Comments	This data item relates only to correspondence sent by the National Cancer Screening Register to an invitee or participant.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F3 Correspondence method

F4 Correspondence failure flag

Identifying and definitional attributes

Data item name	Correspondence failure flag
Definition	An indication that an invitee or participant's contact details for the purpose of sending correspondence are not valid.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Correspondence failure

Data item attributes

Collection and usage attributes

Guide for use	'Correspondence failure' flag is to be used where an invitee or participant's contact details are found to be invalid for the purpose of the National Cancer Screening Register sending correspondence to an invitee or participant. This may take the form of a letter marked 'return to sender', or an email address that 'bounces'. This flag can be used several times for one invitee or participant, if more than one method of contact is determined to be invalid. In some instances an invitee or participant may only have one method of contact (usually a mailing address). If there are no other valid contact details recorded for an invitee or participant, they will be lost to follow-up/will be unable to be invited to screen or rescreen until such time as new contact information is received.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F4 Correspondence failure flag

F5 Correspondence failure date

Identifying and definitional attributes

Data item name	Correspondence failure date
Definition	Date on which correspondence failure notification was received by the National Cervical Screening Register.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The date a letter marked ‘return to sender’ was received, or the date of an email indication of invalid contact details.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F5 Correspondence failure date

F6 Correspondence failure type

Identifying and definitional attributes

Data item name	Correspondence failure type
Definition	The type of details found to be invalid for the purpose of correspondence between the National Cancer Screening Register and an invitee or participant.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Mailing address
	2	Mobile telephone number (SMS)
	3	Email address

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* F6 Correspondence failure type

Group G: Test type data item

G1 Type of test

G1 Type of test

Identifying and definitional attributes

Data item name	Type of test
Definition	Whether the test of interest is an HPV test, a cytology test (either LBC or conventional Pap test), colposcopy, or histology test.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	A	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	V	HPV test
	C	Cytology test
	P	Colposcopy
	H	Histology test

Data item attributes

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* G1 Type of test

Group H: HPV test data items

H1 HPV test date
H2 HPV test collection method
H3 HPV test specimen site
H4 Reason for HPV test
H5 HPV test result – oncogenic HPV
H6 HPV test result – secondary oncogenic HPV
H7 HPV test type
H8 HPV test medium
H9 HPV test batch information – Control kit lot number
H10 HPV test batch information – Control kit expiry date
H11 HPV test batch information – Cellular (LBC) extraction kit lot number
H12 HPV test batch information – Cellular (LBC) extraction kit expiry date
H13 HPV test batch information – Nucleic acid extraction kit lot number
H14 HPV test batch information – Nucleic acid extraction kit expiry date
H15 HPV test batch information – Amplification kit lot number
H16 HPV test batch information – Amplification kit expiry date
H17 HPV test batch information – Detection kit lot number
H18 HPV test batch information – Detection kit expiry date
H19 HPV test batch information – Wash buffer lot number
H20 HPV test batch information – Wash buffer expiry date

H1 HPV test date

Identifying and definitional attributes

Data item name	HPV test date
Definition	The date a specimen for an HPV test was collected.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	This is an important date, as it is used to determine other features of interest that occur ‘at time of test’, such as age at test, remoteness area and socioeconomic area of residence at time of test, HPV vaccination status at time of test, etcetera.
Collection methods	For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date, and a laboratory transmission date. The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected. If test collection date is unknown, another date can be used instead, and will be treated as the test date. The order of priority for an alternative date is: • test request date • laboratory receipt date • laboratory report date • laboratory transmission date.
Comments	The National Cancer Screening Register needs to collect all dates associated with a test (test request date, test collection date, laboratory receipt date, laboratory report date and laboratory transmission date) to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H1 HPV test date

H2 HPV test collection method

Identifying and definitional attributes

Data item name	HPV test collection method
Definition	An indication of whether an HPV test sample is collected by a practitioner or self-collected.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	A1	Practitioner-collected sample
	A2	Self-collected sample

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H2 HPV test collection method

H3 HPV test specimen site

Identifying and definitional attributes

Data item name	HPV test specimen site
Definition	An indication as to the site from which the specimen was collected.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B0	Not stated
	B1	Cervical
	B2	Vaginal
	B3	Other gynaecological site
Comments	Self-collected samples should have an HPV test specimen site of B2 '*Vaginal'* rather than B1 '*Cervical'*.	

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H3 HPV test specimen site

H4 Reason for HPV test

Identifying and definitional attributes

Data item name	Reason for HPV test
Definition	The reason why an HPV test is performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[XXX]	
Maximum character length	5	
Permissible values	**Value**	**Meaning**
	C1	Primary screening HPV test
	C2	Follow-up HPV test (repeat HPV test after intermediate risk result)
	C3i	Co-test – test of cure
	C3ii	Co-test – investigation of signs or symptoms
	C3iii	Co-test – other, as recommended in guidelines
	C4	Other
Comments	‘C2’ originally indicated it should be used for repeat HPV tests after an intermediate risk result and repeat HPV tests after an unsatisfactory test. However, since early 2018, pathology laboratories have used ‘C2’ for repeat HPV tests after an intermediate risk result ONLY. Repeat HPV tests after an unsatisfactory test are allocated the same ‘Reason for HPV test’ as the original test. This data item has been updated accordingly.	

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H4 Reason for HPV test

H5 HPV test result – oncogenic HPV

Identifying and definitional attributes

Data item name	HPV test result – oncogenic HPV
Definition	The result of an HPV test for oncogenic HPV types.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[XXX]	
Maximum character length	5	
Permissible values	**Value**	**Meaning**
	DU	Unsatisfactory
	D0	Oncogenic HPV not detected
	D1	HPV 16/18 detected
	D1i	Type 16 detected
	D1ii	Type 18 detected
	D1iii	Type 18/45 detected
	D2	Oncogenic HPV (not 16/18) detected
	D2i	One or more of the following types detected: 31, 33, 45, 52, or 58
	D2ii	One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68

Data item attributes

Collection and usage attributes

Guide for use

‘DU Unsatisfactory’ indicates that the HPV test was unsatisfactory.

‘D0 Oncogenic HPV not detected’ indicates that no oncogenic HPV types were detected.

‘D1 HPV 16/18 detected’ indicates that one or more of the oncogenic HPV types 16 or 18 were detected. ‘1i Type 16 detected’ indicates that the oncogenic HPV type 16 was detected.

‘D1ii Type 18 detected’ indicates that the oncogenic HPV type 18 was detected.

‘D1iii Type 18/45 detected’ indicates that oncogenic HPV types 18 or 45 were detected (specific to HPV tests that cannot distinguish between the detection of 18 and 45).

‘D2 Oncogenic HPV (not 16/18) detected’ indicates that one or more of the oncogenic HPV types 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, or 68 were detected.

	‘D2i One or more of the following types detected: 31, 33, 45, 52, or 58’ indicates that one or more of the oncogenic HPV types 31, 33, 45, 52, or 58 were detected. ‘D2ii One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68’ indicates that one or more of the oncogenic HPV types 35, 39, 51, 56, 59, 66, or 68 were detected.
Collection methods	The National Cancer Screening Register uses an algorithm to determine the most serious HPV type for each HPV test, which is recorded in this data item.
Comments	This data item combines three data items from the previous version of this data dictionary – H5 HPV test result – oncogenic HPV, H6 Secondary HPV test result – HPV 16/18 detected and H7 Secondary HPV test result – oncogenic HPV (not 16/18) detected.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H5 HPV test result – oncogenic HPV

H6 HPV test result – secondary oncogenic HPV

Identifying and definitional attributes

Data item name	HPV test result – secondary oncogenic HPV
Definition	The secondary result of an HPV test for oncogenic HPV types.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AAN[XXX}]}	
Maximum character length	6	
Permissible values	**Value**	**Meaning**
	DS1	HPV 16/18 detected
	DS1i	Type 16 detected
	DS1ii	Type 18 detected
	DS1iii	Type 18/45 detected
	DS2	Oncogenic HPV (not 16/18) detected
	DS2i	One or more of the following types detected: 31, 33, 45, 52, or 58
	DS2ii	One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68

Data item attributes

Collection and usage attributes

Guide for use

While the most serious HPV type for each HPV test is recorded in H5 ‘HPV test result – oncogenic HPV’, more rarely a secondary HPV type is detected by the pathology laboratory. This data item allows the collection of this secondary oncogenic HPV type.

‘DS1 HPV 16/18 detected’ indicates that one or more of the oncogenic HPV types 16 or 18 were detected as the secondary HPV type.

‘DS1i Type 16 detected’ indicates that the oncogenic HPV type 16 was detected as the secondary HPV type.

‘DS1ii Type 18 detected’ indicates that the oncogenic HPV type 18 was detected as the secondary HPV type.

‘DS1iii Type 18/45 detected’ indicates that one or more of the oncogenic HPV types 18 or 45 were detected (specific to HPV tests that cannot distinguish between the detection of 18 and 45).
‘DS2 Oncogenic HPV (not 16/18) detected’ indicates that one or more of the oncogenic HPV types 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, or 68 were detected as the secondary HPV type.

	‘DS2i One or more of the following types detected: 31, 33, 45, 52, or 58’ indicates that one or more of the oncogenic HPV types 31, 33, 45, 52, or 58 were detected as the secondary type. ‘DS2ii One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68’ indicates that one or more of the oncogenic HPV types 35, 39, 51, 56, 59, 66, or 68 were detected as the secondary HPV type.
Comments	In reality, neither ‘DS1 HPV 16/18 detected’ nor ‘DS1i Type 16 detected’ will ever be valid values for this data item as these will always be the most serious HPV type recorded at H5 ‘HPV test result – oncogenic HPV’. They have been included here to allow the permissible values for the data item to align with permissible values for H5 ‘HPV test result – oncogenic HPV’.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H6 HPV test result – secondary oncogenic HPV

H7 HPV test type

Identifying and definitional attributes

Data item name	HPV test type
Definition	The type of test used to determine the oncogenic HPV test result.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[XXX]	
Maximum character length	5	
Permissible values	**Value**	**Meaning**
	T0	Not stated
	T1i	Qiagen – Hybrid capture II
	T2i	Roche – cobas 4800
	T2ii	Roche – cobas 6800
	T2iii	Roche – cobas 8800
	T3i	Abbott – m2000
	T3ii	Abbott – Alinity m
	T4i	Becton Dickinson – Onclarity
	T5i	Cepheid – Xpert
	T6i	Hologic – Cervista
	T6ii	Hologic – Aptima
	T7i	Seegene – Anyplex
	T8i	Genera – PapType
	T9i	Euroimmun – Euroarray
	T999	Other

Data item attributes

Collection and usage attributes

Guide for use	HPV test types have been grouped according to manufacture, with the specific platforms listed. This will provide detailed information about HPV test type for quality monitoring of this screening test, as well as enabling additional HPV test types to be added in the future.
Comments	The HPV test types listed here will be tests that are registered on the ARTG for HPV testing of cervical samples. It is not an indication of which tests are suitable for use in the National Cervical Screening Program. Only those HPV tests that meet the requirements set out in the NPAAC Standards and Performance Measures for cervical screening should be used in the National Cervical Screening Program. Tests that do not meet the

	requirements now may meet them in future and therefore all tests listed on the ARTG will be coded. The HPV tests currently listed are tests which were known to be registered on the ARTG at the time of developing the data dictionary. There may be others that are on the ARTG and were not identified at the time of development or will be added in future. Any tests that are listed on the ARTG will be added to the data dictionary if the National Cervical Screening Program is informed.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* H7 HPV test type

H8 HPV test medium

Identifying and definitional attributes

Data item name	HPV test medium
Definition	Information about the medium in which a sample is collected for an HPV test.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[N]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	F0	Not stated
	F1	PreservCyt Solution
	F2	SurePath medium
	F97	Other commercial self-collection device
	F98	Specimen transport medium
	F99	Flocked or cotton swab

Data item attributes

Collection and usage attributes

Guide for use	This data item is intended to provide information about the sample that is provided, and whether it is suitable for HPV testing and reflex LBC testing, or whether it is suitable only for HPV testing, with a second sample required for reflex LBC testing (if indicated). Values ≥90 will be suitable for HPV testing only, either due the sample being self-collected, or due to an inappropriate sampling device or sampling media being used.
Collection methods	If the head of a swab is received by the laboratory in sampling media such as PreservCyt or SurePath, then it must be coded as ‘99 Flocked or cotton swab’.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H8 HPV test sample

H9 HPV test batch information – Control kit lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Control kit lot number
Definition	Lot number from the control kit.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H9 HPV test batch information – Control kit lot number

H10 HPV test batch information – Control kit expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Control kit expiry date
Definition	The expiry date of the control kit.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H10 HPV test batch information – Control kit expiry date

H11 HPV test batch information – Cellular (LBC) extraction kit lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Cellular (LBC) extraction kit lot number
Definition	Lot number from the cellular (LBC) extraction kit.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H11 HPV test batch information – Cellular (LBC) extraction kit lot number

H12 HPV test batch information – Cellular (LBC) extraction kit expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Cellular (LBC) extraction kit expiry date
Definition	The expiry date of the cellular (LBC) extraction kit.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H12 HPV test batch information – Cellular (LBC) extraction kit expiry date

H13 HPV test batch information – Nucleic acid extraction kit lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Nucleic acid extraction kit lot number
Definition	Lot number from the nucleic acid extraction kit.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H13 HPV test batch information – Nucleic acid extraction kit lot number

H14 HPV test batch information – Nucleic acid extraction kit expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Nucleic acid extraction kit expiry date
Definition	The expiry date of the nucleic acid extraction kit.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H14 HPV test batch information – Nucleic acid extraction kit expiry date

H15 HPV test batch information – Amplification kit lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Amplification kit lot number
Definition	Lot number from the amplification kit.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H15 HPV test batch information – Amplification kit lot number

H16 HPV test batch information – Amplification kit expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Amplification kit expiry date
Definition	The expiry date of the amplification kit.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H16 HPV test batch information – Amplification kit expiry date

H17 HPV test batch information – Detection kit lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Detection kit lot number
Definition	Lot number from the detection kit.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H17 HPV test batch information – Detection kit lot number

H18 HPV test batch information – Detection kit expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Detection kit expiry date
Definition	The expiry date of the detection kit.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H18 HPV test batch information – Detection kit expiry date

H19 HPV test batch information – Wash buffer lot number

Identifying and definitional attributes

Data item name	HPV test batch information – Wash buffer lot number
Definition	Lot number from the wash buffer.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H19 HPV test batch information – Wash buffer lot number

H20 HPV test batch information – Wash buffer expiry date

Identifying and definitional attributes

Data item name	HPV test batch information – Wash buffer expiry date
Definition	The expiry date of the wash buffer.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	For each of these codes one or more Lot numbers and associated expiry dates need to be reported. The fields need to be able to accept both letters and numbers as well as N/A (in the case of LBC extraction on a self-collected sample). Where a 'kit' includes reagents for multiple testing steps the Lot numbers and expiry dates should be repeated for each of the codes.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* H20 HPV test batch information – Wash buffer expiry date

Group I: Cytology test data items

I1 Cytology test date
I2 Cytology test specimen type
I3 Cytology test specimen site
I4 Reason for cytology test
I5 Cytology test squamous cytology cell analysis
I6 Cytology test endocervical (glandular) cytology cell analysis
I7 Cytology test other/non-cervical cytology cell analysis
I8 Cytology test result

I1 Cytology test date

Identifying and definitional attributes

Data item name	Cytology test date
Definition	The date when a specimen for a cytology test was collected.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	This is an important date, as it is used to determine other features of interest that occur 'at time of test', such as age at test, remoteness area and socioeconomic area of residence at time of test, HPV vaccination status at time of test, etcetera.
Collection methods	For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date, and a laboratory transmission date. The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected. If test collection date is unknown, another date can be used instead, and will be treated as the test date. The order of priority for an alternative date is: • test request date • laboratory receipt date • laboratory report date • laboratory transmission date.
Comments	The National Cervical Screening Register needs to collect all dates associated with a specimen so that analyses can be performed to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date. Collected by pathology laboratories. If the cytology test is a reflex LBC, the cytology test date will be the same as the HPV test date.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* I1 Cytology test date

I2 Cytology test specimen type

Identifying and definitional attributes

Data item name	Cytology test specimen type
Definition	An indication as to whether the cytology specimen is liquid-based cytology (LBC) or a conventional Pap test.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	A0	Not stated
	A1	Conventional smear
	A2	Liquid-based specimen
	A3	Conventional smear and liquid-based specimen

Data item attributes

Collection and usage attributes

Guide for use	While the renewed National Cervical Screening Program uses reflex LBC as part of the screening test rather than a conventional Pap test, it is likely that some participants will have a conventional Pap test after the renewed National Cervical Screening Program commences, and it is important that the National Cancer Screening Register can record details of these tests.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* I2 Cytology test specimen type

I3 Cytology test specimen site

Identifying and definitional attributes

Data item name	Cytology test specimen site
Definition	An indication as to the site from which the sample was collected.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B0	Not stated
	B1	Cervical
	B2	Vaginal
	B3	Other gynaecological site

Data item attributes

Collection and usage attributes

Guide for use	To code a vault smear, record B2 for item 'I3 Cytology test – specimen site' and E- for item 'I6 Cytology test – endocervical (glandular) cell analysis'
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* I3 Cytology test specimen site

I4 Reason for cytology test

Identifying and definitional attributes

Data item name	Reason for cytology test
Definition	The reason why a cytology test is performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX[XXX]	
Maximum character length	5	
Permissible values	**Value**	**Meaning**
	C1	Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test
	C2	Cytology after detection of oncogenic HPV in self-collected sample
	C3	Reflex LBC after detection of oncogenic HPV in follow-up HPV test
	C4	Cytology at colposcopy
	C5i	Co-test – test of cure
	C5ii	Co-test – investigation of signs or symptoms
	C5iii	Co-test – other, as recommended in guidelines
	C6	Other
	CP	Conventional Pap test to screen for cervical cancer precursors

Data item attributes

Collection and usage attributes

Guide for use	'Conventional Pap test to screen for cervical cancer precursors' has been allocated to a code of CP, as it is anticipated that, in time, this code may no longer be required, and will be subsequently dropped.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* I4 Reason for cytology test

I5 Cytology test squamous cytology cell analysis

Identifying and definitional attributes

Data item name	Cytology test squamous cytology cell analysis
Definition	The squamous result of the cytology analysis.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes
	S2	Possible low-grade squamous intraepithelial lesion (LSIL)
	S3	Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)
	S4	Possible high-grade squamous intraepithelial lesion (HSIL)
	S5	High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3)
	S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/invasion
	S7	Squamous carcinoma
	SU	Unsatisfactory for evaluation

Data item attributes

Collection and usage attributes

Guide for use

S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes

Record this code where there is no abnormality detected and cell numbers and preservation are satisfactory.

S2 Possible low-grade squamous intraepithelial lesion (LSIL)

This code encompasses changes in squamous cells where the reporting cytologist/pathologist believes the changes may represent a low-grade squamous intraepithelial lesion, but no definitive changes are present.

S3 Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN 1)

	Record this code where the cytologist/pathologist observes changes which would have been described as HPV effect or CIN 1 (that is, incorporates HPV effect and/or CIN 1). S4 Possible high-grade squamous intraepithelial lesion (HSIL) Record this code when the presence of a high-grade squamous abnormality, such as CIN 2, CIN 3 or SCC is suspected, but the changes are insufficient to justify a confident cytological prediction of a high-grade lesion. S5 High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3) Record this code where the changes observed would have previously been described as CIN 2 or CIN 3 (that is, code S5 incorporates CIN 2 and CIN 3.) S6 High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/invasion Record this code when a definite HSIL is present, but the possibility of invasion cannot be excluded. S7 Squamous carcinoma Record this when squamous carcinoma is present. SU Unsatisfactory for evaluation Record this code if the specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by inflammation/blood/degenerate cells.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* I5 Cytology test squamous cytology cell analysis

I6 Cytology test endocervical (glandular) cytology cell analysis

Identifying and definitional attributes

Data item name	Cytology test endocervical (glandular) cytology cell analysis
Definition	The endocervical result of the cytology analysis.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	E0	No endocervical component
	E-	Not applicable: vault smear/previous hysterectomy
	E1	Endocervical component present. No abnormality or only reactive changes
	E2	Atypical endocervical cells of uncertain significance
	E3	Possible high-grade endocervical glandular lesion
	E4	Endocervical adenocarcinoma-in-situ
	E5	Endocervical adenocarcinoma-in-situ with possible microinvasion/invasion
	E6	Endocervical adenocarcinoma
	EU	Due to unsatisfactory nature of the specimen, no assessment has been made

Data item attributes

Collection and usage attributes

Guide for use

E0 No endocervical component

Record this code when there is no endocervical component.

E- Not applicable: vault smear/previous hysterectomy

Record this code when it is a vault smear or there has been a previous total hysterectomy.

E1 Endocervical component present. No abnormality or only reactive changes

Record this code if no abnormality is detected and cell numbers and preservation is satisfactory.

E2 Atypical endocervical cells of uncertain significance

	Record this code when abnormal glandular cells are identified in a cervical cytology sample, but where the degree of abnormality is not sufficient for a diagnosis of adenocarcinoma-in-situ to be made. E3 Possible high-grade endocervical glandular lesion Record this code if adenocarcinoma-in-situ is suspected but a confident prediction is not possible. E4 Endocervical adenocarcinoma-in-situ Record this code when the reporting cytologist/pathologist is confident of the presence of an adenocarcinoma-in-situ. E5 Endocervical adenocarcinoma-in-situ with possible microinvasion /invasion Record this code when a definite adenocarcinoma-in-situ is present, but the possibility of invasion cannot be excluded. E6 Endocervical adenocarcinoma Record this code when a definite adenocarcinoma is present. EU Due to the unsatisfactory nature of the cytology specimen, no assessment has been made. Unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a cytology specimen is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding and should be coded to reflect the abnormality detected.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* I6 Cytology test endocervical (glandular) cytology cell analysis

I7 Cytology test other/non-cervical cytology cell analysis

Identifying and definitional attributes

Data item name	Cytology test other/non-cervical cytology cell analysis
Definition	The other/non-cervical result from the cytology analysis.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	O1	No other abnormal cells.
	O2	Atypical endometrial cells of uncertain significance
	O3	Atypical glandular cells of uncertain significance – site unknown
	O4	Possible endometrial adenocarcinoma
	O5	Possible high-grade lesion – non-cervical
	O6	Malignant cells – uterine body
	O7	Malignant cells – vagina
	O8	Malignant cells – ovary
	O9	Malignant cells – other
	OU	Due to the unsatisfactory nature of the specimen, no assessment has been made

Data element attributes

Collection and usage attributes

Guide for use

O1 No other abnormal cells

Record this code where there is no abnormality detected and cell numbers and preservation are satisfactory.

O2 Atypical endometrial cells of uncertain significance

Record this code where there are changes in endometrial cells, but insufficient to raise the possibility of an endometrial carcinoma.

O3 Atypical glandular cells of uncertain significance – site unknown

Record this code where there is uncertainty about whether the abnormal cells were endocervical or endometrial in origin. Use where changes are insufficient to raise the possibility of a neoplasm but are beyond a reactive process.

O4 Possible endometrial adenocarcinoma

	Record this code if endometrial adenocarcinoma is suspected, but a confident prediction is not possible. O5 Possible high-grade lesion – non cervical Record this code if abnormal cells are present but do not appear to be cervical in origin. O6 Malignant cells – uterine body Record this code when malignant endometrial cells are present. O7 Malignant cells – vagina Record this code if malignant cells are present in a vaginal or vault cytology specimen. O8 Malignant cells – ovary Record this code if malignant ovarian cells are present. O9 Malignant cells – other Record this code if malignant cells are present which belong to none of the above categories. OU Due to the unsatisfactory nature of the cytology specimen, no assessment has been made Record this code when the specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a specimen is suboptimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding and should be coded to reflect the abnormality detected.
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* I7 Cytology test other/non-cervical cytology cell analysis

I8 Cytology test result

Identifying and definitional attributes

Data item name	Cytology test result
Definition	The overall cytology result assigned to a cytology test.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	DU	Unsatisfactory
	D1	Negative
	D2	pLSIL/LSIL
	D3	pHSIL/HSIL+
	D4	Any glandular abnormality

Data item attributes

Collection and usage attributes

Guide for use

When cytology takes the form of a reflex LBC to be combined with an HPV test to assign a screening episode result, squamous and endocervical (glandular) cytology test results are summarised into a single LBC test result to allow a risk of significant cervical abnormality to be allocated, and a clinical recommendation to be determined according to the clinical guidelines. The clinical guidelines include LBC test results of ‘Unsatisfactory’, ‘Negative’, ‘pLSIL/LSIL’, ‘pHSIL/HSIL+’, and ‘Any glandular abnormality’.

These LBC test results are defined as:

- Unsatisfactory: I5 = SU and I6 = (EU or E- or E0 or E1)
- Negative: I5 = S1 and I6 = (EU or E- or E0 or E1)
- pLSIL/LSIL: I5 = S2 or S3 and I6 < E2
- pHSIL/HSIL+: I5 = S4 or S5 or S6 or S7 and I6 < E2
- Any glandular abnormality: I5 = SU or S1 or S2 or S3 or S4 or S5 or S6 or S7 and I6 = E2 or E3 or E4 or E5 or E6

Note that according to these LBC test results definitions, a result of I5 = S7 and I6 = E2 will have a single LBC test result of ‘Any glandular abnormality’, not ‘pHSIL/HSIL+’.

Comments

Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* I8 Cytology test result

Group J: Screening episode data items

J1 Primary screening episode commencement date
J2 Primary screening episode completion date
J3 Primary screening episode result
J4 Primary screening episode test risk of significant cervical abnormality
J5 Primary screening episode participant risk of significant cervical abnormality
J6 Primary screening episode recommendation
J7 First follow-up episode commencement date
J8 First follow-up episode completion date
J9 First follow-up episode result
J10 First follow-up episode test risk of significant cervical abnormality
J11 First follow-up episode participant of significant cervical abnormality
J12 First follow-up episode recommendation
J13 Second follow-up episode commencement date
J14 Second follow-up episode completion date
J15 Second follow-up episode result
J16 Second follow-up episode test risk of significant cervical abnormality
J17 Second follow-up episode participant of significant cervical abnormality
J18 Second follow-up episode recommendation

J1 Primary screening episode commencement date

Identifying and definitional attributes

Data item name	Primary screening episode commencement date
Definition	The date the primary screening episode commenced.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The primary screening episode date is the date on which the sample was collected for the primary screening HPV test. Where the HPV test is on a self-collected sample and a second sample for LBC collected by a healthcare provider, the primary screening episode date should be the date of the HPV test and not the LBC test.
Collection methods	This date can be derived by H1 ‘HPV test date’ where H4 ‘Reason for HPV test’ = C1

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J1 Primary screening episode commencement date

J2 Primary screening episode completion date

Identifying and definitional attributes

Data item name	Primary screening episode completion date
Definition	The date the primary screening episode was completed.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The primary screening episode completion date is the date on which there was a valid HPV test and a valid LBC test (where this is required) to allow a risk rating to be assigned. For most participants the primary screening episode completion date will be identical to the primary screening episode commencement date. Where a second sample for LBC needs to be collected by a healthcare provider, either because of an unsatisfactory LBC test or because the HPV test was on a self-collected sample, there can be some time between the primary screening episode commencement date and the primary screening episode completion date.
Collection methods	This is a derived date.
Comments	This data item should be used when determining time between primary screening episode and follow-up events.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J2 Primary screening episode completion date

J3 Primary screening episode result

Identifying and definitional attributes

Data item name	Primary screening episode result
Definition	The overall primary screening episode result that is a combination of an HPV test and an LBC test (where this is required).
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	X[XX]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	U	Unsatisfactory HPV test
	1	Oncogenic HPV not detected
	2.X	Oncogenic HPV (not 16/18) + LBC not performed
	2.0	Oncogenic HPV (not 16/18) + unsatisfactory LBC
	2.1	Oncogenic HPV (not 16/18) + negative LBC
	2.2	Oncogenic HPV (not 16/18) + pLSIL/LSIL LBC
	2.3	Oncogenic HPV (not 16/18) + pHSIL/HSIL+ LBC
	2.4	Oncogenic HPV (not 16/18) + any glandular abnormality LBC
	3.X	HPV16/18 + LBC not performed
	3.0	HPV16/18 + unsatisfactory LBC
	3.1	HPV16/18 + negative LBC
	3.2	HPV16/18 + pLSIL/LSIL LBC
	3.3	HPV16/18 + pHSIL/HSIL+ LBC
	3.4	HPV16/18 + any glandular abnormality LBC

Data item attributes

Collection and usage attributes

Guide for use	An HPV test is the primary screening test of the renewed National Cervical Screening Program. However, this is used in conjunction with partial genotyping of the HPV test to distinguish between oncogenic HPV 16/18 and oncogenic HPV (not 16/18), as well as triage of all oncogenic HPV results (16/18 and not 16/18) with reflex liquid-based cytology (LBC). This means that the overall screening episode result is a combination of the primary screening HPV test result and the LBC result (where performed). It also means that it is possible for a participant to have an incomplete screening episode (and therefore no overall result or risk rating assigned). This can be either due to an unsatisfactory

	HPV test or LBC test (which was not repeated), or due to a participant with a self-collected sample testing positive for HPV who then did not have a sample collected for the reflex LBC test. Complete primary screening episode results are comprised of an HPV test result and (unless the result was 'oncogenic HPV not detected') a reflex LBC test result.
Collection methods	Primary screening HPV test results and LBC test results are derived from the HPV test and cytology test sections.
Comments	Categories that include 'not performed' or 'unsatisfactory' can change as tests that are required are performed. The primary screening episode is not complete until receipt of a valid test.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J3 Primary screening episode result

J4 Primary screening episode test risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Primary screening episode test risk of significant cervical abnormality
Definition	Risk of significant cervical abnormality determined from a primary screening episode result, comprised of a primary HPV test with partial genotyping and LBC triage (where this is required).
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	RU	Unsatisfactory
	R1	Low risk
	R2	Intermediate risk
	R3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The primary screening episode result is used to assign a risk of significant cervical abnormality. This is based on the test results from this screening episode only and does not take into consideration previous test results or other screening history.
Collection methods	**Test risk** is allocated as follows: RU Unsatisfactory: J3 ‘Primary screening episode result’ = U or 2.0 R1 Low risk: J3 ‘Primary screening episode result’ = 1 R2 Intermediate risk: J3 ‘Primary screening episode result’ = 2.1 or 2.2 R3 Higher risk: J3 ‘Primary screening episode result’ = 2.3, 2.4, 3.X, 3.0, 3.1, 3.2, 3.3, or 3.4. A test risk is unable to be assigned for 2.X.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J4 Primary screening episode risk of significant cervical abnormality

J5 Primary screening episode participant risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Primary screening episode participant risk of significant cervical abnormality
Definition	Primary screening episode risk of significant cervical abnormality of a participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AAX	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	PRU	Unsatisfactory
	PR1	Low risk
	PR2	Intermediate risk
	PR3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The primary screening episode result, previous test results, and screening history are used to assign a risk of significant cervical abnormality of a participant.
Collection methods	Determined by pathology laboratories and the NCSR as per clinical management guidelines and incorporating screening history.

Relational attributes

Related metadata reference	New data item

J6 Primary screening episode recommendation

Identifying and definitional attributes

Data item name	Primary screening episode recommendation
Definition	The appropriate management based on the primary screening episode risk of significant cervical abnormality of a participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	M0	No recommendation
	M1	Rescreen in 5 years
	M2	Rescreen in 3 years
	M3	Repeat HPV test in 12 months
	M4	Co-test in 12 months
	M5	Retest in 6 weeks
	M6	Refer for colposcopic assessment
	M7	Test taken at time of colposcopy, no recommendation
	M8	Discharge from program
	M9	Other management recommendation
	MS	Symptomatic – clinical management required
	MP	Rescreen in 2 years

Data item attributes

Collection and usage attributes

Collection methods	Determined by pathology laboratories as per clinical management guidelines and incorporating screening history.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J5 Primary screening episode recommendation

J7 First follow-up episode commencement date

Identifying and definitional attributes

Data item name	First follow-up episode commencement date
Definition	The date the first follow-up episode commenced.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The follow-up episode date is the date on which the sample was collected for the first follow-up HPV test. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode commencement date is specific to the first follow-up episode.
Collection methods	This date can be derived by H1 ‘HPV test date’ where H4 ‘Reason for HPV test’ = 2.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J6 Follow-up episode commencement date

J8 First follow-up episode completion date

Identifying and definitional attributes

Data item name	First follow-up episode completion date
Definition	The date the first follow-up episode was completed.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The first follow-up episode completion date is the date on which there was a valid HPV test and a valid LBC test (where this is required) to allow a risk rating to be assigned. For most participants the first follow-up episode completion date will be identical to or similar to the first follow-up episode commencement date. Where a second sample for LBC needs to be collected by a healthcare provider, either because of an unsatisfactory LBC test or because the HPV test was on a self-collected sample, there can be some time between the first follow-up episode commencement date and the first follow-up episode completion date. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode completion date is specific to the first follow-up episode.
Collection methods	This is a derived date.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J7 Follow-up episode completion date

J9 First follow-up episode result

Identifying and definitional attributes

Data item name	First follow-up episode result
Definition	The first follow-up episode result is a combination of an HPV test and an LBC test (where this is performed), where the HPV test is a repeat HPV test performed 12 months after the screening episode.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{X[XX]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	U	Unsatisfactory HPV test
	1	Oncogenic HPV not detected
	2.X	Oncogenic HPV (not 16/18) + LBC not performed
	2.0	Oncogenic HPV (not 16/18) + unsatisfactory LBC
	2.1	Oncogenic HPV (not 16/18) + negative LBC
	2.2	Oncogenic HPV (not 16/18) + pLSIL/LSIL LBC
	2.3	Oncogenic HPV (not 16/18) + pHSIL/HSIL+ LBC
	2.4	Oncogenic HPV (not 16/18) + any glandular abnormality LBC
	3.X	HPV16/18 + LBC not performed
	3.0	HPV16/18 + unsatisfactory LBC
	3.1	HPV16/18 + negative LBC
	3.2	HPV16/18 + pLSIL/LSIL LBC
	3.3	HPV16/18 + pHSIL/HSIL+ LBC
	3.4	HPV16/18 + any glandular abnormality LBC

Data item attributes

Collection and usage attributes

Guide for use	The overall first follow-up episode result is a combination of the first follow-up HPV test result and the LBC result (where performed). Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode result is specific to the first follow-up episode.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk

	screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J8 Follow-up episode result

J10 First follow-up episode test risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	First follow-up episode test risk of significant cervical abnormality
Definition	Risk of significant cervical abnormality determined from a first follow-up episode result, comprised of a primary HPV test with partial genotyping and LBC triage.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AX}	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	RU	Unsatisfactory
	R1	Low risk
	R2	Intermediate risk
	R3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The first follow-up episode result is used to assign a risk of significant cervical abnormality. This is based on the test results from this follow-up episode only and does not take into consideration previous test results, screening history, or individual factors that increase a participant's risk of significant cervical abnormality. The risk of cervical abnormality based on test results is **not** adjusted for participants who were overdue for screening by at least 2 years prior to their intermediate risk screening episode, are Aboriginal and/or Torres Strait Islander, or are aged 50 or older when assigning a test risk of significant cervical abnormality. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode test risk of significant cervical abnormality is specific to the first follow-up episode.
Collection methods	For the first follow-up HPV test after intermediate risk screening episode, test risk should be allocated as: RU Unsatisfactory: J8 'Follow-up episode result' = U or 2.0 R1 Low risk: J8 'Follow-up episode result' = 1

	R2 Intermediate risk: J8 ‘Follow-up episode result’ = 2.1 or 2.2 R3 Higher risk: J8 ‘Follow-up episode result’ = 2.3, 2.4, 3.X, 3.0, 3.1, 3.2, 3.3, or 3.4. A test risk is unable to be assigned for 2.X.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J9 Follow-up episode risk of significant cervical abnormality

J11 First follow-up episode participant risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	First follow-up episode participant risk of significant cervical abnormality
Definition	First follow-up episode risk of significant cervical abnormality of a participant.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AAX}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	PRU	Unsatisfactory
	PR1	Low risk
	PR2	Intermediate risk
	PR3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The first follow-up episode result, previous test results, screening history, and individual factors that increase a participant's risk of significant cervical abnormality are used to assign a risk of significant cervical abnormality of a participant. The risk of cervical abnormality based on test results is adjusted for participants who were overdue for screening by at least 2 years prior to their intermediate risk screening episode, are Aboriginal and/or Torres Strait Islander, or are aged 50 or older when assigning a participant's risk of significant cervical abnormality. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode participant risk of significant cervical abnormality is specific to the first follow-up episode.
Collection methods	Determined by pathology laboratories and the NCSR as per clinical management guidelines and incorporating screening history. Note: for the first follow-up HPV test after an intermediate risk primary screening episode, participants can only remain at intermediate risk if they were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not

	Aboriginal and/or Torres Strait Islander, and are not aged 50 or older. These participants should be considered higher risk.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J12 First follow-up episode recommendation

Identifying and definitional attributes

Data item name	First follow-up episode recommendation
Definition	The appropriate management based on the first follow-up episode risk of significant cervical abnormality of a participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	M0	No recommendation
	M1	Rescreen in 5 years
	M2	Rescreen in 3 years
	M3	Repeat HPV test in 12 months
	M4	Co-test in 12 months
	M5	Retest in 6 weeks
	M6	Refer for colposcopic assessment
	M7	Test taken at time of colposcopy, no recommendation
	M8	Discharge from program
	M9	Other management recommendation
	MS	Symptomatic – clinical management required
	MP	Rescreen in 2 years

Data item attributes

Collection and usage attributes

Guide for use	Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode recommendation is specific to the first follow-up episode.
Collection methods	Determined by pathology laboratories as per clinical management guidelines and incorporating screening history.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* J10 Follow-up episode recommendation

J13 Second follow-up episode commencement date

Identifying and definitional attributes

Data item name	Second follow-up episode commencement date
Definition	The date the second follow-up episode commenced.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The second follow-up episode date is the date on which the sample was collected for the second follow-up HPV test. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode commencement date is specific to the second follow-up episode.
Collection methods	This date can be derived by H1 ‘HPV test date’ where H4 ‘Reason for HPV test’ = 2 if J7 ‘First follow-up episode commencement date’ is not null.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J14 Second follow-up episode completion date

Identifying and definitional attributes

Data item name	Second follow-up episode completion date
Definition	The date the second follow-up episode was completed.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The second follow-up episode completion date is the date on which there was a valid HPV test and a valid LBC test (where this is required) to allow a risk rating to be assigned. For most participants the second follow-up episode completion date will be identical to or similar to the second follow-up episode commencement date. Where a second sample for LBC needs to be collected by a healthcare provider, either because of an unsatisfactory LBC test or because the HPV test was on a self-collected sample, there can be some time between the follow-up episode commencement date and the follow-up episode completion date. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode completion date is specific to the second follow-up episode.
Collection methods	This is a derived date.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J15 Second follow-up episode result

Identifying and definitional attributes

Data item name	Second follow-up episode result
Definition	The second follow-up episode result is a combination of an HPV test and an LBC test (where this is performed), where the HPV test is a repeat HPV test performed 12 months after the first follow-up episode.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{X[XX]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	U	Unsatisfactory HPV test
	1	Oncogenic HPV not detected
	2.X	Oncogenic HPV (not 16/18) + LBC not performed
	2.0	Oncogenic HPV (not 16/18) + unsatisfactory LBC
	2.1	Oncogenic HPV (not 16/18) + negative LBC
	2.2	Oncogenic HPV (not 16/18) + pLSIL/LSIL LBC
	2.3	Oncogenic HPV (not 16/18) + pHSIL/HSIL+ LBC
	2.4	Oncogenic HPV (not 16/18) + any glandular abnormality LBC
	3.X	HPV16/18 + LBC not performed
	3.0	HPV16/18 + unsatisfactory LBC
	3.1	HPV16/18 + negative LBC
	3.2	HPV16/18 + pLSIL/LSIL LBC
	3.3	HPV16/18 + pHSIL/HSIL+ LBC
	3.4	HPV16/18 + any glandular abnormality LBC

Data item attributes

Collection and usage attributes

Guide for use	The overall second follow-up episode result is a combination of the second follow-up HPV test result and the LBC result (where performed). Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode result is specific to the second follow-up episode.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected

	with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J16 Second follow-up episode test risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Second follow-up episode test risk of significant cervical abnormality
Definition	Risk of significant cervical abnormality determined from a second follow-up episode result, comprised of a primary HPV test with partial genotyping and LBC triage.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AX}	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	RU	Unsatisfactory
	R1	Low risk
	R3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The second follow-up episode result is used to assign a risk of significant cervical abnormality. This is based on the test results from this follow-up episode only and does not take into consideration previous test results, screening history, or individual factors that increase a participant's risk of significant cervical abnormality. The risk of cervical abnormality based on test results is **not** adjusted for participants who were overdue for screening by at least 2 years prior to their intermediate risk screening episode, are Aboriginal and/or Torres Strait Islander, or are aged 50 or older when assigning a test risk of significant cervical abnormality. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode test risk of significant cervical abnormality is specific to the second follow-up episode.
Collection methods	For the second follow-up HPV test after intermediate risk follow-up episode, test risk should be allocated as: RU Unsatisfactory: J8 'Follow-up episode result' = U R1 Low risk: J8 'Follow-up episode result' = 1

	R3 Higher risk: J8 ‘Follow-up episode result’ = 2.X, 2.0, 2.1, 2.2, 2.3, 2.4, 3.X, 3.0, 3.1, 3.2, 3.3, or 3.4.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J17 Second follow-up episode participant risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Second follow-up episode participant risk of significant cervical abnormality
Definition	Second follow-up episode risk of significant cervical abnormality of a participant.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AAX}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	PRU	Unsatisfactory
	PR1	Low risk
	PR3	Higher risk

Data item attributes

Collection and usage attributes

Guide for use	The follow-up episode result, previous test results, screening history, and individual factors that increase a participant's risk of significant cervical abnormality are used to assign a risk of significant cervical abnormality of a participant. Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode participant risk of significant cervical abnormality is specific to the second follow-up episode.
Collection methods	Determined by pathology laboratories and the NCSR as per clinical management guidelines and incorporating screening history. Note: for the second follow-up HPV test after intermediate risk follow-up episode, participants cannot be intermediate risk.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

J18 Second follow-up episode recommendation

Identifying and definitional attributes

Data item name	Second follow-up episode recommendation
Definition	The appropriate management based on the second follow-up episode risk of significant cervical abnormality of a participant.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	M0	No recommendation
	M1	Rescreen in 5 years
	M2	Rescreen in 3 years
	M3	Repeat HPV test in 12 months
	M4	Co-test in 12 months
	M5	Retest in 6 weeks
	M6	Refer for colposcopic assessment
	M7	Test taken at time of colposcopy, no recommendation
	M8	Discharge from program
	M9	Other management recommendation
	MS	Symptomatic – clinical management required
	MP	Rescreen in 2 years

Data item attributes

Collection and usage attributes

Guide for use	Participants are able to have two follow-up episodes within a single screening round if they are considered to be intermediate risk at their first 12-month follow-up HPV test. This follow-up episode recommendation is specific to the second follow-up episode.
Collection methods	Determined by pathology laboratories as per clinical management guidelines and incorporating screening history.
Comments	From 1 February 2021, clinical management for participants who, at follow-up HPV test, had oncogenic HPV (not 16/18) detected with a reflex LBC of negative or pLSIL/LSIL and were not overdue for screening by at least 2 years prior to their intermediate risk screening episode, are not Aboriginal and/or Torres Strait Islander, and are not aged 50 or older, are recommended to have a further follow-up HPV test in another 12 months instead of being referred for colposcopy.

Relational attributes

Related metadata reference	New data item

Group K: Colposcopy data items

K1 Date of colposcopy episode
K2 Indication for colposcopy
K3 Indication for colposcopy – other indication free text
K4 General colposcopic assessment – adequacy
K5 General colposcopic assessment – transformation zone visibility
K6 Colposcopic impression – primary diagnosis
K7 Colposcopy impression – other finding free text
K8 Biopsy this episode
K9 Pregnant at time of colposcopy
K10 Colposcopy data source

K1 Date of colposcopy episode

Identifying and definitional attributes

Data item name	Date of colposcopy episode
Definition	The date when a colposcopy or treatment was performed.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection method	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K1 Date of colposcopy episode

K2 Indication for colposcopy

Identifying and definitional attributes

Data item name	Indication for colposcopy
Definition	Clinical indication as to why colposcopy was performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	AN	
Maximum character length	2	
Permissible values:	**Value**	**Meaning**
	C0	Not performed
	C1	New patient with abnormal cervical screening result
	C2	Follow-up of patient with previous abnormal cervical screening result
	C3	Symptomatic
	C4	Abnormal appearance of cervix
	C5	At time of treatment
	C6	Other

Data item attributes

Collection and usage attributes

Guide for use	This item refers to the reason for undertaking the current colposcopy.
Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K2 Indication for colposcopy

K3 Indication for colposcopy – other indication free text

Identifying and definitional attributes

Data item name	Indication for colposcopy – other indication free text
Definition	Clinical indication as to why colposcopy was performed if not one of the coded options in 'Indication for colposcopy'.
Collection status	Conditional

Value domain attributes

Representation class	Text
Data type	String
Format	[X(250)]
Maximum character length	250

Data item attributes

Collection and usage attributes

Rules for use	If K2 'Indication for colposcopy' = C6 ('Other'), then K3 'Indication for colposcopy – other indication free text' should not be NULL.
Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K3 Indication for colposcopy – other indication free text

K4 General colposcopic assessment – adequacy

Identifying and definitional attributes

Data item name	General colposcopic assessment – adequacy
Definition	An indication as to whether the colposcopy was adequate or inadequate.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	Q0	Inadequate
	Q1	Adequate

Data item attributes

Collection and usage attributes

Guide for use	‘Adequate’ indicates that the view of the cervix is not obscured. ‘Inadequate’ indicates that the cervix cannot be adequately visualised, for example due to inflammation, bleeding, atrophy, or scar tissue.
Collection methods	Colposcopy Data Collection Form.
Comments	The terms ‘satisfactory’ and ‘unsatisfactory’ for describing a colposcopy have been replaced with a two-tiered system. The first tier relates to the visibility of the cervix, either adequate for the reason or inadequate if it is obscured, such as by blood, inflammation, or scarring, and is the colposcopic assessment captured in this data item. The second tier relates to the visibility of the transformation zone. A Type 1 transformation zone is completely visible and the squamocolumnar junction is completely seen. A Type 2 transformation zone is also completely visible and the squamocolumnar junction is in the endocervical canal, but can be seen. A Type 3 transformation zone is not completely visible and the squamocolumnar junction cannot be seen.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K4 General colposcopic assessment – adequacy

K5 General colposcopic assessment – transformation zone visibility

Identifying and definitional attributes

Data item name	General colposcopic assessment – transformation zone visibility
Definition	An indication as to whether the transformation zone and/or squamocolumnar junction is visible.
Collection status	Essential (if colposcopy is adequate)

Value domain attributes

Representation class	Code	
Data type	String	
Format	{AAN}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	TZ1	Type 1 transformation zone
	TZ2	Type 2 transformation zone
	TZ3	Type 3 transformation zone

Data item attributes

Collection and usage attributes

Guide for use	'Type 1 transformation zone' indicates that the transformation zone is entirely visible and the squamocolumnar junction is seen. 'Type 2 transformation zone' indicates that the transformation zone extends into the endocervical canal, but the squamocolumnar junction is seen. 'Type 3 transformation zone' indicates that the transformation zone extends into the endocervical canal and either the entire squamocolumnar junction is not seen or the upper limit of the squamocolumnar junction is not seen. A transformation zone type should only be indicated if the colposcopy is considered adequate.
Rules for use	(i) If K4 'General colposcopic assessment – adequacy' = 0 ('Inadequate') then K5 'General colposcopic assessment – transformation zone visibility' should be NULL. (ii) If K4 'General colposcopic assessment – adequacy' = 1 ('Adequate') then K5 'General colposcopic assessment – transformation zone visibility' should not be NULL.
Collection methods	Colposcopy Data Collection Form.
Comments	The terms 'satisfactory' and 'unsatisfactory' for describing a colposcopy have been replaced with a two-tiered system. The first tier relates to the visibility of the cervix, either adequate for the reason or inadequate if it is obscured, such as by blood, inflammation, or scarring.

	The second tier relates to the visibility of the transformation zone and is the colposcopic assessment captured in this data item. A Type 1 transformation zone is completely visible and the squamocolumnar junction is completely seen. A Type 2 transformation zone is also completely visible and the squamocolumnar junction is in the endocervical canal, but can be seen. A Type 3 transformation zone is not completely visible and the squamocolumnar junction cannot be seen.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K5 General colposcopic assessment – transformation zone visibility

K6 Colposcopic impression – primary diagnosis

Identifying and definitional attributes

Data item name	Colposcopic impression – primary diagnosis
Definition	The clinical diagnosis or impression formed at time of colposcopy.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	D1	Normal
	D2	No visible lesion
	D3	LSIL
	D4	HSIL
	D5	Glandular abnormality (adenocarcinoma-in-situ*)*
	D6	Cancer
	D7	Other

Data item attributes

Collection and usage attributes

Guide for use	It is usual for a colposcopist to make a clinical diagnosis/impression and record this impression as the ‘result’ or diagnosis. This ‘diagnosis’ is usually made in the terms related to the likely histological outcome or biopsy result. The correlation between the colposcopic diagnosis and the final histological diagnosis is one of the standards for assessment of the colposcopist’s diagnostic skill and is used for quality improvement programs. Colposcopists will have the capacity to choose 2–3 impressions as well as the ‘Other’ category. The National Cancer Screening Register will use rules to determine which impression is recorded (usually the ‘worse’ finding).
Rules for use	Required if General Colposcopic Assessment is adequate AND transformation zone is Type 1 or 2. (i) If K4 ‘General colposcopic assessment – adequacy’ = 0 (‘Inadequate) then K6 ‘Colposcopic impression – primary diagnosis’ should be NULL. (ii) If K4 ‘General colposcopic assessment – adequacy’ = 1 (‘Adequate’) AND K5 ‘General colposcopic assessment – transformation zone visibility’ = 1 or 2 (Type 1 or Type 2 transformation zone) then K6 ‘Colposcopic impression – primary diagnosis’ should not be NULL.

	(iii) If K4 ‘General colposcopic assessment – adequacy’ = 1 (‘Adequate’) AND K5 ‘General colposcopic assessment – transformation zone visibility’ = 3 (‘Type 3’) then K6 ‘Colposcopic impression – primary diagnosis’ cannot = 1 (‘Normal’).
Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K6 Colposcopic impression – primary diagnosis

K7 Colposcopic impression – other finding free text

Identifying and definitional attributes

Data item name	Colposcopic impression – other finding free text
Definition	Clinical diagnosis or impression formed at time of colposcopy if not one of the coded options in 'Colposcopic impression – primary diagnosis'.
Collection status	Conditional

Value domain attributes

Representation class	Text
Data type	String
Format	[A(250)]
Maximum character length	250

Data item attributes

Collection and usage attributes

Guide for use	It is usual for a colposcopist to make a clinical diagnosis/impression and record this impression as the 'result' or diagnosis. This 'diagnosis' is usually made in the terms related to the likely histological outcome or biopsy result. This data item is available for a colposcopist to record a colposcopic impression other than those coded in K6 'Colposcopic impression – primary diagnosis' using free text. Colposcopists will have the capacity to choose 2–3 impressions as well as the 'Other' category. The National Cancer Screening Register will use rules to determine which impression is recorded (usually the 'worse' finding).
Rules for use	If K6 'Colposcopic impression – primary diagnosis' = 7 ('Other'), then K7 'Colposcopic impression – other finding free text' should not be NULL.
Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K7 Colposcopic impression – other finding free text

K8 Biopsy this episode

Identifying and definitional attributes

Data item name	Biopsy this episode
Definition	An indication as to whether a biopsy was performed as part of the colposcopy episode.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B0	No – biopsy not performed
	B1	Yes – biopsy performed

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K8 Biopsy this episode

K9 Pregnant at time of colposcopy

Identifying and definitional attributes

Data item name	Pregnant at time of colposcopy
Definition	An indication as to whether the participant was pregnant at the time of the colposcopy.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	P0	Not pregnant
	P1	Pregnant

Data item attributes

Collection and usage attributes

Guide for use	A participant should be recorded as pregnant either as a result of a blood or urine test or if they indicate to the colposcopist verbally or in writing that they are pregnant.
Comment	While it is considered safe to have a colposcopy, there may be some procedures that are not performed, either at the participant's request, or at the discretion of the colposcopist.
Collection methods	Colposcopy Data Collection Form.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K9 Pregnant at time of colposcopy

K10 Colposcopy data source

Identifying and definitional attributes

Data item name	Colposcopy data source
Definition	An indication from where the colposcopy data are sourced.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Colposcopy Data Collection Form
	2	MBS
	3	Abnormal result questionnaire
	4	Histology
	9	Unknown

Data item attributes

Collection and usage attributes

Guide for use

This data item is derived by the AIHW for use in performance indicator reporting that requires colposcopy data.

There are four sources of information that a colposcopy has occurred across National Cancer Screening Register data tables.

‘1 Colposcopy Data Collection Form’ indicates that the source is the colposcopy form that is completed and provided to the NCSR. This is the only source that can have all colposcopy and treatment data items populated.

‘2 MBS’ indicates that the source is the Medicare Benefits Scheme. The only data item that can be populated when MBS is the source is ‘K1 Date of colposcopy episode’.

‘3 Abnormal result questionnaire’ indicates that the source is the Abnormal result questionnaire. Data items that can be populated from this source are ‘K1 Date of colposcopy episode’, ‘K8 Biopsy this episode’ and ‘K9 Pregnancy flag’.

‘4 Histology’ indicates that the source is histology data, since if a histological sample was collected there must have been a colposcopy. The only data item that can be populated when histology is the source is ‘K1 Date of colposcopy episode’.

‘9 Unknown’ indicates the source of the colposcopy is unknown.

Comment	This does not prescribe how others collect and use colposcopy data, only how the AIHW collect and use colposcopy data.
Collection methods	Where there is more than one data source for a single colposcopy, an order of priority is used to allow the most information to be collected about the colposcopy. The order of priority would be to select a colposcopy form record over an MBS record, as a greater number of colposcopy and treatment data items can be populated.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* K10 Colposcopy data source

Group L: Histology test data items

L1 Histology test date
L2 Histology test specimen site
L3 Procedure used for obtaining specimen for histological analysis
L4 Squamous histology cell analysis
L5 Endocervical (glandular) histology cell analysis
L6 Other/non-cervical histology cell analysis
L7 Histology test result
L8 Histology report text
L9 Histology stain
L10 Histology stain result
L11 Histology data source

L1 Histology test date

Identifying and definitional attributes

Data item name	Histology test date
Definition	The date when a histology specimen was collected.
Collection status	Essential

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	DDMMYYYY
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	This is an important date, as it is used to determine other features of interest that occur ‘at time of test’, such as age at test. For a single cervical test, there can be a test request date, a test collection date, a laboratory receipt date, a laboratory report date, and a laboratory transmission date. The date of interest for reporting is the test collection date, as this is the date on which the specimen was collected. If test collection date is unknown, another date can be used instead, and will be treated as the test date. The order of priority for an alternative date is: • test request date • laboratory receipt date • laboratory report date • laboratory transmission date.
Comments	Registers need to collect all dates to ensure timely progression of a specimen, for instance by determining the time between the laboratory receipt date, the laboratory report date, and the laboratory transmission date.
Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L1 Histology test date

L2 Histology test specimen site

Identifying and definitional attributes

Data item name	Histology test specimen site
Definition	The site from where a histology specimen has been collected.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B0	Not stated
	B1	Cervical
	B2	Vaginal
	B3	Other gynaecological site

Data item attributes

Collection and usage attributes

Guide for use	Cervical specimen includes all cervical histology including cervical polyps and cervical samples obtained during hysterectomies for benign conditions.
Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L2 Histology test specimen site

L3 Procedure used for obtaining specimen for histological analysis

Identifying and definitional attributes

Data item name	Procedure used for obtaining specimen for histological analysis
Definition	The type of procedure used to collect a gynaecological specimen for histological analysis for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	A1	Biopsy (includes directed punch and random punch)
	A2	Endocervical curettage (includes endocervical tissue obtained during D&C)
	A3	LLETZ/LEEP loop biopsy
	A4	Cone biopsy
	A5	Polypectomy
	A6	Subtotal hysterectomy
	A7	Hysterectomy
	A8	Amputated cervix
	A9	Other gynaecological site

Data item attributes

Collection and usage attributes

Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L3 Procedure used for obtaining specimen for histological analysis

L4 Squamous histology cell analysis

Identifying and definitional attributes

Data item name	Squamous histology cell analysis
Definition	The histological analysis of a cervical specimen (squamous cells of the ectocervix) for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX[XX]	
Maximum character length	4	
Permissible values	**Value**	**Meaning**
	S1	Negative
	S2	Low-grade intraepithelial lesion (LSIL)
	S3.1	High-grade intraepithelial lesion (HSIL) (CIN NOS)
	S3.2	HSIL (CIN 2)
	S3.3	HSIL (CIN 3)
	S4.1	Superficially invasive squamous cell carcinoma (SISCCA)
	S4.2	Squamous cell carcinoma (SCC)
	SU	Unsatisfactory
	SN	Not applicable

Data item attributes

Collection and usage attributes

Comments

Histology nomenclature was revised in the *National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding* (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party).

A two-tiered nomenclature system has been accepted for non-invasive HPV associated squamous proliferations of the cervix. The two groups are LSIL and HSIL, which may be further characterised by the applicable cervical intraepithelial neoplasia (CIN) subcategory.

LSIL is the morphologic expression of acute HPV infection. LSIL encompasses changes previously called ‘HPV effect’ and ‘CIN1’.

	HSIL is the morphologic expression of persistent HPV infection that has the potential to progress to invasive carcinoma. HSIL encompasses lesions previously called ‘CIN2’ and ‘CIN3’. The subcategories HSIL (CIN2) and HSIL (CIN3) should continue to be used. Where a pathologist is considering a diagnosis of CIN2, p16 staining should be performed. If the p16 stain is negative, the lesion is either LSIL or a mimic of HSIL and should not be diagnosed as HSIL. If the p16 stain is positive, the lesion should be diagnosed as HSIL (CIN2). The term ‘microinvasive carcinoma’ is no longer recommended, and the term ‘superficially invasive squamous cell carcinoma’ (SISCCA) should be used instead.
Collection methods	Pathology laboratories

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* L4 Squamous histology cell analysis

L5 Endocervical (glandular) histology cell analysis

Identifying and definitional attributes

Data item name	Endocervical (glandular) histology cell analysis
Definition	The histological analysis of an endocervical specimen (glandular/columnar cells of the endocervix) for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX[XX]	
Maximum character length	4	
Permissible values	**Value**	**Meaning**
	E1	Negative
	E2	Endocervical atypia
	E3.1	Endocervical dysplasia
	E3.2	Adenocarcinoma-in-situ
	E3.3	Mixed carcinoma-in-situ/ adenocarcinoma-in-situ
	E4.1	Endocervical adenocarcinoma, microinvasive
	E4.2	Invasive adenocarcinoma of cervix
	E4.3	Adenosquamous carcinoma
	E4.4	Carcinoma of the cervix (other)
	EU	Unsatisfactory
	EN	Not applicable

Data item attributes

Collection and usage attributes

Comments	Histology nomenclature was revised in the *National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding* (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party). However, while this states that 'Adenocarcinoma-in-situ' (AIS) is the only currently recommended term in Australasia for glandular mucosal preinvasive lesions, other categories are included to allow the collection of these findings.
Collection methods	Pathology laboratories

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* L5 Endocervical (glandular) histology cell analysis

L6 Other/non-cervical histology cell analysis

Identifying and definitional attributes

Data item name	Other/non-cervical histology cell analysis
Definition	The histological analysis of a non-cervical sample.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX[XX]	
Maximum character length	4	
Permissible values	**Value**	**Meaning**
	O1	Negative/no abnormalities reported or benign changes only
	O2	Low-grade neoplasia/hyperplasia NOS
	O3.1	High-grade neoplasia/hyperplasia
	O3.2	Carcinoma-in-situ
	O4.1	Carcinoma, microinvasive
	O4.2	Invasive carcinoma
	ON	Not applicable

Data item attributes

Collection and usage attributes

Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L6 Other/non-cervical histology cell analysis

L7 Histology test result

Identifying and definitional attributes

Data item name	Histology test result
Definition	Cervical histology result based on S and E codes as defined by the Australian Institute of Health and Welfare for national reporting purposes.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character *length*	2	
Permissible values	**Value**	**Meaning**
	DN	No result
	DU	Unsatisfactory
	D1	Negative
	D2	Low-grade
	D3	High-grade
	D4	Cervical cancer

Data item attributes

Collection and usage attributes

Guide for use	Note that for the purposes of national reporting of cervical histology by the Australian Institute of Health and Welfare, categories are based only on S and E codes. An unsatisfactory histology result is defined as specified in each state or territory, since the entire pathology result is required to make an evaluation. For instance, the overall findings may be unsatisfactory, even if there are valid squamous and endocervical (glandular) codes allocated, since a pathologist may code what can be observed, even in the case of an unsatisfactory sample. Hence it is not appropriate to define unsatisfactory histology using S and E codes. Note, however, that if high-grade or malignant cells are seen in an otherwise unsatisfactory specimen, the histology result category should reflect the high-grade or malignant finding, rather than the unsatisfactory nature of the sample. A negative histology result is defined as any histology test that is not unsatisfactory and where there is no evidence of HPV infection, intraepithelial pre-neoplasia, or intraepithelial neoplasia. Note that there is no requirement for both squamous and endocervical (glandular) components to be sampled and to be negative; a histology result that only samples the squamous

	component and the squamous component is negative, or a histology result that only samples the endocervical (glandular) component and the endocervical (glandular) component is negative, are both counted as negative histology tests. A negative histology result can therefore be represented as (L4 = S1 and L5 = E1) or (L4 = S1 and L5 = EN) or (L4 = SN and L5 = E1), although this may not reflect how negative histology is coded by cervical screening registers. A low-grade histology result is defined as L4 = S2 or L5 = E2 (L4 cannot be >S2 and L5 cannot be >E2). A high-grade histology result is defined as L4 = S3 or L5 = E3 (L4 cannot be >S3 and L5 cannot be >E3). A cervical cancer histology result is defined as L4 = S4 or L5 = E4.
Comments	This is the way that histology results are used for reporting and monitoring purposes. Some histology results do not have valid S and E. Where both the S and E code are invalid (such as 'not applicable'), the code DN can be used to capture these tests for which there is no result.
Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L7 Histology test result

L8 Histology report text

Identifying and definitional attributes

Data item name	Histology report text
Definition	Text from the report prepared for cervical histology.
Collection status	Conditional

Value domain attributes

Representation class	Text
Data type	String
Format	[X(4,000)]
Maximum character length	4,000

Data item attributes

Collection and usage attributes

Comment	Histology report text is often required for detailed information on clearance margins et cetera when supporting research requests.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L8 Histology report text

L9 Histology stain

Identifying and definitional attributes

Data item name	Histology stain
Definition	An indication as to what staining was performed on the histology specimen.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N[N]}	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	0	No stain
	1	p16

Data item attributes

Collection and usage attributes

Comments	This data item will be expanded as more stains are used on cervical histology specimens to aid in the identification of high-grade cervical abnormalities.
Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L9 Histology stain

L10 Histology stain result

Identifying and definitional attributes

Data item name	Histology stain result
Definition	Result of the histology staining performed.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	0	Not done
	1	Staining
	2	No staining
	3	Equivocal staining

Data item attributes

Collection and usage attributes

Guide for use	The results refer to each of the staining options in L8 ‘Histology stain’, so if L9 = 1 ‘p16’, then the results in L10 are the staining results for p16.
Collection methods	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L10 Histology stain result

L11 Histology data source

Identifying and definitional attributes

Data item name	Histology data source
Definition	An indication as to the source of data that histology occurred.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Pathology laboratory
	2	MBS
	9	Unknown

Data item attributes

Collection and usage attributes

Guide for use	This data item is derived by the AIHW for use in performance indicator reporting that requires histology data. There are two sources of information that a histology has occurred across National Cancer Screening Register data tables. '1 Pathology laboratory' indicates that the source is a pathology laboratory providing histology results to the National Cancer Screening Register. This is the only source that can have all histology data items populated. '2 MBS' indicates that the source is the Medicare Benefits Scheme. The only data item that can be populated when MBS is the source is 'L1 Histology test date'. '9 Unknown' indicates the source of the histology is unknown.
Collection methods	Where there is more than one data source for a single histology test, an order of priority is used to allow the most information to be collected about the histology. The order of priority would be to select a pathology laboratory record over an MBS record as a greater number of histology data items can be populated.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* L11 Histology data source

Group M: Treatment data items

M1 Treatment this episode
M2 Treatment date
M3 Excision performed this episode
M4 Modality/method used for excision
M5 Ablation performed this episode
M6 Hysterectomy
M7 Treatment anaesthetic type
M8 Location of service
M9 Eligible for test of cure flag
M10 Eligible for test of cure date
M11 Test of cure completion flag
M12 Test of cure completion date

M1 Treatment this episode

Identifying and definitional attributes

Data item name	Treatment this episode
Definition	An indication as to whether treatment was performed as part of the colposcopy episode.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	T0	No – treatment not performed
	T1	Yes – treatment performed

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M1 Treatment this episode

M2 Treatment date

Identifying and definitional attributes

Data item name	Treatment date
Definition	An indication as to the date of treatment.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	This is a derived data item, to be populated with K1 ‘Date of colposcopy episode’ when M1 ‘Treatment this episode’ is equal to 1, indicating that treatment was performed during this colposcopy episode.
Collection methods	Derived.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M2 Treatment date

M3 Excision performed this episode

Identifying and definitional attributes

Data item name	Excision performed this episode
Definition	Whether or not excision was performed this episode, and if yes, the intended excision type.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[A]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	X0	No
	X1a	Yes – Type 1 excision (≤10 mm)
	X1b	Yes – Type 2 excision (>10 and ≤15 mm)
	X1c	Yes – Type 3 excision (>15 mm)

Data item attributes

Collection and usage attributes

Guide for use	Excisions are stratified as Types 1, 2 or 3, according to the length of cervical tissue excised. Treatment types are defined below (modified from the terminology recommended by the International Federation for Cervical Pathology and Colposcopy in 2011). • 'Type 1 excision' (for Type1 transformation zone): Usually to 8 mm and not more than 10 mm length of cervical tissue excised. • 'Type 2 excision' (for Type 2 transformation zone): Not more than 15 mm length of tissue excised. • 'Type 3 excisions' (for Type 3 transformation zones): Equivalent to 'cone biopsy' and >15 mm length. Should be used for participants with: – suspected invasive disease – proven or suspected glandular disease – Type 3 transformation zones with proven or suspected high-grade disease.
Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M3 Excision performed this episode

M4 Modality/method used for excision

Identifying and definitional attributes

Data item name	Modality/method used for excision
Definition	The modality or method used for excision, where this was performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AAN[A]	
Maximum character length	4	
Permissible values	**Value**	**Meaning**
	XM0	Excision not performed
	XM1a	Loop diathermy
	XM1b	Scalpel (Cold knife)
	XM1c	Laser
	XM1d	Other

Data item attributes

Collection and usage attributes

Rules for use	If M3 ‘Excision performed this episode’ = 0, then M4 ‘Modality/method used for excision’ should be 0.
Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M4 Modality/method used for excision

M5 Ablation performed this episode

Identifying and definitional attributes

Data item name	Ablation performed this episode
Definition	Whether or not ablation was performed this episode, and if yes, the ablation type.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN[A]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	L0	No
	L1a	Yes – Laser
	L1b	Yes – Thermal coagulation (Semm)
	L1c	Yes – Diathermy

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M5 Ablation performed this episode

M6 Hysterectomy

Identifying and definitional attributes

Data item name	Hysterectomy
Definition	An indication as to whether hysterectomy was performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	H0	No – hysterectomy not performed
	H1	Yes – hysterectomy performed

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M6 Hysterectomy

M7 Treatment anaesthetic type

Identifying and definitional attributes

Data item name	Treatment anaesthetic type
Definition	An indication as to whether the anaesthetic used was local or general.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	0	Not used/not required
	1	Local
	2	Regional
	3	General

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M7 Treatment anaesthetic type

M8 Location of service

Identifying and definitional attributes

Data item name	Location of service
Definition	An indication as to where treatment was performed.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Public Hospital
	2	Private Hospital
	3	Private Rooms
	9	Unknown/Other

Data item attributes

Collection and usage attributes

Collection methods	Colposcopy Data Collection Form

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M8 Location of service

M9 Eligible for test of cure flag

Identifying and definitional attributes

Data item name	Eligible for test of cure flag
Definition	An indication that, following treatment for a high-grade squamous intraepithelial lesion, a participant is eligible for test of cure.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Eligible for test of cure

Data item attributes

Collection and usage attributes

Collection methods	Calculate based on the date of the previous histologically confirmed high-grade squamous intraepithelial lesion.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M9 Eligible for test of cure flag

M10 Eligible for test of cure date

Identifying and definitional attributes

Data item name	Eligible for test of cure date
Definition	An indication as to the date a participant became eligible for test of cure.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	Derived from the date of treatment for previous histologically confirmed high-grade squamous intraepithelial lesion.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M10 Eligible for test of cure date

M11 Test of cure completion flag

Identifying and definitional attributes

Data item name	Test of cure completion flag
Definition	An indication that, following treatment for a high-grade squamous intraepithelial lesion, a participant has completed test of cure.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Test of cure complete

Data item attributes

Collection and usage attributes

Guide for use	Successful completion of test of cure is as per the management guidelines and comprises two negative co-test (HPV and LBC) results 12 months apart, commencing 12 months after treatment for a histologically confirmed high-grade squamous intraepithelial lesion.
Comments	A negative co-test is defined as an HPV test and cytology test performed on the same day where the HPV test result is ‘no oncogenic HPV types detected’ and the cytology test result is ‘S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes’ and ‘E0 No endocervical component’, ‘E1 Endocervical component present. No abnormality or only reactive changes’, ‘EU Due to the unsatisfactory nature of the cytology specimen, no assessment has been made’, or ‘E- Not applicable: vault smear/previous hysterectomy’.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M11 Test of cure completion flag

M12 Test of cure completion date

Identifying and definitional attributes

Data item name	Test of cure completion date
Definition	An indication as to the date the test of cure was complete.
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Collection methods	Derived from the date of the second negative co-test (contingent on test of cure being followed with co-tests at recommended intervals after treatment).
Comments	A negative co-test is defined as an HPV test and cytology test performed on the same day where the HPV test result is 'no oncogenic HPV types detected' and the cytology test result is 'S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes' and 'E0 No endocervical component', 'E1 Endocervical component present. No abnormality or only reactive changes', 'EU Due to the unsatisfactory nature of the cytology specimen, no assessment has been made', or 'E- Not applicable: vault smear/previous hysterectomy'.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* M12 Test of cure completion date

Group N: Provider data items

Provider data items allow the collection and reporting by provider for all tests that may be performed within a screening round – HPV tests, cytology tests, colposcopy, and histology tests. These can be used in combination with the data item *Type of test* to determine the provider details for each test.

N1 Medicare provider number of provider requesting a test
N2 Healthcare provider identifier – individual (HPI-I) of provider requesting a test
N3 Healthcare provider identifier – organisation (HPI-O) of provider requesting a test
N4 Australian state/territory of provider requesting a test
N5 Australian postcode of provider requesting a test
N6 Medicare provider number of provider collecting a specimen
N7 Non-medical provider number of provider collecting a specimen
N8 Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen
N9 Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen
N10 Type of provider collecting a specimen
N11 Australian state/territory of provider collecting a specimen
N12 Australian postcode of provider collecting a specimen

N1 Medicare provider number of provider requesting a test

Identifying and definitional attributes

Data item name	Medicare provider number of provider requesting a test
Definition	The Medicare provider number of the provider requesting a test.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(7)]
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The provider requesting test is the provider responsible for the test. The Medicare provider number of the provider requesting a test is therefore the Medicare provider number of the provider who is responsible for the test. Only general practitioners, nurse practitioners and specialists have a Medicare provider number, and can therefore be considered responsible for the test. A health professional can have more than one Medicare provider number, as they will have a Medicare provider number at each location at which they work. Medicare provider numbers are comprised of 8 characters, the first 6 of which are the same for each provider, with subsequent characters used for different locations. The Medicare provider number is not always known or available. In these cases, a dummy provider number unique to the practitioner may be used. A generic dummy value of 0000000Y may also be used, if there is no requirement for the dummy number to be unique to the practitioner. Following a participant being referred to a colposcopist or specialist it may also be necessary for the provider number to be changed for contact purposes to reflect ongoing care by the provider, until any further information is received.
Rules for use	As the provider responsible for the test should have a Medicare provider number this field should always be populated.
Comments	Medicare provider numbers are allocated to individual providers and organisations to support payments and claims through government schemes such as Medicare Benefits and Pharmaceutical Benefits Schemes. For screening tests, the provider requesting the test may not be the provider who collects the specimen; for example, a nurse may collect a sample.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N1 Medicare provider number of provider requesting a test

N2 Healthcare provider identifier – individual (HPI-I) of provider requesting a test

Identifying and definitional attributes

Data item name	Healthcare provider identifier – individual (HPI-I) of provider requesting a test
Definition	The healthcare provider identifier – individual (HPI-I) of the provider requesting a test.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Data item attributes

Collection and usage attributes

Guide for use	A healthcare provider identifier – individual (HPI-I) is a unique 16-digit number that will be allocated to healthcare providers involved in providing patient care. Collection of this is essential if Medicare provider number is not available.

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N2 Healthcare provider identifier – individual (HPI-I) of provider requesting a test

N3 Healthcare provider identifier – organisation (HPI-O) of provider requesting a test

Identifying and definitional attributes

Data item name	Healthcare provider identifier – organisation (HPI-O) of provider requesting a test
Definition	The healthcare provider identifier – organisation (HPI-O) of the provider requesting a test.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Data item attributes

Collection and usage attributes

Guide for use	A healthcare provider identifier – organisation (HPI-O) is a unique 16-digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N3 Healthcare provider identifier – organisation (HPI-O) of provider requesting a test

N4 Australian state/territory of provider requesting a test

Identifying and definitional attributes

Data item name	Australian state/territory of provider requesting a test
Definition	The abbreviated name of the Australian state or territory in which the provider requesting a test is located.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Text	
Format	{AA[A]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data item attributes

Collection and usage attributes

Guide for use	The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N4 Australian state/territory of provider requesting a test

N5 Australian postcode of provider requesting a test

Identifying and definitional attributes

Data item name	Australian postcode of provider requesting a test
Definition	The code that represents a postal delivery area, aligned with locality, suburb, or place for the practice where a provider requesting a test is located.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	String
Format	{NNNN}
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	Must accept zero as the leading digit to accommodate all Australian postcodes.
Comments	Australian postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard codes using an ABS concordance.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N5 Australian postcode of provider requesting a test

N6 Medicare provider number of provider collecting a specimen

Identifying and definitional attributes

Data item name	Medicare provider number of provider collecting a specimen
Definition	The Medicare provider number of the provider collecting a specimen.
Collection status	Conditional

Value domain attributes

Representation class	Identifier
Data type	String
Format	{X[X(7)]}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	The provider collecting a specimen is the provider who actually collected the sample for the cervical screening test. The Medicare provider number of the provider collecting a specimen is therefore the Medicare provider number of the provider who collected the sample. Only general practitioners, nurse practitioners and specialists have a Medicare provider number. A health professional can have more than one Medicare provider number, as they will have a Medicare provider number at each location at which they work. Medicare provider numbers are comprised of 8 characters, the first 6 of which are the same for each provider, with subsequent characters used for different locations. The Medicare provider number is not always known or available. In these cases, a dummy provider number unique to the practitioner may be used. A generic dummy value of 0000000Y may also be used, if there is no requirement for the dummy number to be unique to the practitioner. Following a participant being referred to a colposcopist or specialist it may also be necessary for the provider number to be changed for contact purposes to reflect ongoing care by the provider, until any further information is received. If a health professional collecting a specimen does not have a Medicare provider number, their identifier should be collected at N7 ‘Non-medical provider number of provider collecting specimen’.
Rules for use	This data item should only be populated if the provider collecting a specimen is different to the provider requesting a specimen.

Comments	For screening tests, the provider collecting a specimen may not be the provider who requested the test; for example, a nurse may collect a sample.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N6 Medicare provider number of provider collecting a specimen1

N7 Non-medical provider number of provider collecting a specimen

Identifying and definitional attributes

Data item name	Non-medical provider number of provider collecting a specimen
Definition	The non-medical provider number of the provider collecting a specimen.
Collection status	Desirable

Value domain attributes

Representation class	Identifier
Data type	String
Format	{X[X(19)]}
Maximum character length	20

Data item attributes

Collection and usage attributes

Guide for use	The provider collecting a specimen is the provider who actually collected the sample for the cervical screening test. This data item allows for the collection of an identifier other than Medicare provider number for health professionals collecting a specimen that do not have a Medicare provider number.
Rules for use	This data item should only be populated if the provider collecting a specimen is different to the provider requesting a specimen.
Comments	For screening tests, the provider collecting a specimen may not be the provider who requested the test; for example, a nurse may collect a sample.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N7 Non-medical provider number of provider collecting a specimen

N8 Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen

Identifying and definitional attributes

Data item name	Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen
Definition	The healthcare provider identifier – individual (HPI-I) of the provider collecting a specimen.
Collection status	Conditional

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Data item attributes

Collection and usage attributes

Guide for use	A healthcare provider identifier – individual (HPI-I) is a unique 16-digit number that will be allocated to healthcare providers involved in providing patient care.

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N8 Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen

N9 Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen

Identifying and definitional attributes

Data item name	Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen
Definition	The healthcare provider identifier – organisation (HPI-O) of the provider collecting a specimen.
Collection status	Conditional

Value domain attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Data item attributes

Collection and usage attributes

Guide for use	A healthcare provider identifier – organisation (HPI-O) is a unique 16-digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N9 Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen

N10 Type of provider collecting a specimen

Identifying and definitional attributes

Data item name	Type of provider collecting a specimen
Definition	The occupation of the person who collects a specimen.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	String	
Format	{A}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	G	General practitioner
	N	Nurse Practitioner/Eligible Midwife
	R	Registered Nurse/Midwife
	E	Enrolled Nurse
	S	Specialists (Obstetricians and gynaecologists)
	A	Aboriginal and/or Torres Strait Islander health care worker
	O	Other
	X	None – self-collected (only applicable to HPV test)
	U	Unassigned

Data item attributes

Collection and usage attributes

Guide for use	The occupation needs to reflect the occupation of the person who collected the specimen, which may differ from the occupation of the provider number under which the specimen was collected (that is, if a registered nurse collects the specimen under a GP's provider number, the occupation needs to be recorded as nurse, not GP).

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N10 Type of provider collecting a specimen

N11 Australian state/territory of provider collecting a specimen

Identifying and definitional attributes

Data item name	Australian state/territory of provider collecting a specimen
Definition	The abbreviated name of the Australian state or territory in which the provider collecting a specimen is located.
Collection status	Desirable

Value domain attributes

Representation class	Code	
Data type	Text	
Format	{AA[A]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data item attributes

Collection and usage attributes

Guide for use	The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* N11 Australian state/territory of provider collecting a specimen

N12 Australian postcode of provider collecting a specimen

Identifying and definitional attributes

Data item name	Australian postcode of provider collecting a specimen
Definition	The code that represents a postal delivery area, aligned with locality, suburb, or place for the practice where a provider collecting a specimen is located.
Collection status	Desirable

Value domain attributes

Representation class	Code
Data type	String
Format	{NNNN}
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	Must accept zero as the leading digit to accommodate all Australian postcodes.
Comments	Australian postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard codes using an ABS concordance.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* N12 Australian postcode of provider collecting a specimen

Group O: Pathology laboratory data items

O1 Pathology laboratory identifier
O2 Pathology laboratory name
O3 Pathology laboratory accession number/identifier
O4 Pathology laboratory Australian state/territory
O5 Pathology laboratory Australian postcode

O1 Pathology laboratory identifier

Identifying and definitional attributes

Data item name	Pathology laboratory identifier
Definition	A unique accreditation number allocated to the pathology laboratories that perform analyses on cervical specimens as managed by the National Association of Testing Authorities.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	XXXX
Maximum character length	4

Data item attributes

Source and reference attributes

Origin	National Association of Testing Authorities

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* O1 Pathology laboratory identifier

O2 Pathology laboratory name

Identifying and definitional attributes

Data item name	Pathology laboratory name
Definition	The name of the pathology laboratory.
Collection status	Optional

Value domain attributes

Representation class	Text
Data type	String
Format	{X(250)}
Maximum character length	250

Data item attributes

Source and reference attributes

Origin	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* O2 Pathology laboratory name

O3 Pathology laboratory accession number/identifier

Identifying and definitional attributes

Data item name	Pathology laboratory accession number/identifier
Definition	A unique record identifier allocated by the pathology laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory.
Collection status	Essential

Value domain attributes

Representation class	Identifier
Data type	String
Format	X[X(49)]
Maximum character length	50

Data item attributes

Source and reference attributes

Origin	Pathology laboratories

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.1* O3 Pathology laboratory accession number/identifier

O4 Pathology laboratory Australian state/territory

Identifying and definitional attributes

Data item name	Pathology laboratory Australian state/territory
Definition	The abbreviated name of the Australian state or territory in which the pathology laboratory that perform analyses on cervical specimens is located.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Text	
Format	AA[A]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data item attributes

Collection and usage attributes

Guide for use	The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.

Source and reference attributes

Origin	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* O4 Pathology laboratory Australian state/territory

O5 Pathology laboratory Australian postcode

Identifying and definitional attributes

Data item name	Pathology laboratory Australian postcode
Definition	The code that represents a postal delivery area, aligned with locality, suburb, or place for the practice where the pathology laboratory that perform analyses on cervical specimens is located.
Collection status	Essential

Value domain attributes

Representation class	Code
Data type	String
Format	NNNN
Maximum character length	4

Data item attributes

Collection and usage attributes

Guide for use	Must accept zero as the leading digit to accommodate all Australian postcodes.

Source and reference attributes

Origin	Pathology laboratories

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* O5 Pathology laboratory Australian postcode

Group P: Screening history data items

P1 Previously screened flag

P2 Date of last screening test

P3 Last screening test type

P4 Number of days since last screening test

P1 Previously screened flag

Identifying and definitional attributes

Data item name	Previously screened flag
Definition	An indication as to whether a person has ever had a screening test.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	Number	
Format	{N}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Previously screened

Data item attributes

Collection and usage attributes

Guide for use	This flag should be used for any person who has ever had a screening test – either a Pap test through the previous National Cervical Screening Program or an HPV test through the current National Cervical Screening Program. Exclude diagnostic or follow-up tests.
Collection methods	This data item is derived.
Comments	If never previously screened, this flag should be raised when a person has their first screening test.
Rules for use	If P2 ‘Date of last screening test’ is not NULL, P1 ‘Previously screened flag’ should be = 1.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* P1 Previously screened flag

P2 Date of last screening test

Identifying and definitional attributes

Data item name	Date of last screening test
Definition	The date a sample for a participant's last screening test was collected (date of screening test).
Collection status	Conditional

Value domain attributes

Representation class	Date
Data type	Date/Time
Format	{DDMMYYYY}
Maximum character length	8

Data item attributes

Collection and usage attributes

Guide for use	This will need to be updated each time a participant has a screening test so that this reflects their most recent screening test date. If a histology diagnosis of cervical cancer is received by the National Cancer Screening Register with a collection date within 6 months of the date of a previous screening test, this date needs to be replaced with the immediately preceding screening test date until there is a screening test that is not followed by a diagnosis of cervical cancer within 6 months. If this was the participant's first screening test date, or if there is no screening test that is not followed by a cancer diagnosis within 6 months, then it should be reverted to NULL, and P1 flag removed. This is to collect screening tests only. Screening tests that lead to a histological diagnosis of cancer within 6 months are likely to be part of the diagnosis process, rather than a true screen. These tests are important to remove, as this data item will be used to determine whether a person has an interval cancer diagnosed, and the inclusion of these would falsely elevate the number of interval cancers. Diagnosis of cervical cancer must be by histology (L7 = 4). Includes Pap tests under the previous National Cervical Screening Program and screening HPV tests under the current National Cervical Screening Program.
Collection methods	This data item is derived.
Rules for use	If P1 'Previously screened flag' = 1, P2 'Date of last screening test' should not be NULL.
Comments	Date of previous screening test can be combined with date of diagnosis of cervical cancer to assign a screening history to a person diagnosed with cervical cancer (for example, never

	screened, lapsed screening, adequately screened) based on time since last screening test at time of diagnosis with cervical cancer.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* P2 Date of last screening test

P3 Last screening test type

Identifying and definitional attributes

Data item name	Last screening test type
Definition	An indication as to whether the last screening test was a cytology test or an HPV test.
Collection status	Conditional

Value domain attributes

Representation class	Code	
Data type	String	
Format	{A}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	V	HPV test
	C	Cytology test

Data item attributes

Collection and usage attributes

Guide for use	Cytology test should be selected where the last screening test is a screening cytology test under the previous National Cervical Screening Program. HPV test should be selected where the last screening test is an HPV test under the current National Cervical Screening Program.
Collection methods	The data item is derived.
Rules for use	P3 ‘Last screening test type’ can only be populated if P1 ‘Previously screened flag’ = 1, otherwise this data item should be left blank.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* P3 Last screening test type

P4 Number of days since last screening test

Identifying and definitional attributes

Data item name	Number of days since last screening test
Definition	The number of days that have passed since the last recorded screening test for a participant.
Collection status	Essential

Value domain attributes

Representation class	Code
Data type	Number
Format	N[NNNNN]
Maximum character length	6

Data item attributes

Collection and usage attributes

Guide for use	This is the number of days since a participant's last screening test, calculated by subtracting the date of test/collection of the last screening test from the current date. When a new screening test occurs, this should be set to 0. The number of days will increase by one day every day. Number of days should be set to 999999 if no previous screening test is recorded (when P2 'Date of last screening test' is NULL).
Collection methods	Derived from P2 'Date of last screening test' and current date.
Comments	This is used to determine the screening history of a person, as never-screeners, lapsed screeners, regular screeners etcetera, based on time since a person's last screening test.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.1* P4 Number of days since last screening test

4 Screening and follow-up episode result tables

The following tables were developed to assist with the classification of:

- Screening episodes; and
- Follow-up episodes.

Primary screening HPV test result	Cytology test result	Screening episode risk	
Unsatisfactory	. .	Unsatisfactory	
Oncogenic HPV types not detected	. .	Low risk	
Oncogenic HPV (not 16/18)	None (applies to self-collected samples only)		
	Unsatisfactory	Unsatisfactory	
	Negative	Intermediate risk	→ First follow-up (repeat HPV test in 12 months)
	Possible or definite low-grade intraepithelial lesion (LSIL)	Intermediate risk	→
	Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
	Any glandular abnormality	Higher risk	
HPV 16/18	None (applies to self-collected samples only)	Higher risk	
	Unsatisfactory	Higher risk	
	Negative	Higher risk	
	Possible or definite low-grade intraepithelial lesion (LSIL)	Higher risk	
	Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
	Any glandular abnormality	Higher risk	

Risk	First follow-up HPV test result	Cytology test result	Follow-up episode risk	
Intermediate risk	Unsatisfactory	. .	Unsatisfactory	
	Oncogenic HPV types not detected	. .	Low risk	
	Oncogenic HPV (not 16/18)	None (applies to self-collected samples only)		
		Unsatisfactory	Unsatisfactory	
		Negative	Intermediate risk	→ Second follow-up (repeat HPV test in 12 months)
		Possible or definite low-grade intraepithelial lesion (LSIL)	Intermediate risk	→
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
		Any glandular abnormality	Higher risk	
	HPV 16/18	None (applies to self-collected samples only)	Higher risk	
		Unsatisfactory	Higher risk	
		Negative	Higher risk	
		Possible or definite low-grade intraepithelial lesion (LSIL)	Higher risk	
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk	
		Any glandular abnormality	Higher risk	

Exceptions to this are participants who are 2 or more years overdue for screening at the time of the initial screen, participants who identify as being Aboriginal and/or Torres Strait Islander, and participants aged 50 years or older, who should instead be referred to colposcopy if any HPV is detected at 12 months.

Risk	Second follow-up HPV test result	Cytology test result	Follow-up episode risk
Intermediate risk	Unsatisfactory	. .	Unsatisfactory
	Oncogenic HPV types not detected	. .	Low risk
	Oncogenic HPV (not 16/18)	None (applies to self-collected samples only)	Higher risk
		Unsatisfactory	Higher risk
		Negative	Higher risk
		Possible or definite low-grade intraepithelial lesion (LSIL)	Higher risk
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk
		Any glandular abnormality	Higher risk
	HPV 16/18	None (applies to self-collected samples only)	Higher risk
		Unsatisfactory	Higher risk
		Negative	Higher risk
		Possible or definite low-grade intraepithelial lesion (LSIL)	Higher risk
		Possible or definite high-grade intraepithelial lesion (HSIL) or cervical cancer	Higher risk
		Any glandular abnormality	Higher risk

5 Performance indicators

With the major changes that the renewed NCSP has brought, including an HPV test every five years and a commencement age of 25 years, there was a need to develop new performance indicators for the renewed NCSP that would continue to meet the need for national monitoring of this important screening program. These new performance indicators were developed concurrently with the development of new quality measures, safety monitoring measures, as well as measures that are external to the NCSP (such as performance measures for pathology laboratories).

These new performance indicators were developed by the AIHW in consultation with the Department of Health and state and territory cervical screening programs, the NCSP Quality and Safety Monitoring Committee, the Colposcopy Working Group, and cervical screening experts Professors Ian Hammond, Marion Saville, Julia Brotherton, David Roder, and Dorota Gertig.

Performance indicators have been revised since their introduction, to reflect a revised definition of participation (and the introduction of a new coverage measure to replace the previously defined participation), and to incorporate a change to the screening pathway for intermediate risk participants in 2021 and the removal of eligibility requirements for self-collection on 1 July 2022.

The performance indicators for the renewed NCSP are listed in Table 5.1.

Table 5.1: Performance indicators for the renewed National Cervical Screening Program

Screening pathway		Performance indicator	
Recruitment		1	Participation
		2	Response to invitation
		3	Rescreening
Screening	Screening	4	Screening results
		5	Correlation of screening results
	Screening HPV test performance	6	Screening HPV test positivity
		7	Cervical cancer diagnosed after a low risk screening test result
	Self-collection	8	LBC test in self-collection participants positive for oncogenic HPV (not 16/18)
		9	Colposcopy in self-collection participants positive for oncogenic HPV 16/18
	Follow-up	10	Adherence to recommendation for follow-up
		11	Follow-up results
Assessment		12	Colposcopy rate
		13	Time to colposcopy
		14	Biopsy rate
		15	Yield of high-grade abnormalities on biopsy among participants who attend colposcopy with higher risk screening results
		16	Positive predictive value of colposcopy
Diagnosis		17a	High-grade cervical abnormality detection rate
		17b	Cervical cancer detection rate
Outcomes		18	Cervical cancers diagnosed by time since last screen
		19	Incidence of cervical cancer
		20	Mortality from cervical cancer

Disaggregation of performance indicators

Age groups

All performance indicators are defined for the target age group 25–74. Note 25 years is calculated as 24 years and 9 months since this is the age at which people are invited to first screen.

Where appropriate, performance indicators will also be reported separately for birth cohorts that represent whether or not a participant was offered HPV vaccination. Participants not offered HPV vaccination are defined as those born on or before 30 June 1980; participants offered HPV vaccination are defined as those born after 30 June 1980 (1 July 1980 onwards).

Population groups

Performance indicators will be disaggregated, where appropriate, by state and territory of residence, remoteness area of residence, socioeconomic area of residence, Indigenous status, CALD status and HPV vaccination status.

Notes for performance indicators

Cervical screening tests

All screening and histology tests are limited to those associated with cervical screening.

For **screening tests**, cervical screening tests are defined as:

- practitioner-collected samples where HPV test specimen site is NOT *Vaginal* or *Other gynaecological site* (allows *Not stated*, *Cervical* and NULL); and
- self-collected samples where HPV test specimen site is NOT *Other gynaecological site* (allows *Not stated*, *Cervical, Vaginal* and NULL).

Requires *H2 HPV test collection method*; *H3 HPV test specimen site*.

Vault smears are excluded, defined as:

- cytology tests where cytology test specimen site is *Vaginal* and cytology test endocervical (glandular) cytology cell analysis result is *vault smear/previous hysterectomy*.

Requires *I3 Cytology test specimen site*; *I6 Cytology test endocervical (glandular) cytology cell analysis*.

For **histology tests**, cervical screening tests are defined as:

- samples where site is NOT *Vaginal* or *Other gynaecological site* (allows *Not stated*, *Cervical* and NULL).

Further, as a histology result is required for performance indicators that use histology, only histology data where the source is a pathology laboratory are included.

Requires *L2 Histology test specimen site*; *L11 Histology data source*.

Data quality and completeness

Specifications for performance indicators assume a level of data quality and completeness that is sufficient to allow robust and meaningful data to be reported. Where there are concerns about data quality and completeness, and/or where data items required are not available, aspects of performance indicators that have been specified in this document will not be reported.

Indicator 1 Participation

Definition:

Number of participants aged 25–74 screened in a 5-year period as a percentage of eligible females in the population.

Rationale:

Higher participation in cervical screening means that more precancerous abnormalities can be detected and treated, which is necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer.

Calculation:

Participation

$$\frac{\textbf{Number of participants aged 25–74 who had at least one primary screening or follow-up HPV test in a 5-year period} \times 100}{\textbf{Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy}}$$

Coverage

$$\frac{\textbf{Number of participants aged 25–74 who had at least one HPV test or cytology test for any reason in a 5-year period} \times 100}{\textbf{Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy}}$$

Count is of participants

Specifications:

Participation

Numerator specifications

Definition	Number of participants aged 25–74 who had at least one primary screening or follow-up HPV test in a 5-year period
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test*
	H1 HPV test date
	H4 Reason for HPV test = C1 *Primary screening HPV test* or C2 *Follow-up HPV test*

Denominator specifications

Definition	Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy
Source	Australian Bureau of Statistics; AIHW National Hysterectomy Fractions

Coverage

Numerator specifications

Definition	Number of participants aged 25–74 who had at least one HPV test or cytology test for any reason in a 5-year period
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test* or C *Cytology test*
	H1 HPV test date
	I1 Cytology test date

Denominator specifications

Definition	Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy
Source	Australian Bureau of Statistics; AIHW National Hysterectomy Fractions

Indicator 2 Response to invitation

Definition:

Percentage of invitees aged 25–74 invited to screen or rescreen in a calendar year who screened within 6 months.

Rationale:

How many invitees screen in response to an invitation provides a measure of the effectiveness of sending invitations. Measuring this by mode of invitation will also provide useful information as to the most effective method of invitation (which may differ by age or other factors).

Calculation:

$$\frac{\text{Number of invitees aged 25– 74 invited to screen or rescreen in a calendar year who had a primary screening HPV test within 6 months of the invitation being sent}}{\text{Number of invitees aged 25– 74 invited to screen or rescreen in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of invitees

Specifications:

Numerator specifications

Definition	Number of invitees aged 25–74 invited to screen or rescreen in a calendar year who had a primary screening HPV test within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	F2 Correspondence date
	G1 Type of test = V *HPV test*
	H4 Reason for HPV test = C1 *Primary screening HPV test*
	H1 HPV test date

Denominator specifications

Definition	Number of invitees aged 25–74 who are invited to screen or rescreen through the NCSP in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	F1 = Correspondence type = A1 *Screening invitation* or B1 *Screening invitation – self collection eligible** or C1 *Rescreening invitation* or D1 *Rescreening invitation – self-collection eligible**
	F2 Correspondence date
	* self-collection eligible correspondence only applicable before 1 July 2022

Indicator 3 Rescreening

Definition:

Percentage of participants aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who rescreened within a specified period of time.

Rationale:

The proportion of the target population screened within the recommended screening interval is a key determinant of the success of a screening program; screening more frequently increases costs with minimal or no gain in a reduction in incidence and mortality; screening less frequently results in a decrease in overall participation in screening and means that fewer precancerous abnormalities can be detected and treated, necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer. This indicator measures the proportion of participants who rescreened early, appropriately, or late.

Note that although the National Cervical Screening Program target age group is 25–74, only participants aged 25–69 are reported for rescreening because participants aged 70–74 at the time of their screen would be outside the target age group of 25–74 when they are due for their 5-year rescreen.

Calculation:

Early rescreening

$$\frac{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV who had a primary screening HPV test} < \text{4 years and 9 months} \times 100}{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Adequate rescreening: on time

$$\frac{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV who had a primary screening HPV test} \geq \text{4 years and 9 months and} \leq \text{5 years 3 months} \times 100}{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Adequate rescreening: overdue

$$\frac{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV who had a primary screening HPV test} > \text{5 years and 3 months and} \leq \text{6 years} \times 100}{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Late rescreening

$$\frac{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV who had a primary screening HPV test} > \text{6 years} \times 100}{\text{Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV who had a primary screening HPV test < 4 years 9 months, ≥ 4 years 9 months and ≤ 5 years 3 months, > 5 years 3 months ≤ 6 years, or > 6 years
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test = V *HPV test*
	H1 HPV test date
	H4 Reason for HPV test = C1 *Primary screening HPV test*

Denominator specifications

Definition	Number of participants aged 25–69 whose primary screening HPV test in the index calendar year did not detect oncogenic HPV
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test*
	H1 HPV test date
	H4 Reason for HPV test = C1 *Primary screening HPV test*
	H5 HPV test result – oncogenic HPV = D0 *Oncogenic HPV not detected*

Indicator 4 Screening results

Definition:

Percentage of screening episodes in participants aged 25–74 in each risk category in a calendar year.

Rationale:

Distribution of screening episode results is a key measure for the screening program and any changes in these distributions over time will require investigation within the broader context of the screening program.

Calculation:

Unsatisfactory

$$\frac{\text{Number of primary screening episodes that were unsatisfactory in participants aged 25– 74 in a calendar year}}{\text{Number of primary screening episodes in participants aged 25– 74 in a calendar year}} \times 100$$

Low risk

$$\frac{\text{Number of primary screening episodes that were low risk in participants aged 25– 74 in a calendar year}}{\text{Number of primary screening episodes in participants aged 25– 74}} \times 100$$

Intermediate risk

$$\frac{\text{Number of primary screening episodes that were intermediate risk in participants aged 25– 74 in a calendar year}}{\text{Number of primary screening episodes in participants aged 25– 74 in a calendar year}} \times 100$$

Higher risk

$$\frac{\text{Number of primary screening episodes that were higher risk in participants aged 25– 74 in a calendar year}}{\text{Number of primary screening episodes in participants aged 25– 74 in a calendar year}} \times 100$$

Count is of primary screening episodes

Specifications:

Numerator specifications

Definition	Number of primary screening episodes in participants aged 25–74 in a calendar year that had a risk of significant cervical abnormality of: unsatisfactory low risk intermediate risk higher risk
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J1 Primary screening episode commencement date J4 Primary screening episode test risk of significant cervical abnormality

Denominator specifications

Definition	Number of primary screening episodes in participants aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J1 Primary screening episode commencement date

Indicator 5 Correlation of screening results

Definition:

Level of agreement between screening results in participants aged 25–74 in a calendar year and subsequent histology test results within 6 months.

Rationale:

The correlation between a positive screening test result and the histology test or 'truth' (where this is performed) is a key measure of the accuracy of the HPV test, LBC test, and overall risk assigned to a screening episode.

Calculation:

$$\frac{\text{Histology test results within 6 months}}{\text{Primary screening episode results in participants aged 25– 74 in a calendar year that are followed by a histology test within 6 months}}$$

This calculation is applied cell by cell for each primary screening HPV+LBC result and each histology result, such that the number of tests in each histology result category that corresponds with each HPV+LBC result category is reported in a grid

Numerator is a subset of the denominator

Count is of tests

Specifications:

Numerator specifications

Definition	Histology test results within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test = H *Histology test*
	J2 Primary screening episode completion date
	L1 Histology test date
	L7 Histology test result
	Histology test result categories: Negative DN No result DU Unsatisfactory D1 Negative D2 Low-grade D3 High-grade D4 Cervical cancer

Denominator specifications

Definition	Primary screening episode results followed by histology within 6 months in participants aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	H4 Reason for HPV test = C1 *Primary screening HPV test*
	J1 Primary screening episode commencement date
	J2 Primary screening episode completion date
	J3 Primary screening episode result
	Primary screening episode result categories: U Unsatisfactory HPV test 1 Oncogenic HPV not detected 2.X Oncogenic HPV (not 16/18) + LBC not performed 2.0 Oncogenic HPV (not 16/18) + unsatisfactory LBC 2.1 Oncogenic HPV (not 16/18) + negative LBC 2.2 Oncogenic HPV (not 16/18) + pLSIL/LSIL LBC 2.3 Oncogenic HPV (not 16/18) + pHSIL/HSIL+ LBC 2.4 Oncogenic HPV (not 16/18) + any glandular abnormality LBC 3.X HPV16/18 + LBC not performed 3.0 HPV16/18 + unsatisfactory LBC 3.1 HPV16/18 + negative LBC 3.2 HPV16/18 + pLSIL/LSIL LBC 3.3 HPV16/18 + pHSIL/HSIL+ LBC 3.4 HPV16/18 + any glandular abnormality LBC

Indicator 6 Screening HPV test positivity

Definition:

Percentage of valid screening HPV tests that are positive for oncogenic HPV in participants aged 25–74 in a calendar year.

Rationale:

Monitoring the positivity rate provides important information about a screening test. There are three measures of positivity relevant to the NCSP; any oncogenic HPV positivity is the proportion of valid HPV test that are positive for any oncogenic HPV type, oncogenic HPV 16/18 positivity is the proportion of valid HPV tests that are positive for oncogenic HPV 16/18, and oncogenic HPV (not 16/18) positivity is the proportion of valid HPV tests that are positive for oncogenic HPV (not 16/18).

Calculation:

Any oncogenic HPV positivity rate

$$\frac{\text{Number of valid primary screening HPV tests in which any oncogenic HPV type is detected in participants aged 25–74 in a calendar year} \times 100}{\text{Number of valid primary screening HPV tests in participants aged 25–74 in a calendar year}}$$

Oncogenic HPV 16/18 positivity rate

$$\frac{\text{Number of valid primary screening HPV tests in which oncogenic HPV 16/18 is detected in participants aged 25–74 in a calendar year} \times 100}{\text{Number of valid primary screening HPV tests in participants aged 25–74 in a calendar year}}$$

Oncogenic HPV (not 16/18) positivity rate

$$\frac{\text{Number of valid primary screening HPV tests in which oncogenic HPV (not 16/18) is detected in participants aged 25–74 in a calendar year} \times 100}{\text{Number of valid primary screening HPV tests in participants aged 25–74 in a calendar year}}$$

Count is of valid primary screening HPV tests

Specifications:

Numerator specifications

Definition	Number of valid screening HPV tests in participants aged 25–74 in a calendar year in which: any oncogenic HPV detected oncogenic HPV 16/18 detected oncogenic HPV (not 16/18) detected
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth G1 Type of test = V *HPV test* H1 HPV test date H4 Reason for HPV test = C1 *Primary screening HPV test* H5 HPV test result – oncogenic HPV Any oncogenic HPV = D1 *HPV 16/18 detected* or D1i *Type 16 detected* or D1ii *Type 18 detected* or D1iii *Type 18/45 detected* or D2 *Oncogenic HPV (not 16/18) detected* or D2i *One or more of the following types detected: 31, 33, 45, 52, or 58* or D2ii *One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68* Oncogenic HPV 16/18 = D1 *HPV 16/18 detected* or D1i *Type 16 detected* or D1ii *Type 18 detected* or D1iii *Type 18/45 detected* Oncogenic HPV (not 16/18) = D2 *Oncogenic HPV (not 16/18) detected* or D2i *One or more of the following types detected: 31, 33, 45, 52, or 58* or D2ii *One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68*

Denominator specifications

Definition	Number of valid screening HPV tests in participants aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth G1 Type of test = V *HPV test* H1 HPV test date H4 Reason for HPV test = C1 *Primary screening HPV test* H5 HPV test result – oncogenic HPV ≠ DU *Unsatisfactory*

Indicator 7 Cervical cancer diagnosed after a low risk screening test result

Definition:

Percentage of participants aged 25–74 who are diagnosed with cervical carcinoma within 5 years of a screening HPV test that did not detect oncogenic HPV.

Rationale:

This measures the false negative rate of a low risk primary screening HPV test result.

Calculation:

$$\frac{\text{Number of participants with cervical carcinoma diagnosed within 5 years of a primary screening HPV test that did not detect oncogenic HPV in a calendar year} \times 100}{\text{Number of participants aged 25– 74 who had a primary screening HPV test that did not detect oncogenic HPV in a calendar year}}$$

Numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants with cervical carcinoma diagnosed within 5 years of a primary screening HPV test that did not detect oncogenic HPV in a calendar year
Source	AIHW Australian Cancer Database

Denominator specifications

Definition	Number of participants aged 25–74 who had a primary screening HPV test that did not detect oncogenic HPV in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test*
	H1 HPV test date
	H4 Reason for HPV test = C1 *Primary screening HPV test*
	H5 HPV test result – oncogenic HPV = D0 *Oncogenic HPV not detected*

Indicator 8 LBC test in self-collection participants positive for oncogenic HPV (not 16/18)

Definition:

Percentage of participants aged 25–74 who have an LBC test after a self-collected screening HPV test positive for oncogenic HPV (not 16/18) in a calendar year.

Rationale:

Participants who self-collect their screening test and test positive for oncogenic HPV (not 16/18) are recommended to have a practitioner-collected sample within 6 weeks so that an LBC test can be performed. This indicator monitors compliance with this recommendation within 3 months, and within 6 months, by which time it is considered that most participants would have been able to attend an appointment with a practitioner.

Calculation:

Within 3 months

$$\frac{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 3 months} \times 100}{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year}}$$

Within 6 months

$$\frac{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months} \times 100}{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year}}$$

Numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 who self-collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test: within 3 months within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier G1 Type of test = C *Cytology* H1 HPV test date I1 Cytology test date I4 Reason for cytology test = C2 *Cytology after detection of oncogenic HPV in self-collected sample*

Denominator specifications

Definition	Number of participants aged 25–74 who self-collect their primary screening HPV test and test positive for oncogenic HPV (not 16/18) in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth G1 Type of test = V *HPV test* H1 HPV test date H2 HPV test collection method = A2 *Self-collected sample* H4 Reason for HPV test = C1 *Primary screening HPV test* H5 HPV test result – oncogenic HPV = D2 *Oncogenic HPV (not 16/18) detected* or D2i *One or more of the following types detected: 31, 33, 45, 52, or 58* or D2ii *One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68*

Comments:

This performance indicator is affected by the change in eligibility requirements for self-collection.

From 1 July 2022

Eligibility requirements that had previously restricted self-collection to participants aged 30–74 who had never screened or who were 2 or more years overdue for screening were removed. All participants are now eligible to self-collect their sample.

Indicator 9 Colposcopy in self-collection participants positive for oncogenic HPV 16/18

Definition:

Percentage of participants aged 25–74 who have a colposcopy after a self-collected screening HPV test positive for oncogenic HPV 16/18 in a calendar year.

Rationale:

Participants who self-collect and who test positive for oncogenic HPV 16/18 are recommended to have a colposcopy within 8 weeks. This indicator monitors compliance with this recommendation within 3 months, and within 6 months, by which time it is considered that most participants would have been able to attend an appointment with a colposcopist.

Calculation:

Within 3 months

$$\frac{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 3 months} \times 100}{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV 16/18 in a calendar year}}$$

Within 6 months

$$\frac{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months} \times 100}{\text{Number of participants aged 25– 74 who self- collect their primary screening HPV test and test positive for oncogenic HPV 16/18 in a calendar year}}$$

Numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy: within 3 months within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier G1 Type of test = P *Colposcopy* H1 HPV test date K1 Date of colposcopy episode

Denominator specifications

Definition	Number of participants aged 25–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth G1 Type of test = V *HPV test* H1 HPV test date H2 HPV test collection method = A2 *Self-collected sample* H4 Reason for HPV test = C1 *Primary screening HPV test* H5 HPV test result – oncogenic HPV = D1 *HPV 16/18 detected* or D1i *Type 16 detected* or D1ii *Type 18 detected* or D1iii *Type 18/45 detected*

Comments:

This performance indicator is affected by the change in eligibility requirements for self-collection.

From 1 July 2022

Eligibility requirements that had previously restricted self-collection to participants aged 30–74 who had never screened or who were 2 or more years overdue for screening were removed. All participants are now eligible to self-collect their sample.

Indicator 10 Adherence to recommendation for follow-up

Definition:

(a) Percentage of participants aged 25–74 who have an intermediate risk screening episode in a calendar year who have a follow-up HPV test between 9 and 15 months.

(b) Percentage of participants aged 25–74 who have an intermediate risk follow-up episode in a calendar year who have a follow-up HPV test between 9 and 15 months.

Rationale:

Participants who test positive for oncogenic HPV (not 16/18) and have a negative or pLSIL/ LSIL reflex LBC test result are considered to be of intermediate risk for this primary screening episode, and are recommended to have a follow-up HPV test in 12 months. This indicator monitors compliance with this recommendation for a participant's first follow-up HPV test 12 months after their intermediate risk primary screening episode (allowing 3 months either side of the recommended 12 months).

Participants who test positive for oncogenic HPV (not 16/18) and have a negative or pLSIL/ LSIL reflex LBC test result at their first follow-up HPV test are considered to be of intermediate risk for this first follow-up episode, and are recommended to have a second follow-up HPV test in another 12 months. This indicator also monitors compliance with the recommendation for a participant's second follow-up HPV test 12 months after their intermediate risk follow-up episode (again allowing 3 months either side of the recommended 12 months).

Calculation:

First follow-up HPV test after intermediate risk primary screening episode

$$\frac{\begin{array}{c}\text{Number of participants aged 25– 74 who are determined to be of intermediate risk as the result of a primary screening episode}\\ \text{and who are recommended to have a follow- up HPV test in a calendar year}\\ \text{who have a follow- up HPV test between 9 and 15 months} \times 100\end{array}}{\begin{array}{c}\text{Number of participants aged 25– 74 who are determined to be of intermediate risk as the result of a primary screening episode}\\ \text{and who are recommended to have a follow- up HPV test in a calendar year}\end{array}}$$

Second follow-up HPV test after intermediate risk follow-up episode

$$\frac{\begin{array}{c}\text{Number of participants aged 25– 74 who are determined to be of intermediate risk as the result of a follow- up episode}\\ \text{and who are recommended to have a follow- up HPV test in a calendar year}\\ \text{who have a follow- up HPV test between 9 and 15 months} \times 100\end{array}}{\begin{array}{c}\text{Number of participants aged 25– 74 who are determined to be of intermediate risk as the result of a follow- up episode}\\ \text{and who are recommended to have a follow- up HPV test in a calendar year}\end{array}}$$

Numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 who are determined to be of intermediate risk as the result of a screening or follow-up episode in a calendar year who have a follow-up HPV test between 9 and 15 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test = V *HPV test*
	H1 HPV test date
	H4 Reason for HPV test = C2 *Follow-up HPV test*
	J2 Primary screening episode completion date
	J8 First follow-up episode completion date

Denominator specifications

Definition	Number of participants aged 25–74 who are determined to be of intermediate risk as the result of a screening or follow-up episode in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	J1 Primary screening episode commencement date
	J2 Primary screening episode completion date
	J4 Primary screening episode test risk of significant cervical abnormality = R2 *Intermediate risk*
	J6 Primary screening episode recommendation = M3 Repeat HPV test in 12 months
	J7 First follow-up episode commencement date
	J8 First follow-up episode completion date
	J10 First follow-up episode test risk of significant cervical abnormality = R2 *Intermediate risk*
	J12 First follow-up episode recommendation = M3 Repeat HPV test in 12 months

Comments:

This performance indicator is affected by the change in the screening policy for participants at *Intermediate risk*.

From 1 February 2021

For *Intermediate risk* participants, if HPV (not 16/18) is detected and LBC is negative, pLSIL or LSIL in the follow-up HPV test at 12 months, they will continue to be managed as *Intermediate risk* and recommended to undertake a second HPV follow-up test at 12 months (unless the participant is 2 or more years overdue for screening at the time of the initial screen, identifies as Aboriginal and/or Torres Strait Islander, or is aged 50 years or older, in which case any HPV detected in the follow-up HPV test at 12 months indicates they are *Higher risk* and should be referred to colposcopy).

Indicator 11 Follow-up results

Definition:

Percentage of follow-up episodes in participants aged 25–74 in each risk category in a calendar year.

Rationale:

Follow-up results are the follow-up HPV test result and reflex LBC (where indicated) that occur 12 months after an intermediate risk screening episode result, or 12 months after an intermediate risk follow-up episode result. Distribution of follow-up episode results is a key measure for the screening program and any changes in these distributions over time will require investigation within the broader context of the screening program. For this reason, follow-up results are based on test risk, not participant risk.

This indicator is reported separately for first follow-up episodes and second follow-up episodes.

Calculation:

First follow-up episode results

Unsatisfactory

$$\frac{\text{Number of first follow- up episodes that were unsatisfactory in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of first follow- up episodes in participants aged 25– 74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of first follow- up episodes that were low risk in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of first follow- up episodes in participants aged 25– 74}}$$

Intermediate risk

$$\frac{\text{Number of first follow- up episodes that were intermediate risk in participants aged 25– 74 in a calendar year x 100}}{\text{Number of first follow- up episodes in participants aged 25– 74 in a calendar year}}$$

Higher risk

$$\frac{\text{Number of first follow- up episodes that were higher risk in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of first follow- up episodes in participants aged 25– 74 in a calendar year}}$$

Second follow-up episode results

Unsatisfactory

$$\frac{\text{Number of second follow- up episodes that were unsatisfactory in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of second follow- up episodes in participants aged 25– 74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of second follow- up episodes that were low risk in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of second follow- up episodes in participants aged 25– 74}}$$

Higher risk

$$\frac{\text{Number of seond follow- up episodes that were higher risk in participants aged 25– 74 in a calendar year} \times 100}{\text{Number of second follow- up episodes in participants aged 25– 74 in a calendar year}}$$

Count is of follow-up episodes

Specifications:

Numerator specifications

Definition	Number of follow-up episodes in participants aged 25–74 in a calendar year that had a risk of significant cervical abnormality of: unsatisfactory low risk intermediate risk (first follow-up episodes only) higher risk
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J7 First follow-up episode commencement date J10 First follow-up episode test risk of significant cervical abnormality J13 Second follow-up episode commencement date J16 Second follow-up episode test risk of significant cervical abnormality

Denominator specifications

Definition	Number of follow-up episodes in participants aged 25–74 in a calendar year: first follow-up episode second follow-up episode
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J7 First follow-up episode commencement date J13 Second follow-up episode commencement date

Comments:

This performance indicator is affected by the change in the screening policy for participants at *Intermediate risk*.

From 1 February 2021

For *Intermediate risk* participants, if HPV (not 16/18) is detected and LBC is negative, pLSIL or LSIL in the follow-up HPV test at 12 months, they will continue to be managed as *Intermediate risk* and recommended to undertake a second HPV follow-up test at 12 months (unless the participant is 2 or more years overdue for screening at the time of the initial screen, identifies as Aboriginal and/or Torres Strait Islander, or is aged 50 years or older, in which case any HPV detected in the follow-up HPV test at 12 months indicates they are *Higher risk* and should be referred to colposcopy).

Indicator 12 Colposcopy rate

Definition:

Percentage of participants aged 25–74 who have a screening or follow-up episode result that places them at higher risk of significant cervical abnormality in a calendar year who attend colposcopy within 3 months.

Rationale:

The success of a screening program is reliant on assessment being performed when required. This measures compliance with referral for colposcopy based on a screening episode result or follow-up episode result that places them at higher risk of significant cervical abnormality, and should be calculated for each screening episode result and follow-up episode result.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

$$\frac{\text{Number of participants aged 25– 74 with a primary screening HPV test in which oncogenic HPV 16/18 is detected in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of participants aged 25– 74 with a primary screening HPV test in which oncogenic HPV 16/18 is detected in a calendar year}}$$

Oncogenic HPV (not 16/18) detected + reflex LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality

$$\frac{\text{Number of participants aged 25– 74 with a primary screening HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of participants aged 25– 74 with a primary screening HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year}}$$

First follow-up episode result that indicates higher risk

$$\frac{\text{Number of participants aged 25– 74 with a first follow- up HPV test in which oncogenic HPV 16/18 is detected or a follow- up HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality or a follow- up HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of negative/pLSIL/LSIL and who were 2 or more years overdue for screening at the time of their initial screen, is Aboriginal and/or Torres Strait Islander, or is aged 50 years or older in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of participants aged 25– 74 with a first follow- up HPV test in which oncogenic HPV 16/18 is detected or a follow- up HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality or a follow- up HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of negative/pLSIL/LSIL and who were 2 or more years overdue for screening at the time of their initial screen, is Aboriginal and/or Torres Strait Islander, or is aged 50 years or older in a calendar year}}$$

Second follow-up episode result that indicates higher risk

$$\frac{\text{Number of participants aged 25– 74 with a second follow- up HPV test in which any oncogenic HPV is detected in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of participants aged 25– 74 with a second follow- up HPV test in which any oncogenic HPV is detected in a calendar year}}$$

The numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants who had a colposcopy after each specified screening or follow-up episode result within 3 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test
	K1 Date of colposcopy episode

Denominator specifications

Definition	Number of participants aged 25–74 who have a screening or follow-up episode result that places them at higher risk of significant cervical abnormality in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	J2 Primary screening episode completion date
	J3 Primary screening episode result
	J4 Primary screening episode test risk of significant cervical abnormality
	J6 Primary screening episode recommendation = M6 Refer for colposcopic assessment
	J8 First follow-up episode completion date
	J9 First follow-up episode result
	J10 First follow-up episode test risk of significant cervical abnormality
	J12 First follow-up episode recommendation = M6 Refer for colposcopic assessment
	J14 Second follow-up episode completion date
	J15 Second follow-up episode result
	J16 Second follow-up episode test risk of significant cervical abnormality

Comments:

This performance indicator is affected by the change in the screening policy for participants at *Intermediate risk*.

From 1 February 2021

For *Intermediate risk* participants, if HPV (not 16/18) is detected and LBC is negative, pLSIL or LSIL in the follow-up HPV test at 12 months, they will continue to be managed as *Intermediate risk* and recommended to undertake a second HPV follow-up test at 12 months (unless the participant is 2 or more years overdue for screening at the time of the initial screen, identifies as Aboriginal and/or Torres Strait Islander, or is aged 50 years or older, in which case any HPV detected in the follow-up HPV test at 12 months indicates they are *Higher risk* and should be referred to colposcopy).

Indicator 13 Time to colposcopy

Definition:

Participants aged 25–74 who have a screening or follow-up episode result that places them at higher risk of significant cervical abnormality, the time between the screening or follow-up result and colposcopy, measured as median and 90th percentile values, as well as within specified timeframes.

Rationale:

Participants who receive a screening episode result or follow-up episode result that places them at higher risk of significant cervical abnormality will be referred to colposcopy. The recommended timeframes in which they should undergo colposcopic assessment is as per the NCSP Guidelines (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party). Monitoring actual time between screening result or follow-up result and colposcopy provides important information as to whether participants are receiving timely assessment, as delay in assessment may lead to poorer outcomes.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

For participants aged 25–74 with a screening HPV test in which oncogenic HPV 16/18 is detected in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Oncogenic HPV detected (not 16/18) + reflex LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality

For participants aged 25–74 with a screening HPV test in which oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

First follow-up episode result that indicates higher risk

For participants aged 25–74 with a first follow-up HPV test in which oncogenic HPV 16/18 is detected or oncogenic HPV (not 16/18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/ any glandular abnormality or HPV (not 16/18) is detected and who had an LBC result of negative/pLSIL/LSIL and who were 2 or more years overdue for screening at the time of their initial screen, is Aboriginal and/or Torres Strait Islander, or is aged 50 years or older in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Second follow-up HPV episode result that indicates higher risk

For participants aged 25–74 with a second follow-up HPV test in which any oncogenic HPV is detected in a calendar year who had a colposcopy within 365 days, time to colposcopy in number of days

Count is of days

Specifications:

Specifications	
Definition	For participants who had a colposcopy within 365 days of a screening or follow-up episode result that places them at higher risk of significant cervical abnormality, the number of days to colposcopy
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test
	J2 Primary screening episode completion date
	J3 Primary screening episode result
	J4 Primary screening episode test risk of significant cervical abnormality
	J6 Primary screening episode recommendation = M6 Refer for colposcopic assessment
	J8 First follow-up episode completion date
	J9 First follow-up episode result
	J10 First follow-up episode test risk of significant cervical abnormality
	J12 First follow-up episode recommendation = M6 Refer for colposcopic assessment
	J14 Second follow-up episode completion date
	J15 Second follow-up episode result
	J16 Second follow-up episode test risk of significant cervical abnormality
	K1 Date of colposcopy episode

Comments:

This performance indicator is affected by the change in the screening policy for participants at *Intermediate risk*.

From 1 February 2021

For *Intermediate risk* participants, if HPV (not 16/18) is detected and LBC is negative, pLSIL or LSIL in the follow-up HPV test at 12 months, they will continue to be managed as *Intermediate risk* and recommended to undertake a second HPV follow-up test at 12 months (unless the participant is 2 or more years overdue for screening at the time of the initial screen, identifies as Aboriginal and/or Torres Strait Islander, or is aged 50 years or older, in which case any HPV detected in the follow-up HPV test at 12 months indicates they are *Higher risk* and should be referred to colposcopy).

Indicator 14 Biopsy rate

Definition:

Percentage of colposcopies in participants aged 25–74 in which a biopsy was performed in a calendar year.

Rationale:

Although there are reasons why a biopsy would not be performed at colposcopy, a lower than expected biopsy rate would require further investigation.

Calculation:

$$\frac{\text{Number of colposcopy episodes at which a biopsy was performed in participants aged 25– 74 in a calendar year}}{\text{Number of colposcopy episodes in participants aged 25– 74 in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of colposcopy episodes

Specifications:

Numerator specifications

Definition	Number of colposcopy episodes at which a biopsy was performed in participants aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	K1 Date of colposcopy episode
	K8 Biopsy this episode
	K10 Colposcopy data source = 1 *Colposcopy Data Collection Form*

Denominator specifications

Definition	Number of colposcopy episodes in participants aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = P *Colposcopy*
	K1 Date of colposcopy episode

Indicator 15 Yield of high-grade abnormalities on biopsy among participants who attend colposcopy after higher risk screening results

Definition:

Percentage of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopy in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy.

Rationale:

As participants who are referred to colposcopy are at higher risk of significant cervical abnormality, it is expected that a proportion of these will be diagnosed with a high-grade abnormality or cervical cancer. This indicator can be used as a measure of the accuracy of colposcopy in identifying and sampling a high-grade abnormality or cervical cancer that is present.

Calculation:

$$\frac{\text{Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopy in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy} \times 100}{\text{Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopy in a calendar year}}$$

The numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopy in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	K1 Date of colposcopy episode
	L1 Histology test date
	L7 Histology test result

Denominator specifications

Definition	Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopy in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	J2 Primary screening episode completion date
	J3 Primary screening episode result
	J4 Primary screening episode test risk of significant cervical abnormality
	J6 Primary screening episode recommendation = M6 Refer for colposcopic assessment
	J8 First follow-up episode completion date
	J9 First follow-up episode result
	J10 First follow-up episode test risk of significant cervical abnormality
	J12 First follow-up episode recommendation = M6 Refer for colposcopic assessment
	J14 Second follow-up episode completion date
	J15 Second follow-up episode result
	J16 Second follow-up episode test risk of significant cervical abnormality
	K1 Date of colposcopy episode

Indicator 16 Positive predictive value of colposcopy

Definition:

Percentage of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma-in-situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy.

Rationale:

This indicator correlates the colposcopic impression with histological findings to determine the predictive value of colposcopy for high-grade cervical abnormalities. This is an important measure of the quality of colposcopy.

Calculation:

$$\frac{\text{Number of participants aged 25– 74 with a higher risk screening or follow- up episode result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma- in- situ), or cancer in a calendar year who were diagnosed with a high- grade abnormality or cervical cancer on histology within 6 months of colposcopy}}{\text{Number of participants aged 25– 74 with a higher risk screening or follow- up episode result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma- in- situ), or cancer in a calendar year}} \times 100$$

The numerator is a subset of the denominator

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma-in-situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	K1 Date of colposcopy episode
	L1 Histology test date
	L7 Histology test result

Denominator specifications

Definition	Number of participants aged 25–74 with a higher risk screening or follow-up episode result who had a colposcopic impression of high-grade or higher in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	J3 Primary screening episode result
	J4 Primary screening episode test risk of significant cervical abnormality
	J6 Primary screening episode recommendation = M6 Refer for colposcopic assessment
	J9 First follow-up episode result
	J10 First follow-up episode test risk of significant cervical abnormality
	J12 First follow-up episode recommendation = M6 Refer for colposcopic assessment
	J15 Second follow-up episode result
	J16 Second follow-up episode test risk of significant cervical abnormality
	K1 Date of colposcopy episode
	K6 Colposcopic impression – primary diagnosis
	K10 Colposcopy data source = 1 *Colposcopy Data Collection Form*

Indicator 17a High-grade cervical abnormality detection rate

Definition:

Number of participants aged 25–74 with a high-grade abnormality detected on histology in a calendar year per 1,000 participants screened.

Rationale:

The detection of high-grade abnormalities is an indicator of program performance. High-grade abnormalities have a greater probability of progressing to invasive cancer than do low-grade lesions. Detection of high-grade abnormalities provides an opportunity for treatment before cancer can develop, thus the NCSP aims to detect high-grade abnormalities in line with its broader aim to reduce the incidence of cervical cancer.

Calculation:

$$\frac{\text{Number of participants aged 25– 74 with a high- grade abnormality detected on histology in a calendar year}}{\text{Number of participants aged 25– 74 who had at least one HPV test or cytology test for any reason in a calendar year}} \times 1{,}000$$

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 with a high-grade abnormality detected on histology in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = H *Histology*
	L1 Histology test date
	L4 Squamous histology cell analysis
	L5 Endocervical (glandular) histology cell analysis

Denominator specifications

Definition	Number of participants aged 25–74 who had at least one HPV test or cytology test for any reason in a calendar year.
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test* or C *Cytology test*
	H1 HPV test date
	I1 Cytology test date

Indicator 17b Cervical cancer detection rate

Definition:

Number of participants aged 25–74 with cervical carcinoma detected on histology in a calendar year per 1,000 participants screened.

Rationale:

The cancer detection rate will be measured alongside the high-grade detection rate.

Calculation:

$$\frac{\text{Number of participants aged 25– 74 with a cervical carcinoma detected on histology in a calendar year } \times 1{,}000}{\text{Number of participants aged 25– 74 who had at least one HPV test or cytology test for any reason in a calendar year}}$$

Count is of participants

Specifications:

Numerator specifications

Definition	Number of participants aged 25–74 with a cervical cancer detected on histology in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = H *Histology test*
	L1 Histology test date
	L4 Squamous histology cell analysis
	L5 Endocervical (glandular) histology cell analysis

Denominator specifications

Definition	Number of participants aged 25–74 who had at least one HPV test or cytology test for any reason in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test = V *HPV test* or C *Cytology test*
	H1 HPV test date
	I1 Cytology test date

Indicator 18 Cervical cancers diagnosed by time since last screen

Definition:

Number of females aged 25–74 diagnosed with cervical carcinoma in a calendar year categorised into never screened, lapsed screening, and recently screened based on time since last screen.

Rationale:

This is a measure of the burden of disease from a lack of participation in the screening program. Time since last screen is used to categorise all females diagnosed with cervical carcinoma as never screened, lapsed screening, or recently screened. Most cervical carcinomas have historically been diagnosed in those who have never screened, which is evidence of the benefit of participation in cervical screening.

Only cervical carcinomas (cervical cancers of epithelial origin) are included, as cervical cancers not of epithelial origin are not expected to be detected through cervical screening.

Never screened is defined as no record of having had a screening test in Australia prior to cancer diagnosis.
Lapsed screening is defined as last screening test >5.5 and ≤7.5 years, >7.5 and ≤10 years or >10 years prior to cancer diagnosis.
Recently screened is defined as last screening test ≤5.5 years prior to cancer diagnosis.

Calculation:

Never screened

Females aged 25–74 diagnosed with cervical carcinoma in a calendar year who are either on a register with no record of a screening test or not on a register

Lapsed screening

Females aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >5.5 years and ≤7.5 years before the cervical cancer diagnosis date

Females aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >7.5 years and ≤10 years before the cervical cancer diagnosis date

Females aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was >10 years before the cervical cancer diagnosis date

Recently screened

Females aged 25–74 diagnosed with cervical carcinoma in a calendar year whose last screening test was ≤5.5 years before the cervical cancer diagnosis date

Specifications:

Specifications	
Definition	Females aged 25–74 diagnosed with cervical carcinoma in a calendar year categorised into never screened, lapsed screening, and recently screened
Source	AIHW Australian Cancer Database; National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	P2 Date of last screening test
	P3 Last screening test type

Indicator 19 Incidence of cervical cancer

Definition:

Number of new cases of cervical cancer in females aged 25–74 in a calendar year per 100,000 estimated resident population.

Rationale:

Incidence data provide contextual information about the number of new cases of cervical cancer in the population that is an indicator of program performance against its aim to reduce cervical cancer through organised screening.

Calculation:

$$\frac{\text{Number of new cases of cervical cancer diagnosed in females aged 25– 74 in a calendar year } \times 100{,}000}{\text{Estimated resident population for females aged 25– 74 in a calendar year}}$$

Count is of new cases

Specifications:

Numerator specifications

Definition	Number of new cases of cervical cancer diagnosed in females aged 25–74 in a calendar year
Source	AIHW Australian Cancer Database

Denominator specifications

Definition	Estimated resident population for females aged 25–74 in a calendar year
Source	Australian Bureau of Statistics

Indicator 20 Mortality from cervical cancer

Definition:

Number of deaths from cervical cancer in females aged 25–74 in a calendar year per 100,000 estimated resident population.

Rationale:

Mortality data provide contextual information about the number of deaths from cervical cancer in the population that is an indicator of program performance against its aim to reduce mortality from cervical cancer through organised screening.

Calculation:

$$\frac{\text{Number of deaths from cervical cancer in females aged 25– 74 in a calendar year } \times 100{,}000}{\text{Estimated resident population for females aged 25– 74 in a calendar year}}$$

Count is of deaths

Specifications:

Numerator specifications

Definition	Number of deaths from cervical cancer in females aged 25–74 in a calendar year
Source	AIHW National Morbidity Database

Denominator specifications

Definition	Estimated resident population for females aged 25–74 in a calendar year
Source	Australian Bureau of Statistics

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Abbreviations

ABS	Australian Bureau of Statistics
ACD	Australian Cancer Database
AIHW	Australian Institute of Health and Welfare
AIS	adenocarcinoma-in-situ
HPV	human papillomavirus
LSIL	low-grade squamous intraepithelial lesion
HSIL	high-grade squamous intraepithelial lesion
NCSP	National Cervical Screening Program
NCSR	National Cancer Screening Register
NHMRC	National Health and Medical Research Council

Symbols

<	less than
≤	less than or equal to
>	greater than

List of tables

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better decisions,
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