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National Cervical Screening Program Data Dictionary

Version 1.1

AIHW

National Cervical Screening Program Data Dictionary

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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. Here, the more important terms and concepts have been 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** (repeat HPV test after negative or pLSIL/LSIL reflex LBC) and an LBC if this is required.

HPV: This term is used to indicate oncogenic HPV (otherwise known as high-risk HPV), which are the types of HPV associated with cervical cancer.

HPV types: HPV types should be referred to as **oncogenic** or **non-oncogenic** and not high risk and low risk. This is to avoid confusion with the risk of significant cervical abnormality.

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 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).

People: In the context of National Cervical Screening Program data, 'people' refers to any person with a cervix. This may include women, transgender men, intersex people, and non-binary people.

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 'oncogenic HPV not detected'.

Negative cytology is defined as per the previous Pap test program, and requires that the squamous cell component is '*S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes*' and the endocervical (glandular) component is either '*E0 No endocervical component*' or '*E1 Endocervical component present. No abnormality or only reactive changes*'.

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

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

- people who are classified at **low risk** will be invited to re-screen in five years
- people who are classified at **intermediate risk** will be invited to have another HPV test in 12 months. This is to check that the HPV infection has cleared. This second HPV test is a **follow-up test**, not a screening test because people at intermediate risk are not at average population risk
- people 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.

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

Self-collected sample: A vaginal sample taken by a person.

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. Until December 2017, this has been achieved through organised, population-based cervical screening using 2-yearly Pap tests to detect precancerous changes to cervical cells, allowing treatment before any progression to cervical cancer, thereby preventing this disease. Cervical screening using Pap tests has been 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.

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 now 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.

The renewed NCSP means changes to the way that people are screened. Instead of people aged 20–69 having a Pap test every 2 years, people aged 25–74 now have a Cervical Screening Test (CST) every 5 years (the CST is an HPV test, followed by a cytology test if HPV is found). Another change is the collection of cervical screening data by the National Cancer Screening Register (NCSR), which is now the sole source of cervical screening data.

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. After which the renewed NCSP that commenced on 1 December 2017 was supported by a new data dictionary – the *National Cervical Screening Program data dictionary version 1.0*.

Work on this 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, convened specifically for this purpose, 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, Associate Professor Marion Saville, Dr 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 in 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.

This current *National Cervical Screening Program data dictionary version 1.1* is the result of a process to revise and update the data dictionary in line with the renewed NCSP that occurred in 2020, again with the assistance of state and territory cervical screening programs through the National Cervical Screening data dictionary working group and the NCSP Program Management Committee (PMC) more broadly. This was endorsed by the PMC on 5 May 2022 and released by the AIHW on 10 May 2022.

It supersedes the *National Cervical Screening Program data dictionary version 1.0*.

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 1.1* compared to *version 1.0*.

Terminology

Terminology around gender has been changed to be more inclusive of all people who are eligible to screen through the National Cervical Screening Program. Previously the terms ‘woman’ and ’women’ were used throughout this document. These terms have been replaced with the terms ‘person’, ‘people’, and ‘participants’.

> This document uses the terms ‘person’, ‘people’ and ‘participants’ when referring to data collected under the NCSP. These data are not restricted by sex or gender, with all participants in cervical screening included in these data. For NCSP data, ‘person’ or ‘people’ is defined as any person with a cervix. This may include women, transgender men, intersex people, and non-binary people.
>
> This document uses the term 'women' to mean ‘female' when referring to cancer incidence data and cancer mortality data, as these data sources are based on sex assigned at birth. However, it should be noted that some people may not identify with this term.

New terminology is detailed in Table 2.1.

Table 2.1: New terminology

Terminology	Definition	Reason for addition
Person or people	In the context of National Cervical Screening Program data, ‘person’ or ‘people’ refers to any person with a cervix. This may include women, transgender men, intersex people, and non-binary people.	Terminology around gender has been changed to be more inclusive of all people who are eligible to screen through the National Cervical Screening Program
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 oncogenic HPV not detected. Negative cytology is defined as per the previous Pap test program, and requires that the squamous cell component is ‘*S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes’* and the endocervical (glandular) component is either ‘*E0 No endocervical component’* or ‘*E1 Endocervical component present. No abnormality or only reactive changes’*.	A co-test requires both HPV and LBC tests to be performed irrespective of the HPV test result. Practitioners are able to request a co-test for the investigation of symptoms of cervical cancer; for the management of a patient following treatment of high grade squamous intraepithelial lesions (HSIL) of the cervix as part of a ‘test of cure’ process performed at 12 months after treatment and annually thereafter, until receiving a negative co-test on two separate consecutive occasions; for the follow up management of glandular abnormalities; or for screening a patient exposed to diethylstilboestrol (DES) in utero and daughters of patients exposed to DES in utero. Thus it is important that there is an agreed definition of a negative co-test.

Screening pathway

There has been a significant change to the screening pathway for people at intermediate risk, effective from 1 February 2021. This is detailed in Table 2.2.

Table 2.2: Revised screening pathway

Screening pathway		Reason for change
Version 1.1	**Version 1.0**	
For people with a cervical screening result of *Intermediate risk* and recommended to have a follow-up HPV test at 12 months, if HPV (not 16/18) is detected and LBC prediction is negative, pLSIL or LSIL in the follow-up HPV test at 12 months, from 1 February 2021, they will continue to be managed as *Intermediate risk* and recommended to undertake a second HPV follow-up test at 12 months. This change excludes some groups who may be at higher risk of a high-grade abnormality, who should be referred to colposcopy if any HPV is detected at 12 months. These include: • 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.	People with a cervical screening result of *Intermediate risk* are recommended to have a follow-up HPV test at 12 months and be managed as *Higher risk* if any HPV is detected in test.	The Cancer Council Australia Clinical Guidelines working party reviewed new Australian data for the cervical screening pathway recommendation for people with a 12-month follow-up HPV test in which HPV (any type) was detected. In the planning for the change to primary HPV screening, a cautious approach was adopted for management of these people, meaning the pathway for people with this result was universal referral for colposcopy. Current national program data, broken down by HPV type, has shown that the risk of CIN2/3 and cervical cancer is very low for those participants in whom HPV (not 16/18) is detected and the reflex LBC is negative, pLSIL or LSIL. Based on this current evidence, clinical advisors have now recommended that people with a 12-month follow-up HPV test in which HPV (not 16/18) is detected and reflex LBC is negative, pLSIL or LSIL (*Intermediate risk* result) should be recommended to undertake a second follow-up HPV test in a further 12 months' time following their first follow-up HPV test. 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. This took effect from 1 February 2021.

Data items

New, deleted, and revised data items are detailed in Table 2.3, Table 2.4, and Table 2.5.

Table 2.3: New data items

Data item (version 1.1)	Definition	Reason for addition
B6 Gender	The way a person describes their social and cultural identity, expression and experience as man, or boy, or woman, or girl, or non-binary.	Gender was added at the same time that sex was revised to the 2021 definition to provide clarity of how sex and gender differ as well as updating the appropriate terminology and definitions for these two terms.
C1 Defer flag	An indication as to whether a person has requested that their participation in cervical screening be deferred.	Alert that defer is active.
C5 Opt out flag	An indication as to whether a person has opted out of all participation in the National Cancer Screening Register for the National Cervical Screening Program.	Alert that opt out is active.
C6 Reason for opt out	The reason that a person 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.	Participants can choose between three reasons when opting out. This data item has been added to allow this reason to be collected.
C13 DES exposed	An indication of whether a person was exposed to diethylstilboestrol (DES) in utero.	Women exposed to DES in utero are at increased risk of clear cell carcinoma of the vagina and cervix and are offered more frequent screening with co-tests. The addition of this data item allows this to be collected if recorded by a health professional.
C14 Immunocompromised	An indication of whether a person is immunocompromised.	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. 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 more frequent screening. The addition of this data item allows this to be collected if recorded by a health professional.
D4 HPV vaccine dose age	The age at which a person received an HPV vaccine dose.	This data item allows the collection of the age of the person for each HPV vaccine dose administered.
H6 HPV test result – secondary oncogenic HPV	The secondary result of an HPV test for oncogenic HPV types.	This data item allows the collection of any secondary HPV types recorded by a pathology laboratory. This is not used to assign risk, but is useful to increase knowledge of all HPV types detected.

(continued)

Table 2.3: New data items (continued)

Data item (version 1.1)	Definition	Reason for addition
K10 Colposcopy data source	An indication as to the source of data that a colposcopy occurred.	There are several sources of colposcopy data in the NCSR with different information available. This data item allows the source of the colposcopy event to be specified.
L8 Histology report text	Text from the report prepared for cervical histology.	This data item allows histology report text to be included that is often required for detailed information when supporting research requests.
L11 Histology data source	An indication as to the source of data that histology occurred.	There are two sources of histology data in the NCSR with different information available. This data item allows the source of the histology test information to be specified.
N6 Medicare provider number of provider collecting a specimen	The provider number of the provider collecting a specimen.	This data item allows the collection of provider number if the provider who collects a specimen did not request the test.
N11 Australian state/territory of provider collecting a specimen	The abbreviated name of the Australian state or territory in which the provider collecting a specimen is located.	This data item allows the collection of the state or territory of the provider who collects a specimen.
N12 Australian postcode of provider collecting a specimen	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.	This data item allows the collection of the postcode of the provider who collects a specimen.
O4 Pathology laboratory Australian state/territory	The abbreviated name of the Australian state or territory in which the pathology laboratory that perform analyses on cervical specimens is located.	This data item allows the collection of the state or territory of the pathology laboratory that analyses a specimen.
O5 Pathology laboratory Australian postcode	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.	This data item allows the collection of the postcode of the pathology laboratory that analyses a specimen.

Table 2.4: Deleted data items

Data item (version 1.0)	Definition	Reason for deletion
C1 Active status	An indication as to whether a person's record is currently active.	None of the NCSR data items that are provided to the AIHW align with the current active status of a person.
E10 Mailing geocode – latitude	Latitude of mailing address.	As residential address is available, mailing address is not required.
E11 Mailing geocode – longitude	Longitude of mailing address.	As residential address is available, mailing address is not required.
E12 Mailing geocode – quality	A measure of the quality of geocode for mailing address.	As residential address is available, mailing address is not required.
E13 Mailing SA1	SA1 of mailing address.	As residential address is available, mailing address is not required.

(continued)

Table 2.4: Deleted data items (continued)

Data item (version 1.0)	Definition	Reason for deletion
H6 Secondary HPV test results – HPV 16/18 detected	The secondary HPV test result where the primary HPV test result was 'HPV 16/18 detected' providing additional information about oncogenic test types detected.	This was intended to collect additional information about oncogenic test types detected when the primary HPV test detected oncogenic HPV types 16 or 18, but has been replaced by a single data item '*H6 HPV test result – other oncogenic HPV*' used to collect the HPV test result for a second oncogenic HPV type in the event that one is detected in the same sample, to reflect the NCSR data provided to the AIHW.
H7 Secondary HPV test results – oncogenic HPV (not 16/18) detected	The secondary HPV test result where the primary HPV test result was 'Oncogenic HPV (not 16/18) detected' providing additional information about oncogenic HPV types detected.	This was intended to collect additional information about oncogenic test types detected when the primary HPV test detected oncogenic HPV types other than 16 or 18, but has been replaced by a single data item '*H6 HPV test result – other oncogenic HPV*' used to collect the HPV test result for a second oncogenic HPV type in the event that one is detected in the same sample, to reflect the NCSR data provided to the AIHW.
K1 Colposcopy episode identifier	A unique identifier allocated to a colposcopy episode to distinguish it from all other colposcopy episodes.	The data item '*Colposcopy episode identifier*' has been removed, as colposcopy data are part of the NCSR, which removes the need for the episode identifier to be included in the data dictionary (a unique identifier is not included as a data item for other test types in the data dictionary).

Table 2.5: Revised data items

Data item		Reason for change
Version 1.1	**Version 1.0**	
Group A Participant identifier data items	Group A Client identifier data items	Group A has been changed from *Client identifier* data items to *Participant identifier* data items to align with terminology changes that have been made within this version of the data dictionary.
A1 Participant identifier	A1 Client identifier	Name change only.
A2 Previous participant identifier	A2 Previous client identifier	Name change only.
Group B Participant data items	Group B Client data items	Group B has been changed from *Client* data items to *Participant* data items to align with terminology changes that have been made within this version of the data dictionary.
Group C Participant status data items	Group C Client status data items	Group C has been changed from *Client status* data items to *Participant status* data items to align with terminology changes that have been made within this version of the data dictionary.
C3 Reason to defer screening	C2 Reason for temporary inactivation	Terminology changed from *temporary inactivation* to *defer*.
C4 Defer start date	C3 Date of temporary inactivation	Terminology changed from *temporary inactivation* to *defer*.
C5 Defer end date	C4 Date of reactivation	Terminology changed from *reactivation* to *defer end*.

(continued)

Table 2.5: Revised data items (continued)

Data item		Reason for change
Version 1.1	**Version 1.0**	
C8 Opt out date	C5 Withdrawn date	Terminology changed from *withdrawn* to *opt out*.
C9 Opt in date	C6 Withdrawn rescinded date	Terminology changed from *withdrawn rescinded* to *opt in*, noting that to opt in means to withdraw a request to opt out rather than to opt in *per se*.
Group D Participant vaccination status data items	Group D Client vaccination status data items	Group D has been changed from *Client vaccination status* data items to *Participant vaccination status* data items to align with terminology changes that have been made within this version of the data dictionary.
D1 HPV vaccination clinical completion status	D1 HPV vaccination status	Name change only.
D2 HPV vaccination clinical completion date	D2 HPV vaccination completion date	Name change only.
D3 HPV vaccine dose date	D3 HPV vaccination episode date	Name change only.
D5 HPV vaccine implied dose number	D4 HPV vaccine dose number	Changed from actual dose number to implied dose number, which is the clinically relevant dose number.
D6 HPV vaccine type	D5 HPV vaccine type	Addition of the nonavalent HPV vaccine type Gardasil9.
Group E Participant demographic data items	Group E Client demographic data items	Group E has been changed from *Client demographic* data items to *Participant demographic* data items to align with terminology changes that have been made within this version of the data dictionary.
Group F Correspondence data items	Group F Contact data items	Group F has been changed from *Contact* data items to *Correspondence* data items to reflect the data items collected.
F1 Correspondence type	F1 Type of contact	Terminology changed from contact to correspondence.
F2 Correspondence date	F2 Date of contact	Terminology changed from contact to correspondence.
F3 Correspondence method	F3 Method of contact	Terminology changed from contact to correspondence.
F4 Correspondence failure flag	F4 Contact failure flag	Terminology changed from contact to correspondence.
F5 Correspondence failure date	F5 Contact failure date	Terminology changed from contact to correspondence.
F6 Correspondence failure type	F6 Contact failure type	Terminology changed from contact to correspondence.
H4 Reason for HPV test	H4 Reason for HPV test	Value 2 *Follow-up HPV test* (*Repeat HPV test after intermediate risk result or unsatisfactory test*) changed to *Follow-up HPV test* (*Repeat HPV test after intermediate result*). This reflects a change in *NPAAC Requirements for Laboratories Reporting Tests for the National Cervical Screening Program (Second Edition 2019)* that restricts a Reason for HPV test of 2 to Repeat HPV test after intermediate result. Pathology laboratories are advised that the repeat test after a prior unsatisfactory screening test should be coded according to the circumstances of the original (unsatisfactory test), rather than using a value of 2.

(continued)

Table 2.5: Revised data items (continued)

Data item		Reason for change
Version 1.1	**Version 1.0**	
H5 HPV test result – oncogenic HPV	H5 HPV test result – oncogenic HPV	This was intended to collect the oncogenic HPV test result: *Unsatisfactory*, *Oncogenic HPV not detected*, *HPV 16/18 detected* or *Oncogenic HPV (not 16/18) detected*, with two additional data items collecting the type of oncogenic HPV detected where either *HPV 16/18 detected* or *Oncogenic HPV (not 16/18) detected* was the oncogenic HPV test result. These three data items have been replaced by a single data item 'H5 HPV test result – oncogenic HPV', to reflect the NCSR data provided to the AIHW.
K9 Pregnant at time of colposcopy	K10 Pregnancy flag	Name change only.
J9 Follow-up episode risk of significant cervical abnormality	J9 Follow-up episode risk of significant cervical abnormality	From 1 February 2021, people with a 12-month follow-up HPV test in which HPV (not 16/18) is detected and reflex LBC is negative, pLSIL or LSIL (*Intermediate risk* result) should be recommended to undertake a second follow-up HPV test in a further 12 months' time following their first follow-up HPV test, instead of colposcopy (that is, they remain at intermediate risk instead of changing to higher risk), unless they fall into one of the groups that are an exception to this. An *Intermediate* follow-up episode risk of significant cervical abnormality has been added to accommodate this change.
M11 Test of cure completion flag		Now includes definition of negative co-test.
M12 Test of cure completion date		Now includes definition of negative co-test.
N1 Medicare provider number of provider requesting a test	N1 Medicare provider number	Name change to specify this is the provider requesting a test.
N2 Healthcare provider identifier – individual (HPI-I) of provider requesting a test	N3 Healthcare provider identifier – individual (HPI-I)	Name change to specify this is the provider requesting a test.
N3 Healthcare provider identifier – organisation (HPI-O) of provider requesting a test	N2 Healthcare provider identifier – organisation (HPI-O)	Name change to specify this is the provider requesting a test.
N4 Australian state/territory of provider requesting a test	N5 Provider Australian state/territory	Name change to specify this is the provider requesting a test.
N5 Australian postcode of provider requesting a test	N6 Provider Australian postcode	Name change to specify this is the provider requesting a test.
N7 Non-medical provider number of provider collecting a specimen	N7 Identifier of a provider collecting specimen	Name change to use the term non-medical provider number instead of identifier.
N8 Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen	N9 Healthcare provider identifier – individual (HPI-I) of a provider collecting specimen	Name change only.
N9 Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen	N8 Healthcare provider identifier – organisation (HPI-O) of a provider collecting specimen	Name change only.
N10 Type of provider collecting a specimen	N10 Type of provider collecting specimen	Name change only.

Performance indicators

Revised performance indicators are detailed in Table 2.6.

Table 2.6: Revised performance indicators

Performance indicator	Outline of change
Indicator 1 Participation	The definition of *Participation* was revised in late 2020 to restrict participation to screening HPV tests (primary screening HPV tests and follow-up HPV tests). A second measure called *Coverage* was also introduced that includes all HPV and cytology tests performed for any reason, which aligns with the definition of participation in the previous National Cervical Screening Program.
Indicator 18 Cervical cancers diagnosed by time since last screen	Version 1.0 of the data dictionary included an error in the definition of this *Cervical cancers diagnosed by time since last screen*, as the periods listed under *Lapsed screening* were not mutually exclusive. This has been amended in Version 1.1. The term *Adequately screened* has been replaced with *Recently screened*.

Coding sheets

Revised coding sheets are detailed in Table 2.7.

Table 2.7: Revised coding sheets

Coding sheet		Reason for change
Version 1.1	**Version 1.0**	
HPV Test Group Reason for HPV test = 2 Follow-up HPV test (Repeat HPV test after intermediate risk result)	**HPV Test Group** Reason for HPV test = 2 Follow-up HPV test (Repeat HPV test after intermediate risk result or unsatisfactory test)	Value 2 *Follow-up HPV test* (*Repeat HPV test after intermediate risk result or unsatisfactory test*) changed to *Follow-up HPV test* (*Repeat HPV test after intermediate risk result*). This reflects a change in *NPAAC Requirements for Laboratories Reporting Tests for the National Cervical Screening Program (Second Edition 2019)* that restricts a Reason for HPV test of 2 to Repeat HPV test after intermediate result. Pathology laboratories are advised that the repeat test after a prior unsatisfactory screening test should be coded according to the circumstances of the original (unsatisfactory test), rather than using a value of 2.
Screening episode Follow-up episode risk Oncogenic HPV (not 16/18) and Cytology test result *None* = no risk (incomplete) Oncogenic HPV (not 16/18) and Cytology test result *Unsatisfactory* = no risk (unsatisfactory) Oncogenic HPV (not 16/18) and Cytology test result *Negative* = Intermediate risk Oncogenic HPV (not 16/18) and Cytology test result *Possible or definite low-grade intraepithelial lesion (LSIL)* = Intermediate risk	**Screening episode** Follow-up episode risk Oncogenic HPV (not 16/18) and Cytology test result *None* = Higher risk Oncogenic HPV (not 16/18) and Cytology test result *Unsatisfactory* = Higher risk Oncogenic HPV (not 16/18) and Cytology test result *Negative* = Higher risk Oncogenic HPV (not 16/18) and Cytology test result *Possible or definite low-grade intraepithelial lesion (LSIL)* = Higher risk	The Cancer Council Australia Clinical Guidelines working party reviewed new Australian data for the cervical screening pathway recommendation for people with a 12-month follow-up HPV test in which HPV (any type) was detected. In the planning for the change to primary HPV screening, a cautious approach was adopted for management of these people, meaning the pathway for people with this result was universal referral for colposcopy. Current national program data, broken down by HPV type, has shown that the risk of CIN2/3 and cervical cancer is very low for those participants in whom HPV (not 16/18) is detected and in whom reflex LBC is negative, pLSIL or LSIL. Based on this current evidence, clinical advisors have now recommended that people with a 12-month follow-up HPV test in which HPV (not 16/18) is detected and reflex LBC is negative, pLSIL or LSIL (*Intermediate risk* result) should be recommended to undertake a second follow-up HPV test in a further 12 months' time following their first follow-up HPV test. This took effect from 1 February 2021.

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

(continued)

Table 3.4: Summary of data items (continued)

Group D	***Participant vaccination status data items***			
	HPV vaccination clinical completion status	D1	D1	V2
	HPV vaccination clinical completion date	D2	D2	V3
	HPV vaccine dose date	D3	D3	V4
	HPV vaccine dose age	D4	. .	. .
	HPV vaccine implied dose number	D5	D4	V5
	HPV vaccine type	D6	D5	V1
Group E	***Participant demographic data items***			
	Residential address	E1	E1	A11
	Residential suburb/town/locality	E2	E2	A12
	Residential alternative or other names for suburb/town/locality	E3	E3	A13
	Residential Australian state/territory	E4	E4	A14
	Residential Australian postcode	E5	E5	A15
	Residential geocode – latitude	E6	E6	. .
	Residential geocode – longitude	E7	E7	. .
	Residential geocode – quality	E8	E8	. .
	Residential SA1	E9	E9	. .
Screening pathway				
Group F	***Correspondence data items***			
	Correspondence type	F1	F1	. .
	Correspondence date	F2	F2	. .
	Correspondence method	F3	F3	. .
	Correspondence failure flag	F4	F4	. .
	Correspondence failure date	F5	F5	. .
	Correspondence failure type	F6	F6	. .
Group G	***Test type data item***			
	Type of test	G1	G1	T1
Group H	***HPV test data items***			
	HPV test date	H1	H1	D2
	HPV test collection method	H2	H2	. .
	HPV test specimen site	H3	H3	. .
	Reason for HPV test	H4	H4	. .
	HPV test result – oncogenic HPV	H5	H5	D5
	HPV test result – secondary oncogenic HPV	H6	. .	. .
	HPV test type	H7	H8	D6
	HPV test sample	H8	H9	. .
	HPV test batch information – Control kit lot number	H9	H10	. .

(continued)

Table 3.4: Summary of data items (continued)

Group H	***HPV test data items***			
	HPV test batch information – Control kit expiry date	H10	H11	. .
	HPV test batch information – Cellular (LBC) extraction kit lot number	H11	H12	. .
	HPV test batch information – Cellular (LBC) extraction kit expiry date	H12	H13	. .
	HPV test batch information – Nucleic acid extraction kit lot number	H13	H14	. .
	HPV test batch information – Nucleic acid extraction kit expiry date	H14	H15	. .
	HPV test batch information – Amplification kit lot number	H15	H16	. .
	HPV test batch information – Amplification kit expiry date	H16	H17	. .
	HPV test batch information – Detection kit lot number	H17	H18	. .
	HPV test batch information – Detection kit expiry date	H18	H19	. .
	HPV test batch information – Wash buffer lot number	H19	H20	. .
	HPV test batch information – Wash buffer expiry date	H20	H21	. .
Group I	***Cytology test data items***			
	Cytology test date	I1	I1	C2
	Cytology test specimen type	I2	I2	C4
	Cytology test specimen site	I3	I3	C3
	Reason for cytology test	I4	I4	. .
	Cytology test squamous cytology cell analysis	I5	I5	C5
	Cytology test endocervical (glandular) cytology cell analysis	I6	I6	C6
	Cytology test other/non-cervical cytology cell analysis	I7	I7	C7
	Cytology test result	I8	I8	C9
Group J	***Screening episode data items***			
	Primary screening episode commencement date	J1	J1	. .
	Primary screening episode completion date	J2	J2	. .
	Primary screening episode result	J3	J3	. .
	Primary screening episode risk of significant cervical abnormality	J4	J4	. .
	Primary screening episode recommendation	J5	J5	. .
	Follow-up episode commencement date	J6	J6	. .
	Follow-up episode completion date	J7	J7	. .
	Follow-up episode result	J8	J8	. .
	Follow-up episode risk of significant cervical abnormality	J9	J9	. .
	Follow-up episode recommendation	J10	J10	. .
Group K	***Colposcopy data items***			
	Date of colposcopy episode	K1	K2	. .
	Indication for colposcopy	K2	K3	. .
	Indication for colposcopy – other indication free text	K3	K4	. .
	General colposcopic assessment – adequacy	K4	K5	. .
	General colposcopic assessment – transformation zone visibility	K5	K6	. .

(continued)

Table 3.4: Summary of data items (continued)

Group K	***Colposcopy data items***			
	Colposcopic impression – primary diagnosis	K6	K7	. .
	Colposcopy impression – other finding free text	K7	K8	. .
	Biopsy this episode	K8	K9	. .
	Pregnant at time of colposcopy	K9	K10	. .
	Colposcopy data source	K10	. .	. .
Group L	***Histology test data items***			
	Histology test date	L1	L1	H2
	Histology test specimen site	L2	L2	H3
	Procedure used for obtaining specimen for histological analysis	L3	L3	H4
	Squamous histology cell analysis	L4	L4	H5
	Endocervical (glandular) histology cell analysis	L5	L5	H6
	Other/non-cervical histology cell analysis	L6	L6	. .
	Histology test result	L7	L7	H9
	Histology report text	L8	. .	. .
	Histology stain	L9	L8	. .
	Histology stain result	L10	L9	. .
	Histology data source	L11	. .	. .
Group M	***Treatment data items***			
	Treatment this episode	M1	M1	. .
	Treatment date	M2	M2	. .
	Excision performed this episode	M3	M3	. .
	Modality/method used for excision	M4	M4	. .
	Ablation performed this episode	M5	M5	. .
	Hysterectomy	M6	M6	. .
	Treatment anaesthetic type	M7	M7	. .
	Location of service	M8	M8	. .
	Eligible for test of cure flag	M9	M9	. .
	Eligible for test of cure date	M10	M10	. .
	Test of cure completion flag	M11	M11	. .
	Test of cure completion date	M12	M12	. .
Group N	***Provider data items***			
	Medicare provider number of provider requesting a test	N1	N1	B1
	Healthcare provider identifier – individual (HPI-I) of provider requesting a test	N2	N3	B2
	Healthcare provider identifier – organisation (HPI-O) of provider requesting a test	N3	N2	B3
	Australian state/territory of provider requesting a test	N4	N5	B10
	Australian postcode of provider requesting a test	N5	N6	B11

(continued)

Table 3.4: Summary of data items (continued)

Group N	***Provider data items***			
	Medicare provider number of provider collecting a specimen	N6	. .	. .
	Non-medical provider number of provider collecting a specimen	N7	N7	B13
	Healthcare provider identifier – individual (HPI-I) of provider collecting a specimen	N8	N9	B14
	Healthcare provider identifier – organisation (HPI-O) of provider collecting a specimen	N9	N8	B15
	Type of provider collecting a specimen	N10	N10	B12
	Australian state/territory of provider collecting a specimen	N11	. .	. .
	Australian postcode of provider collecting a specimen	N12	. .	. .
Group O	***Pathology laboratory data items***			
	Pathology laboratory identifier	O1	O1	L1
	Pathology laboratory name	O2	O2	. .
	Pathology laboratory accession number/identifier	O3	O3	C1
	Pathology laboratory Australian state/territory	O4	. .	. .
	Pathology laboratory Australian postcode	O5	. .	. .
Group P	***Screening history data items***			
	Previously screened flag	P1	P1	. .
	Date of last screening test	P2	P2	. .
	Last screening test type	P3	P3	. .
	Number of days since last screening test	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 people who exist on the National Cervical Screening Register and participate in cervical screening.
Collection methods	Assigned by the National Cervical Screening Register.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 people 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 people 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 people 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 1.0* 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	Format allows the collection of 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.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 1.0* 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(39)]
Maximum character length	40

Data item attributes

Collection and usage attributes

Guide for use	This should be recorded for all participants. A full history of names should be retained.
Collection methods	Where a person uses multiple names, these should all be recorded to increase data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording – such as the difference between MacIntosh and McIntosh – can make record linkage impossible.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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(40)]
Maximum character length	40

Data item attributes

Collection and usage attributes

Guide for use	This should be recorded for all participants. A full history of names should be retained.
Collection methods	Where a person uses multiple names, these should all be recorded to increase data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording – such as the difference between MacIntosh and McIntosh – can make record linkage impossible.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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(40)]
Maximum character length	40

Data item attributes

Collection and usage attributes

Guide for use	This should be recorded for all participants. A full history of names should be retained.
Collection methods	Where a person uses multiple names, these should all be recorded to increase data linkage.
Comments	Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, and so forth. Even small differences in recording – such as the difference between MacIntosh and McIntosh – can make record linkage impossible.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 1.0* B4 Date of birth

B5 Sex

Identifying and definitional attributes

Data item name	Sex
Definition	The biological sex characteristics 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

‘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 infancy, a person's sex can change over the course of their lifetime and may differ from their sex recorded at birth’ (ABS 2021.)

‘Sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex. Individuals may have a range of circumstances or undergo a variety of treatments that make it difficult to define a true biological sex’ (AG 2015.)

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 Australian Government Guidelines on the Recognition of Sex and Gender (AG 2015) recommends the preferred Australian Government approach of collecting and using gender information, with sex only being collected where there is a legitimate need to know the biological characteristics of the target population.

For statistical purposes, the following category codes, labels, and definitions are preferred:

CODE 1 Male

Individuals who have male or predominantly masculine biological characteristics, had male sex assigned at birth, or report their sex as male.

CODE 2 Female

Individuals who have female or predominantly feminine biological characteristics, had female sex assigned at birth, or report their sex as female.

CODE 3 Another term

Individuals who have mixed or non-binary biological characteristics (if known), had a non-binary sex assigned at birth, or report their sex using another term.

The value meaning of ‘Another term’ has been assigned to Code 3 for this value domain, which replaces ‘Other’ and ‘Intersex or indeterminate’ in previous versions of this element.

Terms such as ‘indeterminate’, ‘intersex’, ‘non-binary’, and ‘unspecified’, etc., are variously used to describe the ‘Another term’ category of sex. The label ‘Another term’ is used because a more descriptive term has not been widely agreed within the general community. Additionally, a small number of people do not have a sex of male or female recorded at birth or infancy. The inclusion of ‘Another term’ as a third response option recognises that across Australian jurisdictions and elsewhere there are a range of options available on birth certificates (such as indeterminate or unspecified).

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

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 at the time of data collection, as a person's 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.

Data collections using this data element should strive for transparency as to whether the element collects data on sex at time of birth, or sex at time of data collection. It is recommended to record this information in the Data Set Specific Information.

Standard questions

Sex 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)

Mandatory elements

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.

Recommended elements

The following elements are recommended:

- 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.

Sex 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)

Mandatory elements

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.

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 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.

Source and reference attributes

Origin	Adapted from METeOR candidate Data Element 741686 July 2021.
Reference documents	Australian Bureau of Statistics 2021. Standard for sex, gender, variations of sex characteristics and sexual orientation variables. Canberra: ABS https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release Australian Bureau of Statistics 2016. Standard for Sex and Gender Variables (Cat. no. 1200.0.55.012). 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 1.0* B5 Sex

B6 Gender

Identifying and definitional attributes

Data item name	Gender
Definition	The way a person describes their social and cultural identity, expression and experience as man, or boy, or woman, or girl, or non-binary.
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, woman, 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).

Gender is part of a person's personal and social identity. It refers to the way a person feels, presents, and is recognised within the community. A person's gender may be reflected in outward social markers, including their name, outward appearance, mannerisms and dress' (AGD 2015).

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 Australian Government Guidelines on the Recognition of Sex and Gender (AG 2015) recommends the preferred Australian Government approach of collecting and using gender information, with sex only being collected where there is a legitimate need to know the biological characteristics of the target population.

This Value Domain is 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

Persons who describe their gender as man, or boy, or male.

CODE 2 Woman, or girl, or female

Persons who describe their gender as woman, or girl, or female.

CODE 3 Non-binary

Persons who describe their gender as non-binary.

CODE 4 Different term

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

CODE 5 Prefer not to answer

Persons who prefer 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.

The ABS Standard also allows for the following Alternative Code system:

CODE M Man, or boy, or male

CODE F Woman, or girl, or female

CODE X Non-binary

CODE T Different term

CODE Z Prefer not to answer

The ABS Standard allows for the following output categories for gender:

Man, or boy

Includes CODE 1 (M)

Woman, or girl

Includes CODE 2 (F)

Non-binary

Includes CODES 3 (X) and 4 (T)

Not stated

Includes CODES 5 (Z) and 9.

Collection methods

Standard Question Module

The Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021) recommends the following standard question module:

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 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).

Comments

Former versions of this Value Domain contained only three permissible values:

CODE 1 Male

CODE 2 Female

CODE 3 Other (formerly 'Gender other/diverse').

Source and reference attributes

Origin

Adapted from METeOR candidate Data Element 741842 July 2021.

Reference documents

Australian Bureau of Statistics 2021. Standard for sex, gender, variations of sex characteristics and sexual orientation variables. Canberra: ABS https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release

Australian Bureau of Statistics 2016. Standard for Sex and Gender Variables (Cat. no. 1200.0.55.012).

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

Relational attributes

Related metadata reference

New data item

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 descent.
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 participant was unable to communicate or a person who knows the participant 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 participant was unable to communicate or a person who knows the participant 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 1.0* B6 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 1.0* 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	{NNNN}
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 1.0* B7 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 status is derived from the two data items B8 'Main language other than English spoken at home' and B9 'Country of birth'. CALD is defined as: • people born in Australia whose main language other than English spoken at home is not English (excluding Aboriginal languages). • people born overseas in countries where English is not the main language spoken (that is, 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 overseas settlers who are likely to speak English); or
Collection methods	CALD status is derived from the two data items B8 'Main language other than English spoken at home' and B9 'Country of birth'.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* B9 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 person 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 person 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	New data item

C2 Reason to defer screening

Identifying and definitional attributes

Data item name	Reason to defer screening
Definition	The reason that a person 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 1.0* C2 Reason for temporary inactivation.

C3 Defer start date

Identifying and definitional attributes

Data item name	Defer start date
Definition	The date from which a person 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 person 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 1.0* C3 Date of temporary inactivation.

C4 Defer end date

Identifying and definitional attributes

Data item name	Defer end date
Definition	The date from which a person 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 person 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 1.0* C4 Date of reactivation.

C5 Opt out flag

Identifying and definitional attributes

Data item name	Opt out flag
Definition	An indication as to whether a person 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 person 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 person will be recorded on the National Cancer Screening Register.

Opt out flag should be raised at such time as it is known that a person 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	New data item

C6 Reason for opt out

Identifying and definitional attributes

Data item name	Reason for opt out
Definition	The reason that a person 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 person 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 person 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	New data item.

C7 Opt out date

Identifying and definitional attributes

Data item name	Opt out date
Definition	The date on which a person 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 person 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 person 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 1.0* C5 Withdrawn date.

C8 Opt in date

Identifying and definitional attributes

Data item name	Opt in date
Definition	The date on which a person 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 person 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 person 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 1.0* C6 Withdrawn rescinded date.

C9 Hysterectomy flag

Identifying and definitional attributes

Data item name	Hysterectomy flag
Definition	An indication as to whether a person 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 person 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 person 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 2016).

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* C7 Hysterectomy flag

C10 Date of hysterectomy

Identifying and definitional attributes

Data item name	Date of hysterectomy
Definition	The date a person 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 person 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 1.0* C8 Date of hysterectomy

C11 Death flag

Identifying and definitional attributes

Data item name	Death flag
Definition	An indication as to whether a person is deceased.
Context	These data are essential to ensure that correspondence is not sent to deceased people to avoid potential distress for the person'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 1.0* C9 Death flag

C12 Date of death

Identifying and definitional attributes

Data item name	Date of death
Definition	The date of death of a person.
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 person 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 1.0* C10 Date of death

C13 DES exposed

Identifying and definitional attributes

Data item name	DES exposed
Definition	An indication of whether a person 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 person 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 2016) 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 people 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 to pregnant people in the first trimester from the1940s until the early 1970s. There is substantial evidence indicating that people 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	New data item

C14 Immunocompromised

Identifying and definitional attributes

Data item name	Immunocompromised
Definition	An indication of whether a person 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 person is immunocompromised due to HIV or solid organ transplant.

Immunocompromised should be coded to ‘2’ at such time as it is known that a person 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 2016) 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 for further information.

Relational attributes

Related metadata references	New data item

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	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 1.0* D1 HPV vaccination 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 for vaccinated participants

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	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 1.0* D2 HPV vaccination 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	Essential for vaccinated participants

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.
Comments	This data item will not be populated for unvaccinated people. 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 1.0* D3 HPV vaccination episode 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	Essential for vaccinated participants

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'.
Comments	This data item will not be populated for unvaccinated people. 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	New data item

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	Essential for vaccinated participants

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

Comments

This data item will not be populated for unvaccinated people.

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 1.0* D4 HPV vaccine 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	Essential for vaccinated participants

Value domain attributes

Representation class	Code	
Data type	String	
Format	N[XX]	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	1i	Gardasil
	1ii	Gardasil9
	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', 'Gardasil9' or 'Cervarix' (for example if the HPV vaccine was administered overseas). 'Unknown' should be used when the HPV vaccine type is not known.
Comments	This data item will not be populated for unvaccinated people. 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 1.0* D5 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 a person usually resides.
Collection status	Essential

Value domain attributes

Representation class	Text
Data type	String
Format	[X(180)]
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 a person. Residential or a postal (mailing) address should be provided for a person.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 a person usually resides.
Collection status	Essential

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	Suburb/town/locality is the text that represents the full name of the locality contained within the specific address of a person. 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 the locality can be known by. Residential or a postal (mailing) address should be provided for a person.

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 a person 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 a person. 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 1.0* 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 a person 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 a person.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 a person usually resides.
Collection status	Essential

Value domain attributes

Representation class	Code
Data type	Number
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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 a person.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
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
	E1	Exit letter
	F0	Follow-up
	G0	Other

Data item attributes

Collection and usage attributes

Guide for use	Screening refers to a person's first screen in the program; rescreening refers to any screen that is not their first. This is based on the 'business as usual' protocol of action for the National Cervical Screening Program. A1 & A2 applies to: • People turning 25 who have never screened before (or were screened prior to 24 years and 9 months); • People aged between 25 and <30 who have been newly identified from Medicare enrolment data and who have not been sent an invitation previously; and • People aged between 25 and <30 who have never previously had a Pap test.

	B1 & B2 applies to: • People aged ≥30 and <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: • People aged between ≥ 30 to <75 years of age who have a screening history and are less than 2 years overdue for their next screening test. D1 & D2 applies to: • People aged between 30 and <75 years of age who have a screening history and are 2 years or more overdue for their next screening test. E1 refers to a letter that is sent to people aged 70–74 who are invited to have an HPV test and oncogenic HPV is not detected in their HPV test, as they will no longer be invited to rescreen. F0 refers to any follow-up contact with a person. G0 refers to other correspondence sent to a person, such as a welcome letter or a letter to acknowledge opt out.
Comments	This data item relates only to correspondence sent by the National Cancer Screening Register to a person.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* F1 Type of contact

F2 Correspondence date

Identifying and definitional attributes

Data item name	Date of correspondence
Definition	The date on which the National Cancer Screening Register sent correspondence to a person.
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 a person. This may not be the same date that the person 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 a person receives this correspondence.
Comments	This data item relates only to correspondence sent from the National Cancer Screening Register to a person, and not to a practitioner or other medical professional.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* F2 Date of contact

F3 Correspondence method

Identifying and definitional attributes

Data item name	Method of correspondence
Definition	The method by which National Cancer Screening Register sent correspondence to a person.
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	Telephone
	3	SMS
	4	Email

Data item attributes

Collection and usage attributes

Guide for use	Method of correspondence is likely to differ depending on the type of correspondence as specified in F1 ‘Correspondence type’.
Comments	This data item relates only to correspondence sent by the National Cancer Screening Register to a person.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* F3 Method of contact

F4 Correspondence failure flag

Identifying and definitional attributes

Data item name	Correspondence failure flag
Definition	An indication that a person'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 in any instance where a person's contact details are found to be invalid. This may take the form of a letter marked 'return to sender', an email address that 'bounces', or verbal communication via telephone that the participant no longer resides or works at the site of the designated telephone number. This flag can be used several times for one person, if more than one method of contact is determined to be invalid. A person may only have one method of contact (usually a mailing address). If there are no other valid contact details recorded for a person, 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 1.0* F4 Contact 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 or verbal indication of invalid contact details.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* F5 Contact 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 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	Mailing address
	2	Telephone number – home
	3	Telephone number – work
	4	Telephone number – mobile
	5	Email address

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* F6 Contact 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 1.0* 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 sample
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 1.0* 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 1.0* 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

Data item attributes

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 1.0* 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 1.0* 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	New data item

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 1.0* H8 HPV test type

H8 HPV test sample

Identifying and definitional attributes

Data item name	HPV test sample
Definition	Information about the sample collected for an HPV test.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	Number	
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 1.0* H9 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 1.0* H10 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 1.0* H11 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 1.0* H12 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 1.0* H13 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 1.0* H14 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 1.0* H15 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 1.0* H16 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 1.0* H17 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 1.0* H18 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 1.0* H19 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 1.0* H20 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 1.0* H21 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 1.0* 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 people 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 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 1.0* 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, cytology test results are summarised into: • Unsatisfactory: I5 = SU and I6 = (EU or E- or E0 or E1) • Negative: I5 = S1 and I6 = (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: I6 = E2 or E3 or E4 or E5 or E6
Comments	Collected by pathology laboratories.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 risk of significant cervical abnormality
J5 Primary screening episode recommendation
J6 Follow-up episode commencement date
J7 Follow-up episode completion date
J8 Follow-up episode result
J9 Follow-up episode risk of significant cervical abnormality
J10 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 1.0* 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 people 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 1.0* 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 person 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 (in which case this can be rectified by a repeat test), or due to a person 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. This means that more than one primary screening episode result will need to be able to be collected within each screening round. The primary screening episode is not complete until receipt of a valid test, or after a specified period of time if no test result is received.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* J3 Primary screening episode result

J4 Primary screening episode risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Primary screening episode 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	This 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	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.
Comments	Risk is unable to be assigned for 2.X.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* J4 Primary screening episode risk of significant cervical abnormality

J5 Primary screening episode recommendation

Identifying and definitional attributes

Data item name	Primary screening episode recommendation
Definition	The appropriate management based on the risk level of the primary screening episode result.
Collection status	Essential

Value domain attributes

Representation class	Code	
Data type	String	
Format	AXX	
Maximum character length	3	
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 1.0* J5 Primary screening episode recommendation

J6 Follow-up episode commencement date

Identifying and definitional attributes

Data item name	Follow-up episode commencement date
Definition	The date the 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 follow-up HPV test.
Collection methods	This date can be derived by H1 ‘HPV test date’ where H4 ‘Reason for HPV test’ = 2.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* J6 Follow-up episode commencement date

J7 Follow-up episode completion date

Identifying and definitional attributes

Data item name	Follow-up episode completion date
Definition	The date the 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 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 people the follow-up episode completion date will be identical to or similar to the 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 (noting that it is preferable that the sample for a follow-up test is clinician-collected rather than self-collected), there can be some time between the follow-up episode commencement date and the follow-up episode completion date.
Collection methods	This is a derived date.
Comments	‘When follow-up HPV testing is required after an initial positive oncogenic HPV test result, the sample should be collected by a clinician, where possible. Participants should be advised that a clinician-collected sample is preferred because it is more effective and reflex LBC can be performed on the same sample, which avoids a further visit to collect a cervical sample for LBC. If the participant declines the clinician-collected sample, they can have a self-collected sample and are eligible for reimbursement under the Medical Benefits Schedule.’ (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016)

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* J7 Follow-up episode completion date

J8 Follow-up episode result

Identifying and definitional attributes

Data item name	Follow-up episode result
Definition	The 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 follow-up episode result is a combination of the follow-up HPV test result and the LBC result (where performed).

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* J8 Follow-up episode result

J9 Follow-up episode risk of significant cervical abnormality

Identifying and definitional attributes

Data item name	Follow-up episode risk of significant cervical abnormality
Definition	Risk of significant cervical abnormality determined from a 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	An HPV test 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 test results with reflex liquid-based cytology (LBC). This means that the overall final follow-up episode result is a combination of the follow-up HPV test result and the LBC result (where performed). This combined 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 or other screening history
Collection methods	For the first follow-up HPV test after intermediate risk screening episode, risk should be allocated as: RU Unsatisfactory: J8 ‘Follow-up episode result’ = U R1 Low risk: J8 ‘Follow-up episode result’ = 1 R2 Intermediate risk: J8 ‘Follow-up episode result’ = 2.1 or 2.2 for people who 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. 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; OR J8 ‘Follow-up episode result’ value other than U or 1 for people 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. For the second follow-up HPV test after intermediate risk screening episode, 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’ value other than U or 1
Comments	From 1 February 2021, clinical management for people 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 1.0* J9 Follow-up episode risk of significant cervical abnormality

J10 Follow-up episode recommendation

Identifying and definitional attributes

Data item name	Follow-up episode recommendation
Definition	The appropriate management based on the risk level of the follow-up episode result.
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 1.0* J10 Follow-up episode recommendation

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 1.0* K2 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 1.0* K3 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 1.0* K4 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 1.0* K5 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 1.0* K6 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 1.0* K7 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 1.0* K8 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 1.0* K9 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 person 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 person 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 person'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 1.0* K10 Pregnancy flag

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	New data item

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 1.0* 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 1.0* 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 1.0* 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	
	SU	Squamous cell carcinoma (SCC)

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 2016).

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 1.0* 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 2016). 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 1.0* 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 1.0* 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 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 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 component and the endocervical 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 1.0* 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	New data item

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	Aspirational

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 1.0* L8 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	Aspirational

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 1.0* L9 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	New data item

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 1.0* 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	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 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 1.0* 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 people 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 1.0* 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 person 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 1.0* 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 person 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 1.0* 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 person 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' or 'E1 Endocervical component present. No abnormality or only reactive changes'.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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’ or ‘E1 Endocervical component present. No abnormality or only reactive changes’.

Relational attributes

Related metadata reference	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 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 person 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 1.0* N1 Medicare provider number

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 1.0* N3 Healthcare provider identifier – individual (HPI-I)

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 1.0* N2 Healthcare provider identifier – organisation (HPI-O)

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 1.0* N5 Provider state/territory

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	Number
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 1.0* N6 Provider Australian postcode

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 person 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	New data item

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 1.0* N7 Identifier of a provider collecting 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 1.0* N9 Healthcare provider identifier – individual (HPI-I) of a provider collecting 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 1.0* N8 Healthcare provider identifier – organisation (HPI-O) of a provider collecting 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 1.0* N10 Type of provider collecting 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	New data item

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	Number
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	New data item

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	XXX
Maximum character length	3

Data item attributes

Source and reference attributes

Origin	Pathology laboratories

Relational attributes

Related metadata references	Supersedes *National Cervical Screening Program data dictionary version 1.0* 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 1.0* 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 1.0* 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	New data item

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	Number
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	New data item

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 all people who have 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. This also needs to be recorded for people under the age of 25, even though they will not be invited to screen until they are aged 25 years. For people who are on the National Cancer Screening Register but never screened, this flag should be raised when a person has their first screening test. Exclude diagnostic or follow-up tests.
Collection methods	This data item is derived.
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 1.0* 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 person'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 person 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 person'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 people have interval cancers 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 people 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 1.0* 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 1.0* 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 person.
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 person'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 1.0* P4 Number of days since last screening test

4 Classification schemes

The following pages contain classification schemes developed for the renewed National Cervical Screening Program, based on permissible values from key data items included in Section 3. There is a classification scheme for each of the following:

- HPV Test Group;
- Cytology Test Group;
- Clinical Management Recommendation Group;
- Histology Test Group; and
- Colposcopy Group;

with additional tables developed to assist with the classification of:

- Screening Episodes; and
- Follow-up Episodes.

HPV Test Group

HPV test collection method	1 Practitioner-collected sample		2 Self-collected sample		
HPV test specimen site	0 Not stated	1 Cervical	2 Vaginal	3 Other gynaecological site	
Reason for HPV test	1 Primary screening HPV test	2 Follow-up HPV test (Repeat HPV test after intermediate risk result)[1]	3 Co-test i. Test of cure ii. Investigation of signs or symptoms iii. Other, as recommended in guidelines		4 Other
HPV test result – oncogenic HPV [2]	U Unsatisfactory	0 Oncogenic HPV not detected	1 HPV 16/18 detected [3] i. Type 16 detected ii. Type 18 detected iii. Type 18/45 detected	2 Oncogenic HPV (not 16/18) detected[4] i. One or more of the following types detected: 31, 33, 45, 52, or 58 ii. One or more of the following types detected: 35, 39, 51, 56, 59, 66, or 68	
HPV test type [5]	1 Qiagen i. Hybrid Capture II	2 Roche i. cobas 4800 ii. cobas 6800 iii. cobas 8800	3 Abbott i. m2000 ii. Alinity m	4 Becton Dickinson i. Onclarity	5 Cepheid i. Xpert
	6 Hologic i. Cervista ii. Aptima	7 Seegene i. Anyplex	8 Genera i. PapType	9 Euroimmun i. Euroarray	999 Other

[1] For the purpose of this coding sheet, a repeat test after prior unsatisfactory screening test should be coded according to the circumstances of the original (unsatisfactory test). While this will most commonly be a primary screening HPV test, it may also be a follow-up test or a test of cure.

[2] All oncogenic HPV types detected are required to be reported, if more than one type is detected, the codes for each detected type must be reported, comma separated. Reporting at the level of 'Not detected', 'HPV type 16/18 detected' and 'Oncogenic HPV (not 16/18) detected' is mandatory. Laboratories should report more detailed information if their test outputs allow, using the more detailed codes as suffixes.

[3] One or more oncogenic HPV types 16 or 18 detected

[4] One or more oncogenic HPV types other than 16 and 18 detected— HPV 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68

[5] 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 NCSP. 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 NCSP. 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 development; 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 if the NCSP is informed.

HPV test sample	0 Not stated		1 PreservCyt Solution		2 SurePath medium
	97 Other commercial self-collection device		98 Specimen transport medium		99 Flocked or cotton swab[6]
HPV test batch information [7]					
Control kit	Lot number	Expiry date	Amplification kit	Lot number	Expiry date
Cellular (LBC) extraction kit	Lot number	Expiry date	Detection kit	Lot number	Expiry date
Nucleic acid extraction kit	Lot number	Expiry date	Wash buffer	Lot number	Expiry date

[6] If 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'.

[7] 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.

Cytology Test Group

Cytology specimen type	A0 Not stated		A1 Conventional smear		A2 Liquid based specimen		A3 Conventional and liquid-based
Cytology specimen site	B0 Not stated		B1 Cervical		B2 Vaginal		B3 Other gynaecological site
Reason for cytology test	1 Reflex LBC cytology after detection of oncogenic HPV in primary screening HPV test		2 Cytology after detection of oncogenic HPV in self-collected sample		3 Reflex LBC after detection of oncogenic HPV in follow-up HPV test		
	4 Cytology at colposcopy		5 Co-test i. Test of cure ii. Investigation of signs or symptoms iii. Other, as recommended in guidelines		6 Other		P Conventional Pap test to screen for cervical cancer precursors
Result	**Squamous**		**Endocervical**		**Other/non-cervical**		
Unsatisfactory	SU	Unsatisfactory for evaluation	EU	Due to unsatisfactory nature of the specimen, no assessment has been made	OU	Due to the unsatisfactory nature of the specimen, no assessment has been made	
Negative	S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes	E- E0 E1	Not applicable: vault smear/previous hysterectomy No endocervical component Endocervical component present. No abnormality or only reactive changes	O1	No other abnormal cells	
Low-grade	S2 S3	Possible low-grade squamous intraepithelial lesion (LSIL) Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN I)	E2	Atypical endocervical cells of uncertain significance	O2 O3	Atypical endometrial cells of uncertain significance Atypical glandular cells of uncertain significance – site unknown	
Possible high-grade	S4	Possible high-grade squamous intraepithelial lesion (HSIL)	E3	Possible high-grade endocervical glandular lesion	O4 O5	Possible endometrial adenocarcinoma Possible high-grade lesion – non-cervical	
High-grade	S5 S6	High-grade squamous intraepithelial lesion (HSIL) (CIN 2/CIN 3) HSIL with possible microinvasion/invasion	E4 E5	Adenocarcinoma-in-situ Adenocarcinoma-in-situ with possible microinvasion/invasion			
Carcinoma	S7	Squamous carcinoma	E6	Adenocarcinoma	O6 O7 O8 O9	Malignant cells – uterine body Malignant cells – vagina Malignant cells – ovary Malignant cells – other	

Clinical Management Recommendation Group

Recommendation
0 No recommendation
1 Rescreen in 5 years
2 Rescreen in 3 years
3 Repeat HPV test in 12 months
4 Co-test in 12 months
5 Retest in 6 weeks
6 Refer for colposcopic assessment
7 Test taken at time of colposcopy, no recommendation
8 Discharge from program
9 Other management recommendation
S Symptomatic – clinical management required
P Rescreen in 2 years

Histology Test Group

Specimen site	0 Not stated	1 Cervical	2 Vaginal	3 Other gynaecological site	
Procedure	1 Punch biopsy	2 Endocervical curettage	3 LLETZ/LEEP loop biopsy	4 Cone biopsy	5 Polypectomy
	6 Subtotal hysterectomy	7 Hysterectomy	8 Amputated cervix	9 other gynaecological sites	

Result	**Squamous histology cell analysis**		**Endocervical (glandular) histology cell analysis**		**Other/non-cervical histology cell analysis**	
Unsatisfactory	SU	Unsatisfactory	EU	Unsatisfactory		
Not applicable	SN	Not applicable	EN	Not applicable	ON	Not applicable
Negative	S1	Negative	E1	Negative	O1	Negative/no abnormalities reported or benign changes only
Low-grade	S2	Low-grade intraepithelial lesion (LSIL)	E2	Endocervical atypia	O2	Low-grade neoplasia/hyperplasia NOS
High-grade	S3.1 S3.2 S3.3	High-grade intraepithelial lesion (HSIL) (CIN NOS) HSIL (CIN 2) HSIL (CIN 3)	E3.1 E3.2 E3.3	Endocervical dysplasia Adenocarcinoma-in-situ Mixed carcinoma-in-situ/adenocarcinoma-in-situ	O3.1 O3.2	High-grade neoplasia/hyperplasia Carcinoma-in-situ
Carcinoma	S4.1 S4.2	Superficially invasive squamous cell carcinoma (SISCCA) Squamous cell carcinoma (SCC)	E4.1 E4.2 E4.3 E4.4	Endocervical adenocarcinoma, microinvasive Invasive adenocarcinoma of cervix Adenosquamous carcinoma Carcinoma of the cervix (other)	O4.1 O4.2	Carcinoma, microinvasive Invasive carcinoma

Colposcopy Group

Indication for colposcopy	0 Not performed	1 New patient with abnormal cervical screening result	2 Follow-up of patient with previous abnormal cervical screening result		
	3 Symptomatic	4 Abnormal appearance of cervix	5 At time of treatment	6 Other	
Adequacy [1]	0 Inadequate		1 Adequate		
Transformation zone visibility	1 Type 1 Transformation zone	2 Type 2 Transformation zone	3 Type 3 Transformation zone		
Colposcopic impression	1	Normal			
	2	No visible lesion			
	3	LSIL			
	4	HSIL			
	5	Glandular abnormality (adenocarcinoma-in-situ)			
	6	Cancer			
	7	Other			
Biopsy this episode	0 No – biopsy not performed	1 Yes – biopsy performed			
Pregnancy flag	1 Pregnant at time of colposcopic episode				
Treatment this episode	0 No – treatment not performed	1 Yes – treatment performed			
Excision performed this episode	0 No	1a Yes – Type 1 excision (≤10 mm)	1b Yes – Type 2 excision (>10 and ≤15 mm)	1c Yes – Type 3 excision (>15 mm)	
Modality/method used for excision	0 Excision not performed	1a Loop Diathermy	1b Scalpel (Cold Knife)	1c Laser	1d Other
Ablation performed this episode	0 No	1a Yes – Laser	1b Yes – Thermal Coagulation (Semm)	1c Yes – Diathermy	
Hysterectomy	0 No	1 Yes			
Treatment anaesthetic type	1 Local	2 Regional	3 General		
Location of service	1 Public hospital	2 Private Hospital	3 Private rooms	9 Unknown/Other	

[1] Adequacy of colposcopy refers to the visibility of the cervix; '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.

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	→ 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	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
		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

→ Follow-up (repeat HPV test in 12 months)

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.

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 both a need and an opportunity 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 standards and measures that are external to the NCSP (such as performance measures for pathology laboratories reporting on cervical screening tests). The new performance indicators are listed in Table 5.1.

These new performance indicators were developed by the AIHW in consultation with the Australian Government Department of Health and state and territory cervical screening programs, as well as 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, Associate Professor Marion Saville, Dr Julia Brotherton, Professor David Roder and Professor Dorota Gertig.

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	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	Self-collection people positive for oncogenic HPV (not 16/18) who have an LBC test within 6 months
	9	Self-collection people positive for oncogenic HPV 16/18 who have a colposcopy within 6 months
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 people 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

Most performance indicators are defined for the target age group 25–74, but are also reported for 5-year age groups within this range, and for ages under 25, and 75 and over.

Where appropriate, performance indicators will also be reported separately for birth cohorts that represent whether or not a person was offered HPV vaccination. People not offered HPV vaccination are defined as those born on or before 30 June 1980; people offered HPV vaccination are defined as those born after 30 June 1980 (1 July 1980 onwards).

Population groups

Performance indicators will be disaggregated, where numbers allow, by state and territory of residence, remoteness area of residence, socioeconomic area of residence, Indigenous status, CALD status and HPV vaccination status, as appropriate.

Remoteness area of residence, socioeconomic area of residence, and other areas of interest such as Primary Health Networks will be assigned using the most accurate geographic area available.

Clinical or program relevance

Performance indicators will also be disaggregated into different categories, where this is clinically relevant and/or provides important program information. These categories include reason for HPV test, HPV test collection method, and test results.

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*.

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 people aged 25–74 screened in a 5-year period as a percentage of females in the population.

Rationale:

Higher participation in cervical screening means that more people with 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

$$\frac{\text{Number of people aged 25–74 who had at least one screening HPV test in a 5-year period} \times 100}{\text{Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy}}$$

Coverage

$$\frac{\text{Number of people aged 25–74 who had at least one HPV test or cytology test for any reason in a 5-year period} \times 100}{\text{Estimated resident population for females aged 25–74 averaged over the 5 years of the reporting period, adjusted for the estimated proportion of females who have had a hysterectomy}}$$

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–74 who had at least one screening HPV test (reason for HPV test of Primary screening HPV test 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
	H1 HPV test date
	H4 Reason for 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

Indicator 2 Response to invitation

Definition:

The percentage of people aged 25–74 invited to screen or rescreen in a calendar year and who screened within 6 months.

Rationale:

How many people 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 inviting people (which may differ by age or other factors).

Calculation:

$$\frac{\text{Number of people aged 25– 74 invited to screen or rescreen in a calendar year who had an HPV test within 6 months of the invitation being sent} \times 100}{\text{Number of people aged 25– 74 invited to screen or rescreen in a calendar year}}$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–74 invited to screen or rescreen in a calendar year who had an HPV test within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	F2 Correspondence date
	G1 Type of test
	H1 HPV test date

Denominator specifications

Definition	Number of people 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
	F2 Correspondence date

Indicator 3 Rescreening

Definition:

The percentage of people 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 people with 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 people who rescreened early, appropriately, or late.

Note that although the National Cervical Screening Program target age group is 25–74, only people aged 25–69 are reported for rescreening because people 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

$$\frac{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had a screening HPV test before 4.5 years} \times 100}{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Adequate rescreening

$$\frac{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had a screening HPV test between 4.5 years and 5.5 years} \times 100}{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Late rescreening

$$\frac{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had a screening HPV test after 5.5 years} \times 100}{\text{Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV}}$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–69 whose screening HPV test in the index calendar year did not detect oncogenic HPV who had a screening HPV test within 4.5 years, between 4.5 years and 5.5 years, or after 5.5 years
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test
	H1 HPV test date

Denominator specifications

Definition	Number of people aged 25–69 whose 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
	H1 HPV test date
	H4 Reason for HPV test
	H5 HPV test result – oncogenic HPV

Indicator 4 Screening results

Definition:

The percentage of screening episodes in each risk category in a calendar year in people aged 25–74.

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

$$\frac{\text{Number of screening episodes that were unsatisfactory in people aged 25– 74 in a calendar year } \times 100}{\text{Number of screening episodes in people aged 25– 74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of screening episodes that were low risk in people aged 25– 74 in a calendar year } \times 100}{\text{Number of screening episodes in people aged 25– 74}}$$

Intermediate risk

$$\frac{\text{Number of screening episodes that were intermediate risk in people aged 25– 74 in a calendar year } \times 100}{\text{Number of screening episodes in people aged 25– 74 in a calendar year}}$$

Higher risk

$$\frac{\text{Number of screening episodes that were higher risk in people aged 25– 74 in a calendar year } \times 100}{\text{Number of screening episodes in people aged 25– 74 in a calendar year}}$$

Count is of screening episodes

Specifications:

Numerator specifications

Definition	Number of screening episodes in people 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 risk of significant cervical abnormality

Denominator specifications

Definition	Number of screening episodes in people 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 J4 Primary screening episode risk of significant cervical abnormality

Indicator 5 Correlation of screening results

Definition:

The level of agreement between screening results in a calendar year and subsequent histology test results within 6 months in people aged 25–74.

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:

$$\frac{\text{Histology test results within 6 months}}{\text{Number of screening episodes in people aged 25– 74 in a calendar year that are followed by a histology test within 6 months}}$$

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
	J2 Primary screening episode completion date
	L1 Histology test date
	L7 Histology test result

Denominator specifications

Definition	Number of screening episodes followed by histology within 6 months in people 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
	H5 HPV test result – oncogenic HPV
	J1 Primary screening episode commencement date
	J2 Primary screening episode completion date

SCREENING HPV TEST PERFORMANCE

Indicator 6 Screening HPV test positivity

Definition:

The percentage of screening HPV tests that are positive for HPV in a calendar year in people aged 25–74.

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 HPV test that are positive for any oncogenic HPV type, oncogenic HPV 16/18 positivity is the proportion of HPV tests that are positive for oncogenic HPV 16/18, and oncogenic HPV (not 16/18) positivity is the proportion of HPV tests that are positive for oncogenic HPV (not 16/18).

Calculation:

Any oncogenic HPV positivity rate

$$\frac{\text{Number of screening HPV tests in which any oncogenic HPV type is detected in people aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in people aged 25–74 in a calendar year}}$$

Oncogenic HPV 16/18 positivity rate

$$\frac{\text{Number of screening HPV tests in which oncogenic HPV 16/18 is detected in people aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in people aged 25–74 in a calendar year}}$$

Oncogenic HPV (not 16/18) positivity rate

$$\frac{\text{Number of screening HPV tests in which oncogenic HPV (not 16/18) is detected in people aged 25–74 in a calendar year} \times 100}{\text{Number of screening HPV tests in people aged 25–74 in a calendar year}}$$

Count is of tests

Specifications:

Numerator specifications

Definition	Number of screening HPV tests in people 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
	H1 HPV test date
	H4 Reason for HPV test
	H5 HPV test result – oncogenic HPV

Denominator specifications

Definition	Number of screening HPV tests in people 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
	H1 HPV test date
	H4 Reason for HPV test

Indicator 7 Cervical cancer diagnosed after a low risk screening test result

Definition:

The percentage of people 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 the screening HPV test.

Calculation:

$$\frac{\text{Number of people with cervical carcinoma diagnosed within 5 years of a screening HPV test that did not detect oncogenic HPV}}{\text{Number of people aged 25– 74 who had a screening HPV test that did not detect oncogenic HPV in a calendar year}} \times 100$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people with cervical carcinoma diagnosed within 5 years of a screening HPV test that did not detect oncogenic HPV
Source	AIHW Australian Cancer Database

Denominator specifications

Definition	Number of people aged 25–74 who had a 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
	H1 HPV test date
	H4 Reason for HPV test
	H5 HPV test result – oncogenic HPV

Indicator 8 Self-collection people positive for oncogenic HPV (not 16/18) who have an LBC test within 6 months

Definition:

The percentage of people aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months.

Rationale:

People who self-collect and who test positive for oncogenic HPV (not 16/18) are recommended to have a practitioner-collected sample taken within 6 weeks. This indicator monitors compliance with this recommendation within 6 months, by which time it is considered that most people would have been able to attend an appointment with a practitioner.
Note that only people aged 30–74 are currently eligible for self-collection.

Calculation:

$$\frac{\text{Number of people aged 30– 74 who self- collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months} \times 100}{\text{Number of people aged 30– 74 who self- collect and test positive for oncogenic HPV (not 16/18) in a calendar year}}$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 30–74 who self-collect and test positive for oncogenic HPV (not 16/18) in a calendar year who have an LBC test within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test
	H1 HPV test date
	I1 Cytology test date

Denominator specifications

Definition	Number of people aged 30–74 who self-collect 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
	H1 HPV test date
	H2 HPV test collection method
	H4 Reason for HPV test
	H5 HPV test result – oncogenic HPV

Indicator 9 Self-collection people positive for oncogenic HPV 16/18 who have a colposcopy within 6 months

Definition:

The percentage of people aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months.

Rationale:

People 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 6 months, by which time it is considered that most people would have been able to attend an appointment with a colposcopist.
Note that only people aged 30–74 are currently eligible for self-collection.

Calculation:

$$\frac{\text{Number of people aged 30– 74 who self- collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months} \times 100}{\text{Number of people aged 30– 74 who self- collect and test positive for oncogenic HPV 16/18 in a calendar year}}$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 30–74 who self-collect and test positive for oncogenic HPV 16/18 in a calendar year who have a colposcopy within 6 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	G1 Type of test
	H1 HPV test date
	K1 Date of colposcopy episode

Denominator specifications

Definition	Number of people aged 30–74 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
	H1 HPV test date
	H2 HPV test collection method
	H4 Reason for HPV test
	H5 HPV test result – oncogenic HPV

Indicator 10 Adherence to recommendation for follow-up

Definition:

The percentage of people aged 25–74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow-up HPV test between 9 and 15 months.

Rationale:

People 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, and are recommended to have a follow-up HPV test in 12 months. This indicator monitors compliance with this recommendation (allowing 3 months either side of the recommended 12 months).

Calculation:

$$\frac{\text{Number of people aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months } \times 100}{\text{Number of people aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year}}$$

The numerator will be additionally disaggregated into the following two groups:

Percentage of people whose follow-up HPV test did not detect any oncogenic HPV

$$\frac{\text{Number of people with a follow- up HPV test that did not detect any oncogenic HPV } \times 100}{\text{Number of people aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months}}$$

Percentage of people whose follow-up HPV test detected oncogenic HPV (any)

$$\frac{\text{Number of people with a follow} - \text{up HPV test that detected oncogenic HPV (any)} \times 100}{\text{Number of people aged 25– 74 who are determined to be of intermediate risk as the result of a screening episode in a calendar year who have a follow- up HPV test between 9 and 15 months}}$$

Numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–74 who are determined to be of intermediate risk as the result of a screening 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
	H1 HPV test date
	J2 Primary screening episode completion date

Denominator specifications

Definition	Number of people aged 25–74 who are determined to be of intermediate risk as the result of a screening 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
	J4 Primary screening episode risk of significant cervical abnormality
	J5 Primary screening episode recommendation

Indicator 11 Follow-up results

Definition:

The percentage of follow-up episodes in each risk category in a calendar year in people aged 25–74

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. 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.

Calculation:

Unsatisfactory

$$\frac{\text{Number of follow} - \text{up episodes that were unsatisfactory in people aged 25–74 in a calendar year} \times 100}{\text{Number of follow} - \text{up episodes in people aged 25–74 in a calendar year}}$$

Low risk

$$\frac{\text{Number of follow- up episodes that were low risk in people aged 25–74 in a calendar year} \times 100}{\text{Number of follow} - \text{up episodes in people aged 25–74}}$$

Intermediate risk

$$\frac{\text{Number of follow- up episodes that were intermediate risk in people aged 25–74 in a calendar year x 100}}{\text{Number of follow- up episodes in people aged 25–74 in a calendar year}}$$

Higher risk

$$\frac{\text{Number of follow- up episodes that were higher risk in people aged 25–74 in a calendar year} \times 100}{\text{Number of follow- up episodes in people aged 25–74 in a calendar year}}$$

Count is of follow-up episodes

Specifications:

Numerator specifications

Definition	Number of follow-up episodes in people aged 25–74 in a calendar year that had a risk of significant cervical abnormality of: – unsatisfactory – low risk – higher risk
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J6 Follow-up episode commencement date J9 Follow-up episode risk of significant cervical abnormality

Denominator specifications

Definition	Number of follow-up episodes in people aged 25–74 in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier B4 Date of birth J6 Follow-up episode commencement date

Indicator 12 Colposcopy rate

Definition:

The percentage of people aged 25–74 who are referred for colposcopy 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 that places them at higher risk of significant cervical abnormality, and should be calculated for each screening episode result.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

$$\frac{\text{Number of people aged 25– 74 with an HPV test in which oncogenic HPV 16/18 is detected in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of people aged 25– 74 with an HPV test in which oncogenic HPV 16/18 is detected in a calendar year}}$$

Oncogenic HPV (not 16/18) detected + reflex LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality

$$\frac{\text{Number of people aged 25– 74 with an HPV test in which oncogenic HPV (not 16 or 18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of people aged 25– 74 with an HPV test in which oncogenic HPV (not 16 or 18) is detected and who had an LBC result of pHSIL/HSIL/cervical cancer/any glandular abnormality in a calendar year}}$$

Follow-up HPV test result that indicates higher risk

$$\frac{\text{Number of people aged 25– 74 with a follow- up HPV test result that indicates they are higher risk in a calendar year who had a colposcopy within 3 months} \times 100}{\text{Number of people aged 25– 74 with a follow- up HPV test in which any oncogenic HPV is detected in a calendar year}}$$

The numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people who had a colposcopy after each specified screening episode result within 3 months
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test
	K1 Date of colposcopy episode

Denominator specifications

Definition	Number of people aged 25–74 who have a screening 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
	G1 Type of test
	J2 Primary screening episode completion date
	J3 Primary screening episode result
	J7 Follow-up episode completion date
	J8 Follow-up episode result

Comments:

This performance indicator is affected by the change in the screening policy for people at *Intermediate risk*.

From 1 February 2021

For people with a cervical screening result of *Intermediate risk* recommended to have a follow-up HPV test at 12 months, if HPV (not 16/18) is detected and LBC prediction 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:

For people aged 25–74 who have a screening episode result that places them at higher risk of significant cervical abnormality, the time between the screening result and colposcopy, measured as median and 90th percentile values, as well as within specified timeframes.

Rationale:

People who receive a screening episode result that places them at higher risk of significant cervical abnormality will be referred to colposcopy. The recommended timeframe in which they should undergo colposcopic assessment is as per the NCSP 2016 Guidelines (Cancer Council Australia and Cervical Cancer Screening Guidelines Working Party 2016). Monitoring actual time between screening result and colposcopy provides important information as to whether people are receiving timely assessment, as delay in assessment may lead to poorer outcomes.

Calculation:

Oncogenic HPV 16/18 detected + any reflex LBC result

For people 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 people 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

Follow-up HPV test result that indicates higher risk

For people aged 25–74 with a follow-up HPV test that indicates they are higher risk 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 people who had a colposcopy within 365 days of a screening 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
	J7 Follow-up episode completion date
	J8 Follow-up episode result
	K1 Date of colposcopy episode

Comments:

This performance indicator is affected by the change in the screening policy for people at *Intermediate risk*.

From 1 February 2021

For people with a cervical screening result of *Intermediate risk* recommended to have a follow-up HPV test at 12 months, if HPV (not 16/18) is detected and LBC *prediction 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:

The percentage of colposcopies in people aged 25–74 in which a biopsy was performed.

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:

$$\frac{\text{Number of colposcopy episodes at which a biopsy was performed in people aged 25–74 in a calendar year} \times 100}{\text{Number of colposcopy episodes in people aged 25–74 in a calendar year}}$$

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 people 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
	K1 Date of colposcopy episode
	K8 Biopsy this episode

Denominator specifications

Definition	Number of colposcopy episodes in people 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
	J2 Primary screening episode completion date
	J7 Follow-up episode completion date
	K1 Date of colposcopy episode

Indicator 15 Yield of high-grade abnormalities on biopsy among people who attend colposcopy after higher risk screening results

Definition:

Percentage of people aged 25–74 with a higher risk screening 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 people 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:

$$\frac{\text{Number of people aged 25– 74 with a higher risk screening episode result who had a colposcopy in a calendar year who were diagnosed with a high- grade abnormality or cervical cancer on histology within 6 months of colposcopy} \times 100}{\text{Number of people aged 25– 74 with a higher risk screening episode result who had a colposcopy in a calendar year}}$$

The numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–74 with a higher risk screening 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
	B4 Date of birth
	K1 Date of colposcopy episode
	L1 Histology test date
	L7 Histology test result

Denominator specifications

Definition	Number of people aged 25–74 with a higher risk screening episode result who had a colposcopy in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	J4 Primary screening episode risk of significant cervical abnormality
	K1 Date of colposcopy episode

Indicator 16 Positive predictive value of colposcopy

Definition:

Percentage of people aged 25–74 with a higher risk screening 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:

$$\frac{\text{Number of people aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma − in − situ) or cancer in a calendar year who were diagnosed with a high-grade abnormality or cervical cancer on histology within 6 months of colposcopy}}{\text{Number of people aged 25–74 with a higher risk screening result who had a colposcopic impression of HSIL, glandular abnormality (adenocarcinoma − in − situ) or cancer in a calendar year}} \times 100$$

The numerator is a subset of the denominator

Count is of people

Specifications:

Numerator specifications

Definition	Number of people aged 25–74 with a higher risk screening 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 people aged 25–74 with a higher risk screening 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
	J4 Primary screening episode risk of significant cervical abnormality
	K1 Date of colposcopy episode
	K6 Colposcopic impression – primary diagnosis

Indicator 17a High-grade cervical abnormality detection rate

Definition:

Number of people aged 25–74 with a high-grade abnormality detected on histology in a calendar year per 1,000 people 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:

$$\frac{\text{Number of people aged 25– 74 with a high- grade abnormality detected on histology in a calendar year } \times 1{,}000}{\text{Number of people aged 25– 74 screened in a calendar year}}$$

Count is of people

Specifications:

Numerator specifications

Definition	Number of people 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
	L1 Histology test date
	L4 Squamous histology cell analysis
	L5 Endocervical (glandular) histology cell analysis

Denominator specifications

Definition	Number of people aged 25–74 screened in a calendar year.
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test
	H1 HPV test date

Indicator 17b Cervical cancer detection rate

Definition:

Number of people aged 25–74 with cervical carcinoma on histology per 1,000 people screened.

Rationale:

The cancer detection rate will be measured alongside the high-grade detection rate.

Calculation:

$$\frac{\text{Number of people aged 25– 74 with a cervical carcinoma detected on histology in a calendar year } \times 1{,}000}{\text{Number of people aged 25– 74 screened in a calendar year}}$$

Count is of people

Specifications:

Numerator specifications

Definition	Number of people 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
	L1 Histology test date
	L4 Squamous histology cell analysis
	L5 Endocervical (glandular) histology cell analysis

Denominator specifications

Definition	Number of people aged 25–74 screened in a calendar year
Source	National Cancer Screening Register
Data items	A1 Participant identifier
	B4 Date of birth
	G1 Type of test
	H1 HPV test date

Indicator 18 Cervical cancers diagnosed by time since last screen

Definition:

Number of females aged 25–74 diagnosed with cervical carcinoma categorised into never screened, lapsed screening, and recently screened based on time since last screen.

Rationale:

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 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 per 100,000 estimated resident population in a calendar year.

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 per 100,000 estimated resident population in a calendar year.

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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