

NSW CERVICAL SCREENING PROGRAM

Strategic Plan

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FOREWARD

The challenge of bringing the health benefits of regular cervical screening to all of the women of NSW remains ahead of us. Although the incidence and mortality from cervical cancer has continued to decline, the number of women and their families affected by this disease is still too large for such a potentially preventable disease.

Effective cervical screening requires collaboration between multiple sectors and providers in many different parts of the health system. The successful imposition of a population health program onto a system of individual clinical encounters needs to overcome the fundamental tensions between these two paradigms. If such a process is not successful, then inefficiencies and inequities will continue. The consequence of this will be inefficient use of public resources and continuing failure to prevent cervical cancer.

It is my great pleasure to present the Strategic Plan for the NSW Cervical Screening Program for the years 2000-2004. The plan addresses the key areas of activity for the Program and lists a number of feasible strategies designed to further improve cervical screening in NSW. The plan has already been widely reviewed, enhanced and endorsed by participants and stakeholders in screening across the state. The plan demonstrates the commitment of all involved in screening and acknowledges the continuing dependence on widespread collaboration to improve the health of women.

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GLOSSARY OF ACRONYMS

ABS	Australian Bureau of Statistics
AHS	Area Health Service
AHTAC	Australian Health Technology Advisory Committee
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ANSWD	Alliance of NSW Divisions
ASC	Australian Society of Cytology
ASCCP	Australian Society for Colposcopy and Cervical Pathology
CDCSH	Commonwealth Department of Community Services and Health
CDHAC	Commonwealth Department of Health and Aged Care
CDHSH	Commonwealth Department of Human Services and Health
CIN	cervical inter-epithelial neoplasia
CME	continuing medical education
DGP	Division of General Practice
DNA	deoxyribonucleic acid
FPA	FPA Health (formerly Family Planning NSW)
GP	general practitioner
HFA	Health Funding Authority
HPV	human papilloma virus
NATA	National Association of Testing Authorities
NHMRC	National Health and Medical Research Council
NPAAC	National Pathology Accreditation Advisory Council
NSW	New South Wales
NSW PTR	NSW Pap Test Register
NSW CSP	NSW Cervical Screening Program
PAA	Practice Assessment Activity
PCC	Preventing Cancer of the Cervix
PDHPE	Personal Development, Health and Physical Education
PIP	Practice Incentive Payment
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCPA	Royal College of Pathologists of Australasia
RDAA	Rural Doctors' Association of Australia
SCU	State Coordination Unit
SES	socio-economic status
VETAB	Vocational Education Training Accreditation Board



INTRODUCTION

Cervical screening is one of the most effective population health screening strategies available. It is estimated to be over 90% effective in preventing cases of cervical cancer in women. The Pap test (or Pap smear) can detect early changes in the cells of the cervix before they have a chance to develop into cancer. If treatment is necessary it is usually simple and effective (CDHSH, 1998).

In 1991 the Commonwealth Government, in conjunction with State and Territory Governments established the Organised Approach to the Prevention of Cancer of the Cervix, later renamed the National Cervical Screening Program in 1995.

An organised approach to cervical screening requires mechanisms to address all steps along the screening pathway as follows:

- **Recruitment**

All eligible women need to be made aware of the importance of and encouraged to have regular two-yearly Pap tests.

- **Pap test taking**

Pap smear providers should be encouraged to ensure optimal quality in Pap test taking.

- **Pap test reporting**

Cytology laboratories need to ensure optimal quality in reading Pap tests and reporting results to providers by instituting quality assurance programs.

- **Notification of results**

Providers must ensure that women are appropriately notified of their Pap test results.

- **Management of women with abnormal Pap tests**

The follow up and management of women with screen-detected abnormalities should be in accordance with NHMRC guidelines.

- **Monitoring of the screening program**

Progress in addressing all steps of the screening pathway can be monitored by analysing data from cervical cytology and cancer registries.

The National Policy on Cervical Screening, developed from this approach, is in Appendix 1.



NSW CERVICAL SCREENING PROGRAM

The NSW Cervical Screening Program (“Program” or “the Program”) is a jointly funded Commonwealth/ State and Territory initiative under the Public Health Outcomes Funding Agreement to implement the National Cervical Screening Policy in NSW. A five year performance and funding contract to manage the state-wide program for the years 1999 to 2004 has been awarded to Western Sydney Area Health Service (AHS). Western Sydney AHS was also the contract holder for the previous phase of the Program, from 1996 to 1999.

The NSW Program is part of the National Cervical Screening Program which operates in all states. As such it operates within national cervical screening policies and guidelines. In addition it works within the NSW Health policy and organisational framework linking with AHSs and cervical screening service providers in the private sector as well as other key stakeholders to achieve its goals, objectives and contracted targets. A schema of this is shown in Appendix 2.

The goal of the Program is to achieve optimal reductions in the incidence of, and mortality and morbidity attributed to, cervical cancer, at an acceptable cost to the community.

As outlined in its Performance and Funding Agreement the Program functions are to:

- Implement the Organised Approach to preventing cancer of the cervix in NSW consistent with the National Screening Policy and other public health programs in NSW.
- Implement a state recruitment strategy for the target population which incorporates strategies for unscreened and under-screened women within the target population, including women in rural and remote areas, older women, women of Aboriginal and Torres Strait Islander origin, women from culturally and linguistically diverse backgrounds, and women with disabilities.
- Develop, maintain and improve systems to ensure that women with screen-detected abnormalities are appropriately followed up, in conjunction with the NSW Pap Test Register (NSW PTR).
- Provide women and service providers with comprehensive and accurate information on the benefits and limitations of cervical screening and on the management of screen-detected abnormalities.
- Liaise with the NSW PTR, AHSs, professional groups, consumer organisations, NSW Health, and Program Managers in other states to ensure that the Program is effective and consistent across NSW and nationally.
- Collect and analyse data sufficient to monitor the implementation of the Program, to evaluate its effectiveness and efficiency, and to provide the basis for future policy and Program development decisions.

The specific targets for the period July 1999 to June 2001 which are detailed in the Program's Performance and Funding Agreement, are shown in Appendix 3.

The Program is a population health program which involves the delivery of a clinical service to individual women primarily by general practitioners (GPs). It recognises that Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse groups and others who may not be accessing GP services, may have special needs. The Program's activities are consistent with Commonwealth and State health policies. It employs an evidence-based approach to identify the most effective strategies and uses data to monitor and evaluate progress. This document outlines a range of strategies which apply at national, state, AHS and Division of General Practice (DGP) level.

For the next phase of the Program, five key areas of activity have been identified. The Program will aim to:

- 1. Develop and implement strategies to recruit all women in the target groups to undergo regular two-yearly Pap tests, including providing appropriate information and ensuring access to appropriate services.**
- 2. Support GP structures and activities to facilitate their primary role in delivering acceptable Pap test services to women.**
- 3. Work with laboratories to optimise their role in cervical screening.**
- 4. Promote best clinical practice in cervical screening.**
- 5. Undertake on-going operations-oriented research, monitoring and evaluation to support and guide the directions of the Program.**

While the Program has responsibility for achieving a range of outcomes across the cervical screening pathway in NSW, and AHSs have responsibility for the health of their populations, neither have direct responsibility for the delivery of most of the cervical screening services in NSW. The implementation of these strategies, which are aimed at achieving sustainable improvements in cervical screening in NSW, will require a comprehensive change of attitude, structures and approaches at all levels.



KEY ACTIVITY AREA 1

Develop and implement strategies aimed at recruiting all women in the target groups to undergo regular two-yearly Pap tests, including providing appropriate information and ensuring access to appropriate services.

Rationale for strategies

During 1997 there were 289 new cases of cervical cancer reported among all women in NSW, compared with 327 new cases in 1996. There were 241 cases of cervical cancer in the target age group 20 - 69 years. In 1997 there were 148 new cases of cancer of the cervix among women aged 20 - 49 years, and 93 new cases in women aged 50 - 69 years. There were 116 deaths from cervical cancer across all age groups during 1997 (NSW CSP, 1999).

Local studies have shown that 70% or more of women who get cervical cancer are either unscreened or under-screened (Wain et al, 1992; Wain et al, 1995; Mitchell et al, 1996). In order to reduce the incidence of, and death from, cervical cancer the Program must, as a priority, recruit both unscreened and under-screened women to cervical screening.

The most recently available data on new cases of cervical cancer by country of birth in NSW is for the period 1993 - 1997. This shows that the greatest number of new cases were among women born in Australia and the United Kingdom. Numbers of cases for other classifications of country of birth are comparatively smaller, however, women born in Vietnam experienced significantly higher incidence rates overall (NSW Health, 2000a).

While no information is currently available on the burden of cervical cancer in Indigenous women in NSW, data available from Western Australia, South Australia and the Northern Territory suggests that mortality from cancer of the cervix is about eight times higher among Indigenous women, compared with all Australian women (AIHW, 1998). There is a modest correlation between premature deaths from cervical cancer and the index of socioeconomic disadvantage in NSW (NSW Health, 2000a).

The screening rate for women in the 20 - 69 year age target group at 31 March 2000 was 62.1%, leaving around 40% of NSW women unscreened and therefore at risk of cervical cancer. Lowest screening rates were in the 65 - 69 year age group (40.3%) and the 20 - 24 year age group (49.47%) (NSW CSP, 2000a).

There is significant variation in screening rates across AHSs. Table 1 shows the proportion of women screened in a two-year period by AHS in NSW for the 24-month reporting period April 1998 to March 2000.

Table 1. Proportion of women screened in a two-year period by Area Health Service in NSW for the 24-month reporting period April 1998 - March 2000

METROPOLITAN AHS	%	RURAL AHS	%
Central Coast	63.7	Far West	49.4
Central Sydney	54.1	Greater Murray	56.2
Hunter	61.5	Macquarie	55.7
Illawarra	58.9	Mid North Coast	64.7
Northern Sydney	64.5	Mid Western	60.6
South Eastern Sydney	62.2	New England	64.6
South Western Sydney	56.3	Northern Rivers	60.2
Wentworth	54.0	Southern	57.2
Western Sydney	53.8		
Metropolitan sub-total	58.9	Rural sub-total	59.7
NSW TOTAL	60.2	NSW TOTAL	60.2

(NSW Cervical Screening Program, 2000a)

Screening rates also vary significantly by regional classification. An analysis of rates by a national regional classification of population and remoteness shows that large rural centres have the highest recorded screening rates (65.0%), followed by small rural centres (62.2%) other metropolitan centres (60.0%), and capital cities (58.6%). Remote areas had the lowest screening rates (46.3%) but these are affected to an unknown extent by under-enumeration of smears in some local government areas (LGAs) due to cytology being processed in other states (NSW CSP & NSW PTR, 2000).

The NSW PTR does not record any markers of socio-economic status, ethnicity or Aboriginal and Torres Strait Islander status. In view of the differing cervical cancer incidence rates in different overseas born communities, each cultural, language, or country-of-birth group needs to be addressed on a group-by-group basis according to risk.

Barriers to screening

Substantial research has addressed women's barriers to cervical screening. Barriers can be linked to a woman's knowledge about cervical cancer and may include emotional barriers such as fear, embarrassment, discomfort, pain, and fear of the outcome (Hennig & Knowles, 1990; Cockburn, 1992).

Environmental barriers relate to the availability of service, the need to have a supportive atmosphere which is both accessible and acceptable to women, and the woman's perception about the importance of Pap tests. There is a perception by women that a Pap test is not necessary if the GP does not take the opportunity to offer one at the time of consultation (Hennig & Knowles, 1990). For some women, the gender of the service provider is an additional barrier for screening (Girgis et al, 1996).

For Aboriginal and Torres Strait Islander women, barriers to screening have been linked to the fact that cervical screening is seen as "women's business" and must only involve women, and that screening must be viewed from an holistic perspective and not in isolation to other health issues (Toussaint, 1996).

Barriers identified for women from culturally and linguistically diverse backgrounds relate to a range of factors which differ from group to group. Some identifiable barriers common to many groups include language, beliefs and cultural practices. However, the diversity means that each group needs to be looked at separately to determine the specific barriers that need to be addressed to ensure that opportunities for women to participate in screening are provided at access points acceptable to the community.

Implementing a population health approach for the recruitment of women

Population health concerns the health of populations based on a particular defining characteristic (NSW Health, 2000b). The target population for the Program is all women in NSW aged 18 - 70 years who have ever been sexually active and have an intact cervix. Social factors which are known to affect the health of populations are often referred to as social determinants of health (Lee & Paxman, 1997). The Program recognises the importance of the known social determinants of health for women, however, as the Program is funded specifically to address cervical screening issues, there is a need to work in partnership with a range of agencies involved in particular population health issues.

The World Health Organisation recommends the use of a settings approach for improving health, and describes settings as places where people live, work and play (Zöllner & Lessof, 1998). The obvious setting in which cervical screening needs to be placed is at women's main access point to health care, the GP. Women's screening rates in NSW can, therefore, be increased by strategies which increase the capacity of GPs to offer a Pap test service which is acceptable and accessible to women. For those women who do not access GPs, strategies will need to draw upon what is presently known about alternative access points to health care for women.

Strategies for recruiting women

1.1 Maintaining an infrastructure for working with women

The involvement of stakeholders in all aspects of the Program's work has been a key principle underpinning the Program's activities (NSW CSP, 1996). To date the Program has established an advisory Taskforce with representatives from key women's groups. The terms of reference and membership of the Taskforce are shown in Appendix 4.

The Program will:

- 1.1.1 continue to maintain a Women's Taskforce to advise the Program on all steps of the screening pathway, as they affect women, particularly on the development and implementation of state-wide communication and recruitment activities. Stakeholders represented on the Taskforce include: FPA Health ; Older Women's Network; Aboriginal Health and Medical Research Council; Indigenous Studies Unit, Koori Centre University of Sydney; NSW Pap Test Register; Rural Women's Health Network; Multicultural Health Communication's Service; NSW Health's Women's Unit; Country Women's Association Australia; a consumer representative; and experts in health promotion; and
- 1.1.2 build partnerships with organisations and services that access women.

1.2 Recruiting women through a social marketing approach

Population surveys show that the mass media is a leading source of information about important health issues (Grilli et al, 2000). However, mass media campaigns do not lead to sustainable participation in screening (Hirst, Mitchell & Medley 1990; Young & Trevan 1990; Shelley et al, 1991).

While it is important to provide women with full information about all aspects of Pap tests, evidence is clear that health education alone has a limited effect on population health. Studies indicate that in general, women are aware of the need to have a Pap test, however, because of the barriers identified, are often reluctant to have one (Neilson & Jones, 1998). Over the past two decades there has been an evolution in thinking about communicating health messages from a one-dimensional announcement technique to the use of the multi-dimensional approach of social marketing (Weinreich, 1999).

To date the Program has produced a variety of information resources ranging from educational videos, brochures, posters, and training manuals for women and health service providers. A selection of these resources is also available in a range of languages.

The Program has also run a state-wide media campaign featuring radio and press advertising targeting six languages. The Program has established a toll free information line for women to contact the Program direct. Utilisation of these resources over the past three years by both women and health service providers highlights the need to continue with this information provision.

The Program will:

- 1.2.1 continue to provide information and resources to women in a variety of formats and languages;
- 1.2.2 extend its current catalogue of information and resources to meet the needs of women with disabilities;
- 1.2.3 incorporate a local multi-dimensional communication strategy in its activities at the AHS level. This will include a communication strategy for:
 - opportunistic recruitment activities for GPs
 - peer education programs for older women
 - partnership activities with BreastScreen NSW
 - community education;
- 1.2.4 identify and utilise opportunities to promote the cervical screening message in established communication and media outlets; and
- 1.2.5 expand its use of information technology by providing all current resources and language-specific resources to women via the Program's Web site.

1.3 Recruiting women at their point of access to health care

Patterns in women's access to health service providers have major implications for the recruitment of women to cervical screening. GPs perform over 90% of Pap tests in NSW and women's health nurses screen around 1% of all eligible women in NSW - this proportion is higher in rural and remote areas where, overall, women's health nurses perform around 4% of Pap tests, (this proportion is higher still in some areas). The remainder of women access non-government organisations, Aboriginal Medical Services, specialists, sexual health clinics and community-based providers for Pap test screening (NSW CSP, 1997b). Access patterns of women from culturally and linguistically diverse backgrounds, and of Indigenous women, are not currently available because such information is not recorded in the screening data.

The Australian Bureau of Statistics (ABS, 1994) identified that 86% of all adult women consult a GP at least annually. There is no information on where the remainder of women are accessing health services but it is likely that some of these women will visit a GP once every two to three years.

Evidence suggests that one of the most effective ways of getting women to have a Pap test is for a GP to advise them to have one. This is particularly effective in women over 40 years of age (Cockburn et al, 1990; Brent 1992). Additionally, there is some evidence to suggest that women may prefer to have a female Pap test provider, particularly women who are younger or from rural areas (Heywood, Firman & Ring, 1996; Bryson & Warner-Smith, 1998). Other evidence suggests that a GP's gender is not important (Cassard, 1997).

Other strategies which could significantly increase screening rates among women in NSW need to be examined and could include incentives for women or direct mail approaches.

The Program will:

- 1.3.1 work in partnership with GPs to increase their capacity to recruit women to cervical screening and to increase their knowledge about the barriers for women in having Pap tests including preferences for female providers (these are further addressed in Key Activity Area 2);
- 1.3.2 work in partnership with providers in other settings within AHSs where women access services or health information to encourage cervical screening, where appropriate;
- 1.3.3 examine ways in which incentives may be used to increase women's screening rates; and
- 1.3.4 examine effectiveness of different types of direct mail strategies to increase women's screening rates.

1.4 Ensuring women have adequate access to acceptable Pap test services

Screening rates in large and small rural centres are some of the highest in NSW. However, outside of these centres and in remote areas in NSW, screening rates are lower (NSW CSP & NSW PTR, 2000). It is acknowledged that there are particular problems in accessing Pap test services in some rural and remote parts of NSW. This is in part, at least, a reflection of a lack of availability of a GP or lack of a female GP. The role of women's health nurses is particularly important in providing a Pap test service for these women.

The Program will:

- 1.4.1 work with DGPs to develop local networks and referral protocols to ensure women are provided with an appropriate service. Such networks may include other GPs, women's health nurses, or non-government organisations;

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- 1.4.2 work with AHSs and DGPs to enable the provision of appropriate services by women's health nurses in parts of the state where GPs are not available, or the preference for a female GP cannot be met, and establish the most appropriate provision of services by women's health nurses

From the ABS statistics referred to above some 14% of women do not routinely access a GP on a yearly basis. There is a paucity of literature about this group. The Program has conducted an action research project in seven AHSs on women living in caravan parks who are thought not to access GPs on a regular basis. A full report of this study will be available soon and will be used to inform strategies for this group of women.

The Program will:

- 1.4.3 develop locally tailored strategies to increase screening in women who do not access GPs which take into account screening data and potential for developing innovative local partnerships; and
- 1.4.4 examine proposals for innovative models for improving recruitment practice in cervical screening.

1.5 Older Women

Of the screening target group, women aged 60 - 69 years have the lowest screening rates, however, women aged over 70 years have the highest age-specific cervical cancer incidence rates in NSW (NSW CSP, 2000). In view of the fact that women who get cervical cancer are often unscreened, it is important to ensure that older unscreened women are encouraged to have a Pap test. Older women often access their GP and are receptive to advice from the GP that they should have a Pap test (Cockburn et al, 1992).

Strategies to target older women which have been implemented by the Program include: promotion of cervical screening through bowling club score cards, which is yet to be fully evaluated; and local GP-based initiatives which have shown an increase in screening rates in certain AHSs. The use of a peer education training program to access this group has also been successfully trialed by the Program in two AHSs.

The Program will:

- 1.5.1 develop a comprehensive peer education training program for older women to promote the importance of Pap tests to their peers in settings appropriate to them. This will involve developing the skills of older women to be community educators who can actively engage womens' groups in providing information about cervical cancer, the importance of two-yearly Pap tests, and how to access appropriate services; and
- 1.5.2 develop an approach to informing women aged over 70 years who are unscreened, to have a Pap test in line with the National Policy on screening.

1.6 Aboriginal and Torres Strait Islander women

For Aboriginal and Torres Strait Islander women there is a need to place Pap test screening within the context of other social, economic and health priorities (Hunt, Gless & Straton, 1998). The preferred model of health care views "healthy women's issues" from an holistic, cultural and spiritual perspective (Angus, & Lea, 1998; Hunter, 1999). The gender of a health practitioner and willingness to perform Pap tests in a suitable and convenient setting, is an important factor for Aboriginal and Torres Strait Islander women (Lumsden, 1996; Toussaint, 1996). There is strong evidence to support the need to include Aboriginal and Torres Strait Islander communities in the planning, implementation and evaluation of screening recruitment programs (Reath & Usherwood, 1998).

To date the Program has produced and distributed state-wide, an information brochure and a poster specifically targeting Aboriginal and Torres Strait Islander women. This was developed collaboratively through a partnership agreement with Aboriginal and Torres Strait Islander women across the state under the auspices of the Aboriginal Health Resources Collective. It has also supported the local development of Aboriginal health worker training materials and education materials for Aboriginal and Torres Strait Islander women which has been accredited by the Vocational Education Training Accreditation Board (VETAB).

The Program will:

- 1.6.1 work in partnership with Aboriginal and Torres Strait Islander communities and health service providers including Aboriginal Medical Services (AMS) and Community Controlled Health Services to develop a state-wide strategy to improve participation of Aboriginal and Torres Strait Islander women in cervical screening;
- 1.6.2 support Aboriginal and Torres Strait Islander health workers by providing them with the information and educational resources developed in the last phase of the Program through the partnership agreement; and

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- 1.6.3 work with relevant organisations and a range of Aboriginal and Torres Strait Islander communities to evaluate these resources.

1.7 Women from culturally and linguistically diverse backgrounds

Women from culturally and linguistically diverse backgrounds need information on cervical screening in a form that is accessible to them. They may need services which are both culturally appropriate and accessible, and these needs may differ from community to community.

Over the past three years the Program developed and implemented a state-wide media campaign featuring radio and press advertising for six community languages, as well as a number of locally based communication activities. These included a multi-dimensional communications activity in South Western Sydney AHS targeting Vietnamese women; a campaign targeting women and service providers from the Korean and Chinese communities in Northern Sydney AHS; and a number of community-based campaigns in the Illawarra AHS. Currently South Western Sydney and Western Sydney AHSs are developing a multi-dimensional communication activity directed at women from the former Yugoslavia.

The Program will:

- 1.7.1 continue to develop strategies that target women from culturally and linguistically diverse backgrounds in consultation with each community using cancer incidence rates, screening rates, and local demographic data to identify areas of priority for each AHS;
- 1.7.2 continue to provide information pamphlets on cervical screening in a range of languages appropriate to the local community; and
- 1.7.3 develop a directory of culturally specific services available in each Area.

1.8 Women with disabilities

There is limited research literature that specifically examines cervical screening patterns for women with disabilities. To date the Program has funded two needs assessments on women with intellectual disabilities. The first report recommended the need for disability awareness training for GPs, and for information on Pap tests to be made available for women with intellectual disabilities. The second report, which is due June 2000, will identify those factors which prevent or limit women with mild to moderate intellectual disability from accessing cervical and breast screening services, and factors which may improve their access.

The Program will:

- 1.8.1 investigate ways of communicating cervical screening information to women with intellectual disabilities, and their carers and health care providers through the development of fact sheets and pamphlets, and through GP training programs; and
- 1.8.2 identify and promote access to appropriate services for women with physical disabilities.

1.9 Younger Women

The natural history of human papilloma virus (HPV) in young women is complex. Whilst there is a high incidence of abnormalities in young screened women (NSW CSP & NSW PTR, 2000), the clinical significance of many of these lesions is unclear. Therefore, the screening message to young women aged 18 - 25 years needs to be clarified and disseminated.

In keeping with the settings approach, schools have been shown to have a major influence across a wide range of health issues for young people. The National Health and Medical Research Council's Health Advancement Standing Committee (1996) concluded that 'programs which are comprehensive, integrated and holistic, and which embrace aspects across the curriculum, the environment and the community, are more likely to lead to advancements in the health of school children'. To date the Program has made available promotional materials such as pamphlets, posters and post cards to schools, FPA Health, and other points where young women access health care.

The Program will:

- 1.9.1 develop clearer messages for women aged 18 - 25 years on the significance of abnormal Pap test results and disseminate to young women and to providers; and
- 1.9.2 work within the context of the *Health Promoting Schools* framework to design, implement and evaluate a Secondary School Cervical Screening package for young women aged 16 - 18 years.

1.10 Recruitment of women in partnership with BreastScreen NSW

The NSW Cervical Screening Program and BreastScreen NSW differ considerably in the way their programs are delivered. Cervical screening is largely delivered through the private sector while screening mammography is delivered through the public sector in discrete units. While both programs target women, the age of the target groups differ. The Program targets women aged 18 - 70 years and BreastScreen NSW targets women aged 50 - 69 years.

The Program is committed to working with BreastScreen NSW to maximise both program's capacities to reach women in the 50 - 69 year age group. The Program and BreastScreen NSW have jointly promoted their programs through "multicultural health days" and through reminders "to have a Pap test" on letters sent out by some BreastScreen services. In addition, an opportunistic screening package developed by the Program for GPs includes material to prompt women to have a mammogram. A pilot project has also been established to link the two services in an AHS where access to GPs for Pap tests was limited. This was carried out with the support of the local GPs.

The Program will:

- 1.10.1 identify opportunities for joint promotional activities with BreastScreen NSW, as appropriate, including general advertising, direct mail, education of health workers and provision of information to GPs; and
- 1.10.2 assess the opportunities for linking services in rural areas in association with AHSs and DGPs.



KEY ACTIVITY AREA 2

Support GP structures and activities to facilitate their primary role in delivering acceptable Pap test services to women.

Rationale for strategies

General practice is an integral part of the Australian health care system. It occupies a unique position at the interface of the primary health and community care system and other parts of the health system and, as such, is the usual point of entry into the Australian health care system (NSW Health, 2000c).

GPs are trained to provide the full range of primary care services as the basic component of their practice and contribute to the delivery of primary health care in a variety of settings and circumstances (CDHAC, 1999a). They also have a central focus of patient management through their referrals to consultants, allied health professionals and community health, and for hospital admissions, pathology and imaging. GPs also coordinate patient care and provide continuity of care (NSW Health, 2000c).

Historically, the links between general practice and population health have been weak, with a great deal of general practice activity occurring in isolation from population-based approaches to health care delivery (Rogers, Veale & Weller, 1999). However, there is a trend of increasing recognition of the role of general practice and GPs in public health activities as part of the primary health care network (CDHAC, 1999b). This is reflected in the RACGP policy and guideline statement on prevention and health promotion in general practice (RACGP, 1996). NSW Health also recognises that a key strategy to improving the health of the people of NSW will be to improve integration of general practice with the public health system (NSW Health, 2000c).

In 1992 the Commonwealth General Practice Reform Strategy was launched to encourage closer integration with the broader health system. Notably, DGPs were established to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level. As such, they have a core role in focussing on the needs of their local communities, particularly in areas of unmet need, and in strengthening collaboration with other health service providers to improve population health (CDHAC, 1999a). Currently there are thirty nine DGPs in NSW funded by the Commonwealth. In 1997, funding for DGPs began moving from a focus on discrete short-term projects toward block grants that focus on achieving longer-term health policy outcomes. In 1998, the Alliance of NSW Divisions (ANSWD) was established to support NSW DGPs.

Health financing arrangements in Australia have as their basis universal access with low out-of-pocket costs for medical care at the point of service, especially for GP services. The number of GPs relative to the population has grown dramatically, and this has led to the expansion of consumer choice, particularly in urban areas, but to a lesser and variable degree in regional and rural areas (CDHAC, 1999a).

The majority of the population appears to be in favour of general health screening (Byles et al, 1996). With 86% of all adult women visiting a GP at least annually (ABS, 1994), such an attendance rate provides opportunities for GPs to remind women about the importance of screening, to talk about their concerns, to offer a Pap test, and to check on and address reasons for non-attendance (Austoker, 1994).

Implementing an evidence-based approach

As with women, GPs also experience barriers to effective cervical screening. Time pressure appears to be the most frequent and consistently cited barrier to cervical screening (McPhee & Detmer, 1993; RACGP, 1996; Schattner & Coman, 1998; Tomlin, Humphry & Rogers, 1999). Other barriers cited include practice logistics, lack of training in effective health promotion and prevention strategies, lack of confidence, lack of computer-based information management and technology to support systematic preventive activities, and a lack of Divisional strategies to support opportunities for community-based preventive activities (RACGP, 1996). The scheduled Medicare consultation fee structure is also seen by many GPs as a financial disincentive for GPs taking Pap tests. Many of these issues have been confirmed by GPs participating in the Program's GP Forums (NSW CSP, 1997a). Overcoming these barriers will require a multifaceted approach that addresses the competency, social and organisational barriers faced by GPs, in adopting cervical screening guidelines into routine clinical practice (Moulding et al, 1997).

There are a number of obstacles to preventive health screening in the general practice setting. The perceived inability of GPs to change behaviour is seen as a major obstacle (Himmelman, 1997). In theoretical terms, evidence-based practice can potentially achieve improved health outcomes via two steps: changing practitioner knowledge and attitudes, and changing practitioner behaviour (Moulding et al, 1997). The various approaches to introducing evidence and changing behaviour include educational, epidemiologic, marketing, behaviourist, social and peer influence, organisational and coercive (Grol & Grimshaw, 1999).

Another major obstacle for many GPs is the lack of incentive payments for many preventive activities, including cervical screening. Financial incentives have been shown to have a positive impact on screening rates in England when combined with a national call and recall system (Quinn et al, 1999). In Australia, the possibility of future Commonwealth practice incentive payments (PIP) for cervical screening, similar to those currently being paid for immunisation, remains on the agenda.

Strategies which enable and/or reinforce best clinical practice appear to be effective at changing performance and health outcome (Davis, 1998). Systematic reviews of the educational literature have found that the most effective strategies include learning linked to clinical practice, interactive educational meetings, outreach visits and multiple interventions. Less effective strategies include audit, feedback, local consensus processes, and the influence of opinion leaders; and the least effective include lecture format teaching and unsolicited printed material, including clinical guidelines (Davis et al, 1995; Oxman et al, 1995; Davis et al cited in Cantillon & Jones, 1999).

Broadly speaking, GPs are aware of and accept the policy and guidelines for screening. At an individual level, however, there is considerable variation in experience and attitudes of GPs, as evidenced by the wide variations in screening rates across NSW, and high rates of early re-screening. The Program currently has no data on provider types and screening patterns of individual GPs in NSW.

Strategies for general practice

2.1 Maintaining an infrastructure for working with GPs

The Program has an established GP Taskforce which is representative of a range of GP organisations including the RACGP, Australian Medical Association (AMA), Alliance of NSW Divisions (ANSWD), RDAA, and Doctors' Reform Society. The GP Taskforce also includes a consumer representative. The Taskforce provides advice on general practice issues in cervical screening, assists in the development and implementation of state-wide strategies, advises on quality assurance and workforce training issues, ensures widespread consultation with GPs, and assists in the dissemination of information about the Program. The terms of reference and membership of the Taskforce are shown in Appendix 5.

Over the last two years the Program has held an annual GP Forum to enable representatives from DGPs in NSW and other general practice associations, to come together and receive an update on Program activities, to report and discuss local and Divisional projects addressing cervical screening, and to identify and recommend local and divisional strategies for the future. The Program has also provided advice to the RACGP (NSW Faculty) on the development and adoption of a Pap Test Policy Statement to promote a better understanding of the role and responsibilities of GPs toward those patients who should have a regular Pap test.

The Program will:

- 2.1.1 continue to support the ongoing role and function of the GP Taskforce;
- 2.1.2 continue to hold regular GP Forums to maintain existing links with GPs to promote cervical screening throughout NSW;
- 2.1.3 establish an information database to assist with regular contact with DGPs and other associated professional organisations; and
- 2.1.4 attend relevant GP conferences and workshops where there are opportunities to promote cervical screening and the resources that the Program has to assist GPs.

2.2 Providing educational outreach to GPs

As previously indicated, there are numerous barriers which need to be addressed in order to improve delivery of cervical screening in the general practice setting. Educational outreach visits (or academic detailing), particularly when combined with social marketing, appears to be a promising approach for modifying professional behaviour and optimising the organisation of preventive services in the general practice setting (Oxman et al, 1995; Moulding et al, 1997; Thomson O'Brien et al, 1999). This approach involves the use of trained educators to visit GP practices to deliver a targeted education message and provide some form of reminder. This has been shown to be a key strategy in changing GP cervical screening behaviour in a large population study in the Netherlands (Hermens et al, 1999).

The Program will:

- 2.2.1 develop an educational outreach strategy which involves one-on-one visits to GPs aimed at influencing change in GP practice and behaviour through persuasion and/or assisting to streamline office procedures in the practice setting. The strategy will consist of several components including written material and educational meetings, and will be combined with a variety of complementary interventions including reminder systems, patient checklists, and clinical audit and feedback; and
- 2.2.2 develop a training package and provide the necessary skills training for those undertaking the outreach visits.

2.3 Providing skills enhancement and continuing medical education (CME) opportunities

Good technical skills are needed in taking Pap tests (Molodysky & Bridges-Webb, 1996) as well as an understanding of women's concerns and priorities in this area; an understanding of the current State and National programs; and sound knowledge in areas such as the accuracy of screening tests, implications of pre-cancerous lesions, and incidence and mortality of the disease (Weller, 1997). Current screening practices have wide variations in practice (Robson, 1998).

A study by Lewis & Mitchell (1994) identified that a considerable proportion of GPs (almost 50% of the sample) do few or no Pap tests. Further education and skills training in cervical screening is therefore required for these GPs. In particular, male GPs, graduates of less than four or greater than twenty years, and those without post-graduate training were shown to be under-screening. Similar findings to this study were found in a secondary analysis of the Australian Morbidity and Treatment Survey (Reid, Simpson & Britt 1997) and in an earlier New Zealand study (McMaster & Arroll, 1992).

Over the last three years the Program has held CME interactive education seminars at most DGPs in NSW. These were aimed at encouraging GPs to increase their screening rates and provided the opportunity to update their knowledge and skills in this area. The Program has also piloted a CME upskilling course for GPs in South Eastern Sydney AHS with positive results.

The Program will:

- 2.3.1 work with FPA Health to develop a CME up-skilling workshop program for GPs, which will cover the technical skills necessary to perform a satisfactory pelvic examination and Pap test;
- 2.3.2 develop and make available to DGPs, a series of user-friendly “Pap tips” for inclusion in regular newsletter mailouts; and
- 2.3.3 explore opportunities with the RACGP for developing online-CME activities involving case discussions, clinical quizzes, and multimedia presentations, much like a conventional interactive workshop.

2.4 Enhancing information management and technology for GPs

The potential for computers to improve clinical care has been appreciated for some time, however, it has only been in recent years that the wide-spread use of computers for decision-making and reminder and recalls has been shown to improve the performance of practitioners in terms of the provision of preventive services (Johnston et al, 1994; Shea et al, 1996).

The Commonwealth PIP scheme provides financial incentives to general practices for providing quality care across five broad elements of general practice. Information management / technology, including data collection, has been one of the targeted elements since the introduction of PIP in July 1998 (CDHAC, 1999).

The introduction of the PIP was identified by the Program as an opportunity to work with the medical software industry. A GP “Think Tank” was subsequently formed to provide advice and assistance in the development of detailed functional software specifications about cervical screening. Medical Director, the largest medical software company supporting practice management software for GPs, is in the process of upgrading its cervical screening software module in accordance with these specifications.

The Program will:

- 2.4.1 in association with Medical Director, continue to develop the cervical screening module in stages. It will include provision for actions processing, on-line requests and results from pathology laboratories, a recall and reminder system, decision-support, patient and doctor education material, comparative analysis of screening rates, and external links with the NSW PTR;
- 2.4.2 work with other members of the medical software industry to develop their cervical screening modules;
- 2.4.3 continue to upgrade its Internet service to support general practice information needs; and
- 2.4.4 in association with the NSW PTR, explore the capacity for GPs to link with the NSW PTR to access on-line data on practice screening rates and screening history of patients.

2.5 Establishment of local referral networks

Some studies report that women may prefer to have a female Pap test provider, particularly those who are younger and from rural areas (Heywood, Firman & Ring, 1996; Bryson & Warner-Smith, 1998), although other evidence suggests that the gender of Pap test providers may not be important (Cassard, 1997). The Program is also aware of anecdotal evidence from its GP Forums that some GPs feel uncomfortable performing Pap tests.

A pilot referral system has been developed and trialed by the Western Sydney DGP. Although not extensively taken up during the three month trial period it forms the basis of a strategy that can be further developed.

The Program will:

- 2.5.1 work with DGPs to encourage the use of guidelines and protocols for the establishment of local referral networks for cervical screening; and
- 2.5.2 work with DGP to engage participants in local referral networks for cervical screening. These could include referral to other local GPs who perform Pap tests, non-government services such as FPA Health, women's health nurses, or by engaging a practice nurse or other GP to do inter-practice visits.

2.6 Improving practice management

The level of preventive services provided by GPs is largely determined by factors within the practice setting (Deitrich et al, 1994). This is demonstrated by a number of studies which show low screening rates where office management systems for cervical screening have not been implemented (Rogers, Veale & Weller, 1999). Reminder systems, both for patients and GPs have been successful in improving cervical screening rates with patient reminders being the more effective of the two (Pirkis, Jolley & Dunt, 1998; Marcus & Crane, 1998).

To date, the Program has developed several versions of Pap test reminder stickers for tagging patient record files. These have proved to be a popular resource in practices, especially those that do not have computerised reminder/recall systems.

The Program will:

- 2.6.1 continue to market a range of existing practice-based reminder/prompt resources for tagging medical files; and
- 2.6.2 continue working with Medical Director to develop the cervical screening software module which will include a computerised reminder/recall system.

2.7 Promoting opportunistic screening in the general practice setting

Opportunistic recruitment to cervical screening has been advocated for some time as a means of ensuring that large numbers of women participate in cervical screening. The distribution of checklists to patients prior to GP consultation has been shown to increase cervical cancer screening by up to 10%, especially among low income and minority groups (various cited in Marcus & Crane, 1998). Medical receptionists have an important role to play, as they are in a position to support GPs in increasing opportunistic screening (Carnegie et al, 1996).

The Program has piloted and evaluated the *Opportunistic Cervical Screening in General Practice* recruitment package across three AHSs. The package consists of a core module comprising receptionist training, a women's health checklist, and a record reminder system. An optional clinical audit module was made available which includes a GP action sheet, data collection and analysis, and an evaluation component.

The Program will:

- 2.7.1 package the *Opportunistic Cervical Screening in General Practice* recruitment activity and market it through DGPs across NSW as part of the educational outreach strategy.

2.8 Providing clinical audit opportunities for GPs

At present, vocationally registered GPs are required to participate in the RACGP Quality Assurance and Medical Education (QA&CE) Program as a means of assisting them to maintain and improve the quality of care they provide to patients, and to promote the highest possible standard of care to the community. They must gain 130 points per triennium with at least 20 of these being from clinical audit activities (RACGP, 1999). Audit and feedback has been shown to be moderately effective in improving the practice of health care professionals, particularly when combined with other strategies (Thomson O'Brien et al, 1999).

The Program has developed *Preventing Cancer of the Cervix*, a clinical audit package based on the *Practice Assessment Activity* (PAA) developed by the Central Sydney AHS Needs Assessment and Health Outcomes Unit and the Western Sydney DGP. Participation in the clinical audit is aimed at enhancing GP awareness of the cervical screening pathway, by providing a snap-shot of their current practice against peer results. Approximately 10% of NSW GPs have either expressed an interest in, or have participated in the clinical audit to date.

The Program will:

- 2.8.1 continue to offer the clinical audit package to GPs for the RACGP 1999-2001 triennium.

2.9 Other options for increasing GP cervical screening

The use of incentive payments has proven successful in increasing rates of preventive interventions in other programs such as immunisation. The Program sees the importance of encouraging such incentives payments as a way of increasing cervical screening rates.

The Program will:

- 2.9.1 advocate for the introduction of a Practice Incentive Payment to GPs for Pap tests through its GP Task Force and other available avenues; and
- 2.9.2 examine other options and models to increase GP screening rates.



KEY ACTIVITY AREA 3

Work with laboratories to optimise their role in cervical screening.

Rationale for strategies

Pathology laboratories have a major impact on the performance of the cervical screening program. This impact is most noticeable in four specific areas:

- examination of cytology and histology specimens,
- utilisation of new technologies,
- reporting of specimens to both service providers and to the NSW PTR,
- communicating information to service providers about cervical screening.

Optimising their contribution to cervical screening will require that the Program encourage both laboratories and professionals within these organisations to review aspects of their work practice and undertake activities to improve them.

The past five years have seen a number of developments in relation to laboratories. The National Pathology Accreditation Advisory Council (NPAAC) has developed the *Requirements for Gynaecological (Cervical) Cytology* (1997) which outlines minimum acceptable standards of practice. The National Screening Program has produced *Performance Standards for Australian Laboratories Reporting Cervical Cytology* (1996) which has been endorsed by the Royal College of Pathologists of Australasia (RCPA). Since July 1999, laboratories have been assessed against these standards for National Association of Testing Authorities (NATA) accreditation. Together, these guidelines ensure that laboratories report against performance standards as well as requirements relating to training, qualifications and ongoing education of laboratory staff, staff/workload ratios, follow-up systems for women with CIN1 or worse, and participation in the RCPA Quality Assurance Program (NPAAC, 1997). Concurrently, the RCPA and the Australian Society of Cytology (ASC) have developed continuing education programs for pathologists and cytologists respectively.

Most cervical cytology in NSW is processed in private laboratories that operate in a highly competitive commercial environment. Laboratory size and structure have an effect on an individual laboratory's ability to initiate performance improvement. Workforce issues and under-staffing remain overriding concerns for many laboratories, with the maintenance of work output potentially overriding other objectives including assessment of performance, and continuing education for professionals (NSW CSP, 1997b).

The Program's broad strategy for the next phase will be to pursue an approach that supports and encourages initiatives that will improve performance within individual laboratories, and supplement these initiatives with state-wide, laboratory-guided activities.

Specimen examination

There appears to be considerable variation in laboratory quality in NSW. Data from the Annual Statistical Report (NSW CSP & NSW PTR, 2000) reveals variation between laboratories in terms of the percentage of smears reported as negative or as mild atypia. Results range from 64% to 95 % and 0% to 18% respectively, yet the performance standards recommend that no less than 81% of tests should be negative and no more than 14% of smears should be abnormal.

The report on breast and cervical cancer screening in Australia (AIHW, 1998) shows NSW as having the lowest reported rate of histologically confirmed high-grade abnormalities per thousand women screened. Additionally, the AIHW reports the ratio of histologically proven low-grade lesions to histologically proven high-grade lesions in NSW, as the highest in the country. This indicator provides a broad indication of the sensitivity of screening for high grade lesions - the higher the ratio the lower the specificity (NSW CSP & NSW PTR, 2000).

Information about individual laboratory performance in relation to compliance with requirements for cervical cytology and the national performance standards, is not currently available to the Program. During the last phase of the Program, in association with the NSW PTR, the Program supported the development of a system that would allow laboratories to meet their reporting requirements to the established performance standards from data stored at the NSW PTR. This information is provided to individual laboratories, but is not available to the Program.

To ensure accuracy in cytology reporting the National Screening Program has recommended that cytology professionals be encouraged to participate in continuing education activities (CDHSH, 1994a). The ASC reports that 35% of laboratories still do not conduct formal training sessions, and that attendance at local ASC meetings is poor (Stevens, 1999). In NSW, cytologists tend to have a scientific background in cellular pathology and then undergo an informal apprenticeship with laboratories. Training and education have been reported as being variable, being controlled by a wide range of different bodies (NSW CSP, 1997b).

While the Program will encourage and work with laboratories to improve performance and overcome the barriers that inhibit performance improvement, the Program's limited access to data on laboratories restricts its ability to work with laboratories and develop supplementary state-wide activities.

Monitoring new technology

The growth in the availability of automated and semi-automated cervical screening devices prompted a review by the Australian Health Technology Advisory Committee (1998). The review found no data that could demonstrate the cost-effectiveness of these new technologies, and the apparent increased uptake could not be justified from a population health perspective. There is no Medicare rebate available for these adjunctive tests.

Technologies will continue to influence cervical screening in the future. A National Advisory Committee survey (unpublished) found that 20.2% of Pap tests from NSW were accompanied by a fluid preparation specimen and 6.8% underwent computer image analysis compared to 10.3 % and 7.2% in the rest of Australia. National standards for new technologies are currently under development.

HPV-DNA testing is becoming available to practitioners. A systematic review carried out in the United Kingdom (Cuzick et al, 1999) has recommended against widespread implementation of HPV testing, stating that further research and evaluation is required to assess its cost effectiveness and potential roles, including its role as a triage tool for low grade abnormalities.

Reporting of specimens

The NPAAC *Requirements for Gynaecological (Cervical) Cytology* (1997) outline the structure and information to be incorporated into cytology reports. Laboratories are required to include a “management recommendation” that is consistent with NHMRC guidelines when reporting cervical cytology. There appears to be wide variation amongst laboratories in relation to this recommendation. The 1998 Annual Statistical Report (NSW CSP & NSW PTR, 2000) has revealed that 40% of reports to women contain no management recommendation.

Initial analysis of Program data collected in 1998 shows that 54% of negative inflammatory test reports, with no previous history of CIN, suggested recommendations requesting repeats earlier than those outlined in NHMRC guidelines (CDHSH, 1994b) for the management of women with screen-detected abnormalities. Additionally, information sent to the Program by service providers suggests that some laboratories are still not utilising the general reporting categories recommended by the NHMRC, and required by NPAAC.

Communication with service providers

Laboratories communicate regularly with service providers in their service provision functions. GPs identify them as a major source of information and are quite likely to be influenced by their recommendations (Blue Moon Research, 1999). It is important therefore, that messages from laboratories to service providers are consistent with national policies and messages.

Strategies for laboratories

3.1 Developing and maintaining effective communication with stakeholders

Both the Program and the NSW PTR have a close relationship with laboratories. The Program and the NSW PTR have worked collaboratively in the past to communicate the messages of both organisations, and to develop laboratory-specific resources.

The Program has an established Laboratory Taskforce to advise on laboratory issues, and to assist in developing strategies for laboratory quality improvement. The terms of reference and membership of the Taskforce are shown in Appendix 6. To supplement the expert information received from the Taskforce, the Program regularly communicates with laboratories about developments in cervical screening by way of seminars, education sessions and correspondence.

The Program will:

- 3.1.1 continue this collaborative approach and work with the NSW PTR to maintain a close relationship with laboratories, involve the NSW PTR in strategies to optimise laboratory performance, and encourage laboratories to continue their accurate reporting to the NSW PTR;
- 3.1.2 maintain the Laboratory Taskforce whose terms of reference include continuing to advise the Program on aspects of the cervical screening pathway, as they relate to laboratories; and
- 3.1.3 continue to provide information and resources to laboratories.

3.2 Encouraging optimisation of laboratory performance

In order to report, cervical cytology laboratories must be accredited by NATA to perform gynaecological pathology (CDHSH, 1994a). Since July 1999, the accreditation process has involved assessing a laboratory's performance in relation to NPAAC requirements, and the laboratory's reporting against national performance standards to the RCPA. The Program has supported this process by providing information about the policies underlying the accreditation process.

The Program will:

- 3.2.1 in collaboration with the NSW PTR, continue to assist and support laboratories to meet their NPAAC reporting requirements;

3.2.2 actively support and promote the NATA and RCPA accreditation system; and

3.2.3 work towards improving its data on laboratories to enhance its, and the NSW PTR's, ability to encourage laboratories to improve performance.

3.3 Improving the accuracy of specimen examination

To date the Program has only been able to perform limited analysis of data to ascertain causes for variation in specimen reporting. At a limited level the data has informed decision-making processes for strategies aimed at improving the accuracy of laboratory reporting.

Following concerns about missed signs of cervical cancer in cytology specimens in New Zealand, a Ministerial Inquiry (HFA, 1999) has been established to investigate the accuracy of reporting by the laboratory.

The Program will:

3.3.1 work towards establishing a process for monitoring laboratory performance and improving the laboratory data received;

3.3.2 further investigate the variation in reporting of both cytology and histology specimens. The analysis will help develop strategies to optimise performance and minimise variation in laboratory reporting;

3.3.3 continue to support health professionals and laboratories by addressing workforce and training issues for cytologists, cytopathologists and pathology registrars. Part of this commitment will include the development of a program of workshops and resources to increase knowledge about locating and interpreting difficult high-grade cervical lesions;

3.3.4 continue to monitor the role of new technologies; and

3.3.5 support the introduction of national standards covering new technologies.

3.4 Improving specimen reporting

Whilst laboratories are required to provide management recommendations to Pap test providers the limited information available suggests that some laboratories are either not providing recommendations at all, or are providing recommendations that are not consistent with NHMRC policy. At this stage it is unclear what approach NATA or NPAAC will take to enforce this.

The Program will:

- 3.4.1 develop activities to encourage and improve laboratory compliance with the Australian system of reporting gynaecological cytology; and
- 3.4.2 support activities occurring at a national level to address histology reporting of cervical biopsies. As part of this commitment, the Program and the NSW PTR have begun to develop a resource to encourage the accurate coding of histology reports being transferred to the NSW PTR.

3.5 Communicating with service providers

Laboratories provide information to service providers about cervical screening. In the past the Program has informed laboratories about upcoming recruitment campaigns and provided them with the necessary resources to inform their customers.

The Program will:

- 3.5.1 continue to inform laboratories about recruitment campaigns and provide resources for distribution to their customers.



KEY ACTIVITY AREA 4

Promote best clinical practice in cervical screening.

Rationale for strategies

In promoting good clinical practice for cervical screening, each clinical provider within the screening pathway needs encouragement to establish routine quality practices. Recruitment for cervical screening is the first step in good clinical practice, and has been covered elsewhere. Good clinical practice is especially important with regard to the technical aspects of taking, examining and reporting specimens; the notification of results to women; and the appropriate management of women with screen-detected abnormalities.

The Program's broad strategy for the next phase will be to pursue an approach that:

- fosters communication between providers about cervical screening,
- promotes compliance with national policy and guidelines,
- encourages clinical service providers to become involved in professional and practice development activities.

Technical aspects of taking, examining and reporting of Pap test specimens have already been covered in this document. The other areas of best practice are discussed below.

Notification of Pap test results

Processes for the notification of Pap test results to women have been variable. The National Screening Program is currently developing guidelines for the notification of Pap test results to women. These recommend establishing a fail-safe method for notifying women of both normal and abnormal results that is appropriate to both the woman and the practitioner.

Screening intervals

The National Screening Policy states that asymptomatic, sexually active women between the age of 18 - 70 years, should be screened every two years. However, there is clear evidence that a substantial proportion of women undergo screening more frequently than two-yearly. Compliance with this policy is important to ensure that resources are appropriately utilised in targeting under-screened women (AIHW, 1998).

Under-screening and early re-screening are important state and national issues. NSW has the lowest rate of biennial screening in Australia, but has the highest level of early re-screening (AIHW, 1998) with approximately 45% of screened women being re-screened early (NSW CSP, NSW PTR, 2000).

Research, commissioned by the National Screening Program into aspects of this problem, suggest that GPs tend to be cautious, that they have a tendency to repeat Pap tests early, and that they tend to screen patients outside the recommended age group (Blue Moon Research, 1999). Additionally, the research suggests that laboratories are contributing to early re-screening by recommending early repeats. A recent study in Victoria considered the predictors of early re-screening (Mitchell, 1999). These included laboratory reports lacking a recommendation, and reports with any mention of reactive or inflammatory changes. Women from capital cities, young age and high socio-economic status, more than one practitioner involved in screening, and the involvement of a specialist in screening were also predictors of early re-screening.

At present, the Program has no NSW data on provider type and their screening patterns which would allow an analysis of the factors that contribute to early re-screening, as in the Victorian study.

Management of women with abnormal Pap test results

In 1994 the NHMRC published guidelines on the management of women with screen-detected abnormalities (CDHSH, 1994). Management of these women can be divided into investigation and treatment of the abnormality, and subsequent follow up of these women.

Investigation and Treatment

Within NSW, the NSW PTR has a role to ensure that women are followed up after the initial diagnosis of an abnormality. A report from the NSW PTR states that only 1.5% of women with a high-grade abnormality still required follow-up care after two years (Leiboff, Lewis, & Macansh 1999). However, the NSW PTR has raised concerns about the follow-up of women with a cytological prediction of CIN 1. In a recent report (Lewis et al, 1999), it was found that over half the women with a Pap test report of CIN 1 in 1997 had no record of a biopsy, and less than a third of those without a biopsy had a subsequent Pap test within the recommended interval.

A joint working party of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Australasian Society for Colposcopy and Cervical Pathology (ASCCP) has developed a draft document on standards in colposcopy and treatment (RANZCOG and ASCCP, 1999). These are currently undergoing final review. Access to diagnostic services for women with screen-detected abnormalities has been raised as a concern, in particular within rural NSW (Lewis et al, 1999). A study conducted by the Program did not support anecdotal views of long waiting lists for colposcopic services in rural areas, nor that colposcopy was undertaken by a large number of non-specialists (NSW CSP, 1998).

Follow up

Follow up after diagnosis and/or treatment is important to detect persistent or recurrent disease. A study by Towler, Irwig & Shelley (1993) identified that follow-up of these women was variable, with 40% not being followed up 17 months after their initial Pap test. The 1998/99 Annual Report for the Program reported that 12.3 % of women with a history of CIN did not have a further Pap test within 24 months (NSW CSP, 1999).

At present the Program has no data on the role of various providers in relation to the follow up of women with abnormal Pap tests.

Strategies for promoting best clinical practice

4.1 Maintaining effective communication with stakeholders

The Program recognises that best clinical practice involves effective communication between the various stakeholders within the cervical screening pathway including women, GPs, gynaecologists, laboratories and the NSW PTR. The Program recognises the influential role that many of these stakeholders have on attitudes and clinical activities.

Involvement of key stakeholders is a key principle of the Program's strategic approach. The Program has already established a Gynaecological, General Practice and Laboratory Taskforce to advise and assist the Program in the development of evidence-based strategies that will facilitate effective clinical management of women. The terms of reference and membership of the Gynaecological Taskforce are shown in Appendix 7.

The Program will:

- 4.1.1 maintain the General Practice, Laboratory and Gynaecological Taskforces to advise the Program on development of strategies to encourage best clinical practice;
- 4.1.2 develop strategies that utilise existing networks between stakeholders to encourage peer discussion about cervical screening;
- 4.1.3 expand information access points for stakeholders by disseminating up-to-date information via the Internet;
- 4.1.4 investigate strategies to reduce misinformation about cervical cancer and clearly define those at risk of cervical cancer. These strategies will be evidence-based and target laboratories, gynaecologists and GPs; and
- 4.1.5 investigate strategies that will encourage gynaecologists to provide accurate information to GPs about cervical screening.

4.2 Encouraging adherence to national policy and guidelines for all elements of the screening and treatment pathway

Policies and guidelines covering all aspects of the cervical screening pathway exist, or are in development. The Program has, in the past, disseminated such information to the various stakeholders within the pathway.

The Program will:

- 4.2.1 improve communication with service providers so that the Program can enhance their ability to assist in delivering best clinical practice;
- 4.2.2 undertake further analysis of the predictors for early re-screening within NSW to inform strategies to minimise early re-screening rates in NSW;
- 4.2.3 continue to support the implementation of the National Screening Policy and the guidelines for management of women with screen-detected abnormalities;
- 4.2.4 develop and implement strategies to encourage increased compliance with both the National Screening Policy and NHMRC guidelines;
- 4.2.5 monitor the development of the policy on notification of Pap test results to women, and promote its implementation; and
- 4.2.6 promote the implementation of standards for colposcopy and treatment.

4.3 Encouraging professional development

The Program has provided continuing education seminars for general practitioners as part of its commitment to professional development for clinical service providers. The professional development of other Pap test providers may also need to be supported by the Program.

The Program will:

- 4.3.1 examine the potential for supporting educational activities aimed at improving quality in cervical screening for Pap test providers through interaction between professions and collaboration with their professional bodies.

4.4 Encouraging practice development

General practice and gynaecological cervical screening services can be affected by structures and procedures within the practice environment. The Program has supported changes to clinical practice through the use of clinical audit, ongoing input into the development of information technology and the provision of practice resources.

The Program will:

- 4.4.1 work with GPs and gynaecologists to develop activities that encourage improvement in practice processes;
- 4.4.2 continue to support the use of clinical audit and information technology that is responsive to service provider needs and facilitates practice improvement;
- 4.4.3 in collaboration with the RANZCOG, develop a quality improvement initiative for gynaecologists with associated CME points; and
- 4.4.4 continue with a project designed to allow GPs to utilise information about their patients stored with the NSW PTR, to ascertain and improve, practice screening information.

4.5 Monitoring medico-legal matters in relation to cervical screening

During its last phase the Program established a Medico-legal Reference Group. In response to their advice, the Program developed a legal issues paper on cervical screening and has disseminated this to stakeholders in NSW. The terms of reference and membership of the Medico-legal Reference Group are shown in Appendix 8.

The Program will:

- 4.5.1 continue to monitor medico-legal matters relating to cervical screening; and
- 4.5.2 maintain the Medico-legal Reference Group to advise on medico-legal issues as they arise.



KEY ACTIVITY AREA 5

Undertake on-going operations-oriented research, monitoring and evaluation to support and guide the directions of the program.

Overview

The Program recognises that monitoring and evaluation are key components of any population health program. Since its inception, the Program has adopted an evidence-based approach to clinical and population health issues and is committed to the strengthening of its monitoring and evaluative processes. The research and evaluation plan will identify areas of need and assist in the identification of strategies that will improve the effectiveness of cervical cancer screening in NSW. This plan is based on the following principles:

- responsiveness to the needs and priorities of the Program,
- commitment to methodological rigour in applied cancer screening research and evaluation,
- dissemination of results through a process of peer review,
- a pro-active approach to research transfer and application in the population health setting,
- consumer orientation, and
- timeliness, reliability and relevance of research undertaken.

Over the last three years the Program has provided quarterly, annual, annual statistical and other ad-hoc reports to NSW Health and the Commonwealth. During this period, the Program has also been involved in a number of major research projects. Scientific publications arising from those research projects are currently under preparation for publication in peer-reviewed journals. The Program will continue its reporting and operations-oriented research program into the next phase.

5.1 Regular reporting

Screening data and other information received from the NSW PTR are required for the monitoring of the Program's performance and management, and for fulfilling its reporting requirements to the State and Commonwealth Health Departments. The Program compiles and analyses cervical screening data, conducts research to assist in the evaluation of strategies promoting screening, and engages stakeholder collaboration at the local, state-wide and professional level.

The Program has implemented quarterly reporting of screening data to AHSs. The Program will maintain its monitoring requirements at both the State and Commonwealth level by providing the following reports which are prepared in accordance with the schedule described in the Performance and Funding Agreement 1999 - 2004.

-
- 5.1.1 Quarterly Reports
 - 5.1.2 Annual Report
 - 5.1.3 Annual Statistical Report
 - 5.1.4 Senior Executive Forum Report
 - 5.1.5 Australian Institute of Health and Welfare (AIHW) Report

The Program has identified key areas for future research directions. These centre on under and over-screening, women with special needs, recruitment of women, GP strategies, quality and other special projects.

5.2 Under-screening

The most recent available screening data (as at the end of March 2000 quarter) indicate that the two-yearly screening rates for NSW were 62.1% for the 20-69 year age group and 59.3% for the 50-69 year age group (NSW CSP, 2000). These screening rates indicate that approximately 40% of at-risk women in NSW are under-screened or unscreened.

The Program will:

- 5.2.1 identify under-screened or unscreened women by analysing available data sources to enable targeting of these specific groups.

5.3 Over screening / early re-screening

The issue of over-screening has been identified by the Commonwealth as an important priority for the Program, both at a national and a state level. The rate for women in NSW who screen earlier than 24-months following a normal Pap test is approximately 45% (NSW CSP & NSW PTR, 2000).

The Program will:

- 5.3.1 analyse the over-screening / early re-screening rates for women and develop recommendations for targeted strategies.

5.4 Women with special needs

Evidence suggests that some women from culturally and linguistically diverse backgrounds have significantly lower screening rates compared to Australian and New Zealand born women (Mitchell et al, 1997; NSW CSP, 2000b).

Additionally, women from low socio-economic status (SES) groups have been observed as having significantly lower odds of having a Pap test compared to women from a high SES group (NSW CSP, 2000b). Although there is no reliable data available regarding Pap test patterns in Aboriginal and Torres Strait Islander women, anecdotal and circumstantial evidence (NSW CSP, 2000b) suggests that this group have lower screening rates and higher incidence rates of cervical cancer than other Australians. The Program has undertaken a pilot study to examine screening rates in a cohort of Vietnamese women. The report will be available in August 2000.

The Program will:

- 5.4.1 continue investigation of the feasibility of methods for determining Pap test rates in women from culturally and linguistically diverse backgrounds and women from Aboriginal and Torres Strait Islander backgrounds in NSW, using local-area data; and
- 5.4.2 continue to explore methods for identifying the relationship between ethnicity, SES and Pap tests, using external data bases.

5.5 Recruitment project evaluation

The Program currently provides evaluation support for key recruitment strategies such as the multicultural media campaign, including the Vietnamese and the former Yugoslavian women's campaigns, and the National Media Campaign. It also provides evaluation support for local AHS projects if required.

The Program will:

- 5.5.1 develop and implement an evaluation plan for all activities and interventions undertaken by the Program; and
- 5.5.2 develop monitoring and evaluation components to support Area recruitment activities and supervise and provide ongoing support for their evaluation and monitoring processes.

5.6 GP strategy

The differences in work patterns and patient mix that have been identified between male and female GPs (Britt et al, 1996) may have important repercussions at a population health or population level in respect of service provision and Pap test rates. Research suggests a trend of increasing proportions of active GPs being women (CDHAC, 1999a). The Program currently provides screening rate data analysed by DGP to GPs and Divisions and has conducted an evaluation of the GP educational strategy.

It should be noted that the Program currently has no access to data to analyse screening patterns by service provider types.

The Program will:

- 5.6.1 develop and implement evaluation strategies to assess/measure the effect of GP recruitment activities including their effect on screening rates;
- 5.6.2 analyse socio-demographic issues relating to service providers which may have an impact on screening rates, such as the relationship between gender of service provider and provision of cervical screening; and
- 5.6.3 engage interested DGPs to participate in a series of evaluations of GP intervention strategies.

5.7 Best clinical practice

It is important to ensure that women within the cervical screening pathway receive high quality health care. Accordingly, the Program needs to encourage best clinical practice by GPs, laboratories and gynaecologists. To this end, the Program is committed to the transfer and application of information from research into health practices. In attempting to influence stakeholders to examine their practices and work towards improving it, the Program must be able to provide empirical evidence.

The data that the Program currently receives restricts its ability to identify where improvements are needed and to monitor whether it has been successful in activities aimed at improving practice. At present the Program has no data on laboratory performance in relation to compliance with NPAAC requirements for cervical cytology, factors affecting cytology/histology correlation, or the role of laboratories in early re-screening. The Program also has no data on the screening patterns by provider type, their role in early re-screening, nor their role in the follow-up of women with abnormal Pap tests. Without such data, the Program is severely limited in its ability to encourage or monitor change in clinical practice.

The Program will:

- 5.7.1 work towards improving the data it obtains to address issues relating to laboratories, GPs and gynaecologists;

5.7.2 investigate the follow-up patterns of women with cervical abnormalities and develop strategies to encourage appropriate follow-up for these women;

5.7.3 investigate laboratory compliance with NHMRC reporting guidelines and develop strategies to encourage laboratories to report according to these; and

5.7.4 further analyse data to investigate laboratory reporting of cytological abnormalities and subsequent histological correlation, with the aim of improving cytology and histology reporting.

5.8 Special projects to assist in targeting Program strategies

Projects which will enable better targeting of Program strategies will be developed as required. The following projects relate to current priorities.

The Program will:

5.8.1 establish projects to examine the effectiveness of direct mail and media campaigns;

5.8.2 develop methods to assess barriers for women who do not attend for screening; and

5.8.3 further analyse data on which women get cancer of the cervix, and therefore enable better targeting of strategies to prevent it.

5.9 Research Advisory Committee

In order to ensure the relevance and rigour of the Program's research and evaluation activities, the

Program will:

5.9.1 establish a Research Advisory Committee comprising experts in various relevant fields. The advice of the Committee will be sought on an ad-hoc basis, according to the research needs and activity of the Program.



ROLES AND RESPONSIBILITIES IN RELATION TO STRATEGIC PLAN

This Strategic Plan reflects a Program which is made up of component parts working towards a common objective. The component parts include the Commonwealth Department of Health and Family Services, NSW Health, the State Coordination Unit (SCU), AHSs, women and service providers along the screening pathway including private, public and non-government sector providers.

The role of the SCU is to:

1. Manage the Program on behalf of Western Sydney AHS under a contract with NSW Health.

This stipulates performance measures which:

- have been derived in part from the contract that NSW Health has with the Commonwealth under the National Public Health Outcomes Funding Agreement (PHOFA); and
- reflect the national policies and priorities for an Organised Approach to Cervical Screening.

2. Implement the national and state policies in accordance with the contract deliverables. The SCU undertakes this role by:

- assessing the literature, monitoring the data and conducting research and evaluation. This enables the Program to determine its overall direction, to set priorities for action, to report against screening targets, and evaluate activities;
- consulting with all stakeholders through Task Forces representing key umbrella organisations along the screening pathway and through forums and other consultation mechanisms;
- developing strategies, projects and resources and evaluation protocols to support implementation. A variety of resources including brochures, posters and packages, have already been developed, some of which were originally developed and successfully piloted at AHS level. Any further resource development will need to be centralised through the SCU for distribution to AHSs to avoid duplication and unnecessary expenditure. To ensure consistency in evaluation, protocols for all future activities and projects will be provided to AHSs.
- providing expertise to support AHSs in the development of strategic activities and projects. SCU staff have a range of expert skills and are available to provide support to AHSs where they require it.

-
- funding AHSs to undertake some Program functions. The Program does not have a service delivery function in relation to cervical screening. Its role is limited to influencing service providers. The SCU asks AHSs to act on its behalf in relation to some of the Program's non-service delivery functions as outlined in the Strategic Plan. These will vary across AHSs depending on the composition of the unscreened population.

The Program's schedule of deliverables is updated annually and it is proposed that a similar approach be followed when negotiating performance and funding agreements with AHSs. The Program will not be prescribing organisational arrangements for AHSs to achieve the contracted deliverables, but would encourage the development of partnerships and networks with other organisations that are able to access the target groups.

Funding will be provided according to a population-need formula based on screening rate, size of the unscreened population, and a baseline to ensure rural areas do not fall below a viable funding level. In addition, funding will be provided to cover the processing of women's health nurse cytology.

Cervical screening service delivery functions undertaken by AHSs (eg. in community health centres, antenatal clinics and sexual health clinics) are not part of the Program's functions and are therefore not included in the Strategic Plan. These are part of the AHS's normal function and AHSs are therefore responsible for ensuring that the services they are providing are operating effectively, and that screening providers are delivering quality services.

A schedule of strategies notated in accordance with the identified roles and responsibilities developed in consultation with Area Health Services is attached at Appendix 9.



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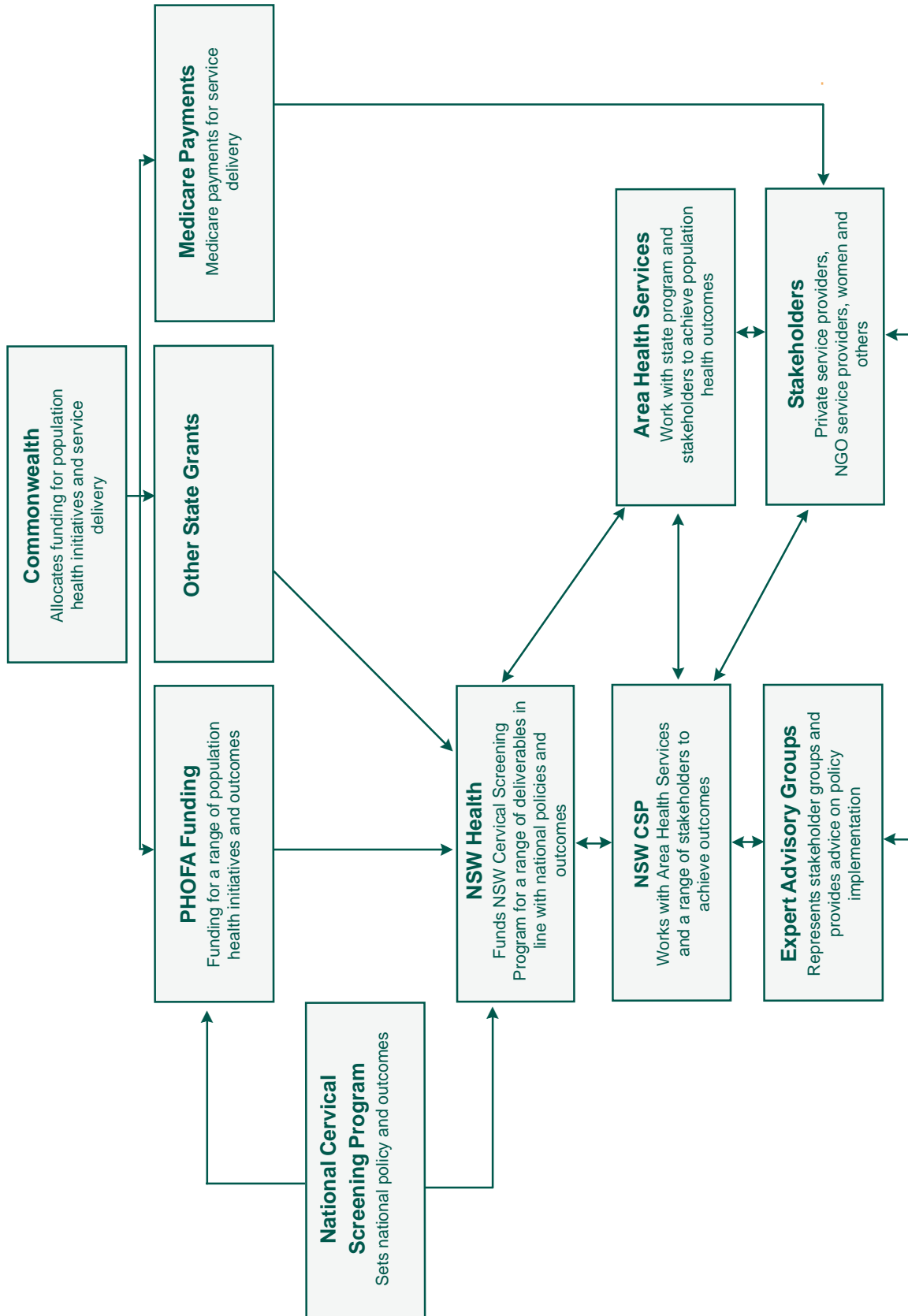
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The National Cervical Screening Policy states that:

- Routine screening should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology.
- All women who have ever been sexually active should commence having a Pap smear between the ages of 18 to 20 years or one or two years after first sexual intercourse, whichever is the later. In some cases it may be appropriate to start screening before 18 years of age.
- Pap smears may cease at the age of 70 years for women who have had two normal Pap smears within the last five years. Women over 70 years who have never had a Pap smear or who request a Pap smear should be screened.

This policy applies to women without symptoms which could be due to cervical pathology. Women with a past history of high grade cervical lesions or who are being followed up for a previous abnormal smear should be managed in accordance with the NHMRC guidelines for the management of abnormal Pap smears. (CDHSH, 1998)





1. Participation

- Target 1.1 Increase the percentage of women in the target group who have been screened during a 24-month period to 65% by 30 June 2001.
- Target 1.2 Increase the percentage of eligible women aged 50 to 69 years who have been screened during a 24-month period to 58% by 30 June 2001.
- Target 1.3 Increase the percentage of women in the target group in rural/remote areas who have been screened during a 24-month period to 60% by 30 June 2001.
- Target 1.4 Increase the percentage of women in the target group from non-English speaking backgrounds who have been screened during a 24-month period through recruitment strategies specifically targeting these women.
- Target 1.5 Increase the percentage of Aboriginal and Torres Strait Islander women in the target group who have been screened during a 24-month period through recruitment strategies specifically targeting these women.

2. Early Screening

- Target 2.1 Reduce the proportion of women having early re-screens following a negative smear to 40% by 30 June 2001.

3. Technically unsatisfactory smears for cytology diagnosis

- Target 3.1 Reduce the percentage of technically unsatisfactory smears reported annually to 2% by 30 June 2001.

4. Follow-up

- Target 4.1 Reduce the number of women with high-grade intraepithelial abnormalities who have no follow-up within a 12-month period to a negligible number.
- Target 4.2 Reduce the percentage of women with any screen detected abnormalities who have no record of further investigations within 24-months.

5. Cytology reports

- Target 5.1 Increase the percentage of women with cytology reports of CIN of any degree where histology performed within 6 months confirms the abnormality as being CIN of any degree to 75% by 30 June 2001.



Terms of Reference

- To advise the Program on all aspects of the cervical screening pathway as they affect women.
- To advise the Program on the development and implementation of state-wide communication /recruitment activities.
- To advise on the dissemination of information about the Program and cervical screening to all women in NSW in settings that are appropriate to women including:
 - the need for two yearly screening
 - issues related to screening age
- To advise on strategies to identify and to reach women who have not been screened.
- To advise on potential partnership arrangements at the point where women access health care.

Membership

Dr Edith Weisberg (Chair)	FPA Health
Ms Sue Burke	Women's Health Service, Mid Western AHS
Ms Karen Filocamo	Health Promotion & Disabilities Expert
Ms Trude Kallir	Older Women's Health Network
Ms Barbara Kendrick	Country Women's Association Australia
Ms Ilona Lee	NSW Multicultural Health Communication Service
Ms Elena Murty	Women's Health Policy Unit, NSW Health
Ms Juanita Sherwood	Consultant on Aboriginal Women's Issues for the NSW CSP
Ms Paula Vallentine	NSW Pap Test Register
Dr Trish Vezgoff	Consumer representative
Ms Lola McNaughton	Aboriginal Health & Medical Research Council
Ms Jayne Ross	Manager (NSW CSP)

Secretariat

Ms Amanda Niciak	Manager, Health Promotion & Communication (NSW CSP)
Ms Dina Retter	Research Assistant (NSW CSP)

**Terms of Reference**

- To provide advice to the Program on general practice issues in cervical screening.
- To assist in the development and implementation of a state-wide general practice strategy for cervical screening.
- To advise on quality assurance and workforce training issues that relate to general practice.
- To ensure widespread consultation with general practitioners about the Program.
- To ensure that information about the Program and cervical screening is disseminated to general practitioners.

Membership

Dr Diana Bradbury (Chair)	Royal Australian College of General Practitioners
Dr Diane Chambers	Doctors' Reform Society
Dr Elizabeth Hindmarsh	Alliance of NSW Divisions (Metropolitan Divisions)
Dr Elvira Morey	Australian Medical Association
Dr Caroline Renko	Alliance of NSW Divisions (Rural Divisions)
Dr David Sanders	Hunter Rural Division of General Practice
Dr Jenny Webster	New England Division of General Practice
Dr Trish Vezgoff	Consumer representative
Dr Geoff White	Rural Doctors Association (NSW)
Dr Gerry Wain	Director (NSW CSP)
Ms Jayne Ross	Manager (NSW CSP)

Secretariat

Ms Annie Stenlake	Manager, Clinical Service Delivery (NSW CSP)
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**Terms of Reference**

- To advise the Program on laboratory issues relating to cervical screening laboratories.
- To support current quality activities as endorsed by the RCPA Quality Assurance Program, NPAAC requirements and NATA-RCPA laboratory accreditation, and assist cytopathology laboratories implement new NPAAC requirements and national CSP performance standards.
- To advise the Program on workforce issues for cytotechnologists and cytopathologists and support appropriate training activities as required.
- To advise the Program on the distribution of resources from the NSW PTR and NSW CSP to best meet the needs of laboratories and encourage a positive interaction between the parties.

Membership

Dr Annabelle Farnsworth (Co-chair)	Royal College of Pathologists of Australasia (RCPA) Director of Cytology, Douglass Hanly Moir
Dr Paul McKenzie (Co-chair)	Pathologist, Royal Prince Alfred Hospital
Ms Penny Athanasatos	Cytologist, Prince of Wales Hospital
Dr Jan Bishop	Consultant Pathologist, Hunter Area Pathology
Mr Ron Bowditch	Consultant Cytologist, Colin Laverty & Associates
Dr Merle Greenberg	Director Clinical Services, HCoA
Ms Sasha Macansh	NSW Pap Test Register
Mrs Anne Peebles	Laboratory Manager, Nextpath
Ms Jayne Ross	Manager (NSW CSP)

Secretariat

Ms Jacoline O'Callaghan	Manager, Clinical Quality (NSW CSP)
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**Terms of Reference**

- To identify key issues in gynaecological practice that impact on the identification and management of women with abnormal Pap tests, including access to colposcopic services.
- To assist in the development and implementation of strategies to ensure best clinical practice in the management of women with abnormal Pap tests results.
- To advise on quality assurance and workforce issues for gynaecologists in cervical screening.
- To facilitate input into the Program by key gynaecological stakeholder groups.

Membership

Dr Alan Ferrier (Chairperson)	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) representative
Dr Chris Hunter	Australian Society of Colposcopy and Cervical Cytology (ASCCC) representative
Dr Ron Vaughan	Rural gynaecologist
Dr Gerry Wain	Director (NSW CSP)
Ms Jayne Ross	Manager (NSW CSP)

Secretariat

Ms Jacoline O'Callaghan	Manager, Clinical Quality (NSW CSP)
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Terms of Reference

- To review and advise the Program on medico-legal issues in relation to cervical screening
- To identify key issues and concerns of the clinical and laboratory communities that may be progressed through the Program

Membership

Ms Julie Hamblin (Chair)	Lawyer, Ebsworth and Ebsworth
Mr David Hirsch	Lawyer, Cashman and Partners
Ms Mary Chiarella	NSW College of Nursing
Ms Libby Menadue	Legal Officer, NSW Health
A/Prof Colin Thomson	Executive Officer, AIHW Law and Ethics
Dr Gerry Wain	Director (NSW CSP)
Ms Jayne Ross	Manager (NSW CSP)

Secretariat

Ms Jacoline O'Callaghan	Manager, Clinical Quality (NSW CSP)
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Roles and Responsibilities in relation to Strategic Plan

APPENDIX 9

1. Develop and implement strategies aimed at recruiting all women in the target groups to undergo regular two-yearly Pap tests, including providing appropriate information and ensuring access to appropriate services.		
STRATEGY	ACTIVITY	ROLES & RESPONSIBILITIES
1.1 Maintaining an infrastructure for working with women.	1.1.1 continue to maintain a Women's Taskforce to advise the Program on all steps in the screening pathway, as they affect women.	SCU.
	1.1.2 build partnerships with organisations and services that access women.	SCU and AHS.
1.2 Recruiting women through a social marketing approach.	1.2.1 continue to provide information and resources to women in a variety of formats and languages.	SCU to develop and provide to AHSs for distribuion.
	1.2.2 extend its current catalogue of information and resources to meet the needs of women with disabilities.	SCU with FPA Health.
	1.2.3 incorporate a local multi-dimensional communication strategy into activities at the AHS level. This will include a communication strategy for: <ul style="list-style-type: none"> • opportunistic recruitment activities for GPs • peer education programs for older women • partnership activities with BreastScreen NSW • community education. 	AHSs to take primary responsibility for implementation of resource packages, evaluation guidelines, key messages etc provided by SCU.
	1.2.4 identify and utilise opportunities to promote the cervical screening message in established entertainment, communication and media outlets.	SCU for state-wide media - AHSs for local media.
	1.2.5 expand its use of information technology via the Internet by providing all current resources and language-specific resources to women via the Program's Web site.	SCU.
1.3 Recruiting women at their point of access to health care.	1.3.1 work in partnership with GPs to increase their capacity to recruit women to cervical screening and to increase their knowledge about the barriers for women in having Pap tests including preferences for female providers and to encourage strategies to overcome these barriers.	SCU and AHSs.
	1.3.2 work in partnership with providers in other settings within AHSs where women access services or health information to encourage cervical screening, where appropriate.	AHSs.
	1.3.3 examine ways in which incentives may be used to increase women's screening rates.	SCU in consultation with AHSs.
	1.3.4 examine effectiveness of different types of direct mail strategies to increase women's screening rates.	SCU.

<p>1.4 Ensuring women have adequate access to acceptable Pap test services.</p>	<p>1.4.1 work with DGPs to develop local networks and referral protocols to ensure women are provided with an appropriate service. Such networks may include other GPs, women's health nurses, or non-government organisations.</p> <p>1.4.2 Identify, in collaboration with DGPs, parts of the state where GPs are not accessing or available, or the preference for a female GP cannot be met, and establish the most appropriate provision of services by women's health nurses.</p> <p>1.4.3 develop locally tailored strategies to increase screening in women who do not access GPs. These will take into account screening data and potential for developing innovative local partnerships.</p> <p>1.4.4 examine proposals for innovative models for improving recruitment practice in cervical screening.</p>	<p>AHSs to take the lead, SCU to negotiate policies and protocols with RACGP.</p> <p>AHSs with DGPs.</p> <p>AHS with SCU support.</p> <p>SCU and AHS.</p>
<p>1.5 Older Women.</p>	<p>1.5.1 develop a comprehensive peer education training program for older women to promote the importance of Pap tests to their peers in settings appropriate to them.</p> <p>1.5.2 develop an approach to informing women aged over 70 years who are unscreened, to have a Pap test in line with the National Policy on screening and encourage GPs to provide positive reinforcement of the policy to women over 70.</p>	<p>SCU to develop in collaboration with Learning Circles Australia, and make available to AHSs.</p> <p>SCU and AHSs</p>
<p>1.6 Aboriginal and Torres Strait Islander women.</p>	<p>1.6.1 work in partnership with Aboriginal and Torres Strait Islander communities and health service providers including Aboriginal Medical Services (AMS) and Community Controlled Health Services to develop a state-wide strategy to improve participation of Aboriginal and Torres Strait Islander women in cervical screening.</p> <p>1.6.2 support Aboriginal and Torres Strait Islander health workers by providing them with the information and educational resources developed in the last phase of the Program through the partnership agreement.</p> <p>1.6.3 work with a relevant organisations and a range of Aboriginal and Torres Strait Islander communities to evaluate these resources.</p>	<p>SCU in consultation with community and other bodies mentioned, the Aboriginal Health Branch of NSW Health, the AHMRC and AHSs.</p> <p>SCU to provide to AHSs for distribution if desired by workers and community.</p> <p>SCU</p>

<p>1.7 Women from culturally and linguistically diverse backgrounds.</p>	<p>1.7.1 continue to develop strategies that target women from culturally and linguistically diverse backgrounds through a partnership approach with other service providers and the community. Priority setting for such strategies to be based on cancer incidence rates, screening rates, and local demographic data.</p> <p>1.7.2 continue to provide information pamphlets on cervical screening in a range of languages appropriate to the local community.</p> <p>1.7.3 develop a directory of culturally specific services available in each Area.</p>	<p>SCU in partnership with Women's Taskforce and relevant AHSs.</p> <p>SCU to provide to AHSs for distribution.</p> <p>AHSs - also provide to SCU to support 131556 toll free information service.</p>
<p>1.8 Women with disabilities.</p>	<p>1.8.1 investigate ways of communicating cervical screening information to women with intellectual disabilities, and their carers and health care providers through the development of fact sheets and pamphlets, and through GP training programs.</p> <p>1.8.2 identify and promote access to appropriate services for women with physical disabilities.</p>	<p>SCU with FPA Health.</p> <p>AHSs through appropriate partnerships.</p>
<p>1.9 Younger Women.</p>	<p>1.9.1 develop clearer messages for women aged 18 - 25 years on the significance of abnormal Pap test results and disseminate to young women and to providers.</p> <p>1.9.2 work within the context of the <i>Health Promoting Schools</i> framework to design, implement and evaluate a Secondary School Cervical Screening package for young women aged 16 - 18 years.</p>	<p>SCU to develop - AHSs to support dissemination.</p> <p>SCU to develop in partnership with Department of Education. AHSs to support delivery through appropriate channels.</p>
<p>1.10 Recruitment of women in partnership with BreastScreen NSW.</p>	<p>1.10.1 identify opportunities for joint promotional activities with BreastScreen NSW, at State and service level, as appropriate, including general advertising, direct mail, education of health workers and provision of information to GPs.</p> <p>1.10.2 assess the opportunities for linking services in rural areas in association with AHSs and DGPs.</p>	<p>SCU and AHSs with BreastScreen NSW at state and service level.</p> <p>AHSs in association with DGPs and BreastScreen NSW at service level.</p>

2. Support GP structures and activities to facilitate their primary role in delivering acceptable Pap test services to women.		
STRATEGY	ACTIVITY	ROLES & RESPONSIBILITIES
2.1 Maintaining an infrastructure for working with GPs.	2.1.1 continue to support the ongoing role and function of the GP Taskforce.	SCU.
	2.1.2 continue to hold regular GP Forums to maintain existing links with GPs to promote cervical screening throughout NSW.	SCU.
	2.1.3 establish an information database to assist with regular contact with DGPs and other associated professional organisations.	SCU with AHS support.
	2.1.4 attend relevant GP conferences and workshops where there are opportunities to promote cervical screening and the resources that the Program has to assist GPs.	SCU with AHSs as appropriate.
2.2 Providing educational outreach to GPs.	2.2.1 develop an educational outreach strategy which involves one-on-one visits to GPs is aimed at influencing change in GP practice and behaviour through persuasion and/or assisting to streamline office procedures in the practice setting. The strategy will consist of several components including written material and educational meetings, and will be combined with a variety of complementary interventions including reminder systems, patient checklists, and clinical audit and feedback.	SCU to develop and pilot test strategy and materials. Some metropolitan AHS may become involved in implementation after pilot testing completed. Rural AHSs not interested.
	2.2.2 develop a training package and provide the necessary skills training for those undertaking the outreach visits.	SCU.
2.3 Providing skills enhancement and continuing medical education (CME) opportunities.	2.3.1 work with FPA Health to develop a CME up-skilling workshop program for GPs, which will cover the technical skills necessary to perform a satisfactory pelvic examination and Pap test.	SCU with FPA Health - AHSs to promote.
	2.3.2 develop and make available to DGPs, a series of user-friendly "Pap tips" for inclusion in regular newsletter mailouts.	SCU.
	2.3.3 explore opportunities with the RACGP for developing online-CME activities involving case discussions, clinical quizzes, and multimedia presentation, much like a conventional interactive workshop.	SCU.

<p>2.4 Enhancing information management and technology for GPs.</p>	<p>2.4.1 in association with Medical Director, continue to develop this module in stages. It will include provision for actions processing, on-line requests and results from pathology laboratories, a recall and reminder system, decision-support, patient and doctor education material, comparative analysis of screening rates, and external links with the NSW PTR.</p> <p>2.4.2 work with the other members of the medical software industry to develop their cervical screening modules.</p> <p>2.4.3 continue to upgrade its Internet service to support general practice information needs.</p> <p>2.4.4 in association with the NSW PTR, explore the capacity for GPs to link with the NSW PTR to access on-line data on practice screening rates and screening history of patients.</p>	<p>SCU - AHS to incorporate in educational outreach activities.</p> <p>SCU.</p> <p>SCU.</p> <p>SCU and NSW PTR.</p>
<p>2.5 Establishment of local referral networks.</p>	<p>2.5.1 work with DGPs to encourage the use of guidelines and protocols for the establishment of local referral networks for cervical screening.</p> <p>2.5.2 work with DGP to engage participants in local referral networks for cervical screening. These could include referral to other local GPs who perform Pap tests, non-government services such as FPA Health, women's health nurses, or by engaging a practice nurse or other GP to do inter-practice visits.</p>	<p>SCU will work with RACGP to develop policies and protocols - AHSs with local DGPs to implement.</p> <p>AHSs using policies and protocols provided by SCU.</p>
<p>2.6 Improving practice management.</p>	<p>2.6.1 continue to market a range of existing practice-based reminder/prompt resources for tagging medical files.</p> <p>2.6.2 ensure a computerised reminder/recall system is incorporated into the Medical Director Software.</p>	<p>SCU to provide through resource order forms and AHSs through local networks using material provided.</p> <p>SCU.</p>
<p>2.7 Promoting opportunistic screening in the general practice setting.</p>	<p>2.7.1 package the <i>Opportunistic Cervical Screening in General Practice</i> recruitment activity and market it through DGPs across NSW as part of the educational outreach strategy.</p>	<p>SCU to provide package and materials to AHSs to implement.</p>
<p>2.8 Providing clinical audit opportunities for GPs.</p>	<p>2.8.1 continue to offer the clinical audit package to GPs for the RACGP 1999-2001 triennium.</p>	<p>SCU.</p>

2.9 Encouraging other options for increasing GP cervical screening.	2.9.1 advocate for the introduction of a Practice Incentive Payment to GPs for Pap tests. 2.9.2 examine other options and models to increase GP screening rates.	SCU and GP taskforce. SCU.

3. Work with laboratories to optimise their role in cervical screening.

STRATEGY	ACTIVITY	ROLES & RESPONSIBILITIES
3.1 Developing and maintaining effective communication with stakeholders.	<p>3.1.1 continue this collaborative approach and work with the NSW PTR to maintain a close relationship with laboratories, involve the NSW PTR in strategies to optimise laboratory performance, and encourage laboratories to continue their accurate reporting to the NSW PTR.</p> <p>3.1.2 maintain the Laboratory Taskforce whose terms of reference will include continuing to advise the Program on aspects of the cervical screening pathway, as they relate to laboratories.</p> <p>3.1.3 continue to provide information and resources to laboratories.</p>	<p>SCU and NSW PTR.</p> <p>SCU.</p> <p>SCU.</p>
3.2 Encouraging optimisation of laboratory performance.	<p>3.2.1 in collaboration with the NSW PTR, continue to assist and support laboratories to meet their NPAAC reporting requirements.</p> <p>3.2.2 actively support and promote the NATA and RCPA accreditation system.</p> <p>3.2.3 work towards improving its data on laboratories to enhance its, and the NSW PTR's ability to encourage laboratories to improve performance.</p>	<p>SCU and NSW PTR.</p> <p>SCU.</p> <p>SCU.</p>
3.3 Improving the accuracy of specimen examination.	<p>3.3.1 work towards establishing a process for monitoring laboratory performance and improving the laboratory data received.</p> <p>3.3.2 further investigate the variation in reporting of both cytology and histology specimens. The analysis will help develop strategies to optimise performance and minimise variation in laboratory reporting.</p> <p>3.3.3 continue to support health professionals and laboratories by addressing workforce and training issues for cytologists, cytopathologists and pathology registrars. Part of this commitment will include the development of a program of workshops and resources to increase knowledge about locating and interpreting difficult high-grade cervical lesions.</p> <p>3.3.4 continue to monitor the role of new technologies.</p> <p>3.3.5 support the introduction of national standards covering new technologies.</p>	<p>SCU and NSW PTR.</p> <p>SCU.</p> <p>SCU.</p> <p>SCU and Commonwealth.</p> <p>SCU and Commonwealth.</p>

3.4 Improving specimen reporting.	3.4.1 develop activities to encourage and improve laboratory compliance with the Australian system of reporting gynaecological cytology. 3.4.2 support activities occurring at a national level to address histology reporting of cervical biopsies. As part of this commitment, the Program and the NSW PTR have begun to develop a resource to encourage the accurate coding of histology reports being transferred to the NSW PTR.	SCU. SCU.
3.5 Communicating with service providers.	3.5.1 continue to inform laboratories about recruitment campaigns and provide resources for distribution to their customers.	SCU.

4. Promote best clinical practice in cervical screening.

STRATEGY	ACTIVITY	ROLES & RESPONSIBILITIES
<p>4.1 Maintaining effective communication with stakeholders.</p>	<p>4.1.1 maintain the General Practice, Laboratory and Gynaecological Taskforces to advise the Program on development of strategies to encourage best clinical practice.</p> <p>4.1.2 develop strategies that utilise existing networks between stakeholders to encourage peer discussion about cervical screening.</p> <p>4.1.3 expand information access points for stakeholders by disseminating up-to-date information via the Internet.</p> <p>4.1.4 investigate strategies to reduce misinformation about cervical cancer and clearly define those at risk of cervical cancer. These strategies will be evidence-based and target laboratories, gynaecologists and GPs.</p> <p>4.1.5 investigate strategies that will encourage gynaecologists to provide accurate information to GPs about cervical screening.</p>	<p>SCU.</p> <p>SCU to develop package for AHSs to implement.</p> <p>SCU.</p> <p>SCU to develop strategies - AHSs to assist in implementation.</p> <p>SCU.</p>
<p>4.2 Encouraging adherence to national policy and guidelines for all elements of the screening and treatment pathway.</p>	<p>4.2.1 improve communication with service providers so that the Program can enhance their ability to assist in delivering best clinical practice.</p> <p>4.2.2 undertake further analysis of the predictors for early re-screening within NSW to inform strategies to minimise early re-screening rates in NSW.</p> <p>4.2.3 continue to support the implementation of the National Screening Policy and the guidelines for management of women with screen-detected abnormalities.</p> <p>4.2.4 develop and implement strategies to encourage increased compliance with both the National Screening Policy and NHMRC guidelines.</p> <p>4.2.5 monitor the development of the policy on notification of Pap test results to women, and promote its implementation.</p> <p>4.2.6 promote the implementation of standards for colposcopy and treatment.</p>	<p>SCU and AHSs.</p> <p>SCU.</p> <p>SCU and AHSs.</p> <p>SCU and AHSs.</p> <p>SCU.</p> <p>SCU.</p>

4.3 Encouraging professional development.	4.3.1 support educational activities aimed at improving quality in cervical screening for Pap test providers through interaction between professions and collaboration with their professional bodies.	SCU to develop, AHSs to assist implementation.
4.4 Encouraging practice development.	4.4.1 work with GPs and gynaecologists to develop activities that encourage improvement in practice processes. 4.4.2 continue to support the use of clinical audit and information technology that is responsive to service provider needs and facilitates practice improvement. 4.4.3 in collaboration with the RANZCOG, develop a quality improvement initiative for gynaecologists with associated CME points. 4.4.4 continue with a project designed to allow GPs to utilise information about their patients stored with the NSW PTR, to ascertain and improve, practice screening information.	SCU. SCU. SCU. SCU.
4.5 Monitoring medico-legal matters in relation to cervical screening.	4.5.1 continue to monitor medico-legal matters relating to cervical screening. 4.5.2 maintain the Medico-legal Reference Group to advise on medico-legal issues as they arise.	SCU. SCU.
4.6 Develop Best Practice Models of Service Delivery.	4.6.1 examine options for best practice in service delivery for particular groups such as rural women and women with special needs.	SCU and AHSs.

STRATEGY	ACTIVITY	ROLES & RESPONSIBILITIES
5.1 Regular reporting.	5.1.1 Quarterly Reports. 5.1.2 Annual Report. 5.1.3 Annual Statistical Report. 5.1.4 Senior Executive Forum Report. 5.1.5 Australian Institute of Health and Welfare (AIHW) Report.	SCU to support recruitment direction at state and AHS level. SCU to provide to NSW Health. SCU and NSW PTR to provide data to public. SCU to provide progress on outcome targets for NSW Health and AHS CEOs. SCU for reporting to Commonwealth.
5.2 Under-screening.	5.2.1 identify under-screened or unscreened women by analysing available data sources to identify and target these specific groups.	SCU to support state-wide and AHS activities.
5.3 Over screening / early re-screening.	5.3.1 analyse the over-screening / early re-screening rates for women and develop recommendations for targeted strategies.	SCU.
5.4 Women with special needs.	5.4.1 continue investigation of the feasibility of methods for determining Pap test rates in women from culturally and linguistically diverse backgrounds and women from Aboriginal and Torres Strait Islander backgrounds in NSW, using local-area data. 5.4.2 continue to explore methods for identifying the relationship between ethnicity, SES and Pap tests, using external data bases.	SCU. SCU.
5.5 Recruitment project evaluation.	5.5.1 develop and implement an evaluation plan for all activities and interventions undertaken by the Program. 5.5.2 develop monitoring and evaluation components to support Area recruitment activities and supervise and provide ongoing support for their evaluation and monitoring processes.	SCU. SCU to work with AHSs to implement.

<p>5.6 GP strategy.</p>	<p>5.6.1 develop and implement evaluation strategies to assess/measure the effect of GP recruitment activities including their effect on screening rates.</p> <p>5.6.2 analyse socio-demographic issues relating to service providers which may have an impact on screening rates, such as the relationship between gender of service provider and provision of cervical screening.</p> <p>5.6.3 engage interested DGPs to participate in a series of evaluations of GP intervention strategies.</p>	<p>SCU and AHSs.</p> <p>SCU.</p> <p>SCU with DGPs.</p>
<p>5.7 Best clinical practice.</p>	<p>5.7.1 work towards improving the data it obtains to address issues relating to laboratories, GPs and gynaecologists.</p> <p>5.7.2 investigate the follow-up patterns of women with cervical abnormalities and develop strategies to encourage appropriate follow-up for these women.</p> <p>5.7.3 investigate laboratory compliance with NHMRC reporting guidelines and develop strategies to encourage laboratories to report according to these.</p> <p>5.7.4 further analyse data to investigate laboratory reporting of cytological abnormalities and subsequent histological correlation, with the aim of improving cytology and histology reporting.</p>	<p>SCU with NSW PTR.</p> <p>SCU.</p> <p>SCU with NSW PTR.</p> <p>SCU with NSW PTR.</p>
<p>5.8 Special projects to assist in targeting Program strategies.</p>	<p>5.8.1 establish projects to examine the effectiveness of direct mail and media campaigns.</p> <p>5.8.2 develop of methods to assess barriers for women who do not attend for screening.</p> <p>5.8.3 further analyse data on which women get cancer of the cervix, and therefore enable better targeting of strategies to prevent it.</p>	<p>SCU.</p> <p>SCU with BreastScreen NSW.</p> <p>SCU with NSW Cancer Council.</p>
<p>5.9 Research Advisory Committee.</p>	<p>5.9.1 establish a Research Advisory Committee comprising experts in various relevant fields. The advice of the committee will be sought on an ad-hoc basis, according to the research needs and activity of the Program.</p>	<p>SCU.</p>