NSW Primary Care Strategy
for the bowel, breast and
 cervical screening programs

August 2016
About the Cancer Institute NSW

The Cancer Institute NSW is a state government organisation, established in 2003 to lessen the impact of cancer across NSW. The Institute works in partnership with all involved in the cancer community to:

- reduce the incidence of cancer
- increase the survival of people with cancer
- improve the quality of life of people with cancer.

Underpinning the Institute’s work are initiatives to improve cancer outcomes across diverse cultural communities, report on the performance of cancer services, engage with primary care and enhance research capabilities across NSW.

Division of Cancer Screening & Prevention

The Division of Cancer Screening and Prevention leads a number of programs aimed at reducing the incidence of cancer, and increasing survival from cancer for the people of NSW. This is achieved through the coordination of cancer screening programs, and the implementation of population-based programs and strategies that encourage healthier lifestyle choices to reduce modifiable risk factors.

The key areas of work include:

- program management and funding for three population-based screening programs (bowel, breast and cervical), including coordination of activities to increase participation in these programs
- the development of mass media and other marketing campaigns to reduce smoking prevalence, reduce overexposure to ultraviolet radiation and promote participation in screening programs.
- providing advice and contributing to policy development and implementation.
Contents

Section 1
Introduction .......................................................................................................................... 2

Section 2
Key drivers for a primary care strategy ............................................................................... 6

Section 3
The critical success factors ............................................................................................... 8

Section 4
Translating opportunities to strategies ................................................................................ 9

Section 5
The framework, rationale and strategic actions .................................................................. 10

Appendix
1. Summary of the evidence for interventions in primary care ........................................ 22
2. Information about the screening programs ...................................................................... 24
   2a. Information about BreastScreen NSW ........................................................................ 25
   2b. Information about the National Bowel Screening Program ...................................... 28
   2c. Information about the National Cervical Screening Program ................................... 29
3. Abbreviations .................................................................................................................. 33

Acknowledgements
The Cancer Institute NSW would like to acknowledge the many stakeholders who have provided valuable contributions throughout the consultation process that has informed this Strategy.

We also appreciate the contributions made by the representatives of Primary Health Networks (PHNs), Local Health Districts (LHDs), Royal Australian College of General Practitioners (RACGP), Aboriginal Health & Medical Research Council (AH&MRC), Australian Association of Practice Management (AAPM), Australian Primary Health Care Nurses Association (APNA) and other organisations for their time to review and comment on drafts of the Strategy.
1. Introduction

Purpose of the Primary Care Strategy

The NSW Primary Care Strategy for the bowel, breast and cervical screening programs (the Strategy) provides a roadmap for the Cancer Institute NSW to work with the primary care sector to increase primary care involvement in these cancer screening programs.

As it aligns with national and state policy and plans, the intended outcome of the Strategy is that more primary care providers, particularly in general practice, will recommend screening and follow-up with patients who are eligible for screening. This will contribute to an increase in breast, bowel and cervical screening participation rates across NSW.

While an individual’s decision to participate in breast, bowel or cervical screening is influenced by multiple factors, it is well recognised that primary health care can have a significant impact on improving screening rates. In particular, general practitioners (GPs) are recognised as having an influential role with patients. However, formative research undertaken by the Cancer Institute NSW has found that there are a range of factors that shape an individual primary care provider’s decision to recommend, or not recommend, screening.

The National Bowel Cancer Screening Program, BreastScreen Australia and the National Cervical Screening Program are national programs developed by the Australian Government in collaboration with the States and Territories.

Breast and bowel screening programs offer free access to screening for eligible individuals.

BreastScreen NSW offers breast cancer screening through regional Screening and Assessment Services (SASs), managed by Local Health Districts (LHDs). Bowel cancer screening is offered by the National Bowel Cancer Screening Program (NBCSP). Eligible participants are sent a faecal occult blood test (FOBT) by mail.

Cervical screening is available through general practices, women’s health services, Aboriginal Community Controlled Health Services (ACCHS) and, in some cases, specialist clinics. The cost of conventional cytology is covered by a Medicare rebate; however, there may be some costs to women if services do not bulk bill for the consultation.

Given the evidence that supports primary health care engagement in improving cancer screening rates, and as part of a broader strategy to increase screening rates in NSW, the Cancer Institute NSW has developed this Strategy in consultation with key stakeholders.

“GPs are recognised as having an influential role with patients”
Structure of the Strategy

While there are differences between the breast, bowel and cervical screening programs, many of the significant issues around engagement with primary care are the same. The Strategy therefore addresses three elements:

1. **Foundational elements:** Building a quality-based partnership approach with primary care to support and direct screening within primary care that is applicable to all three programs.

2. **Generic elements:** Common strategies that apply to primary care capacity and capability, and approaches to preventive health. These also have relevance to all three programs.

3. **Specific elements:** Strategic elements that address the specific challenges unique to each of the bowel, breast and cervical screening programs.

Context

In NSW, participation in population-based bowel, breast and cervical screening programs is substantially below national averages and targets. Some priority populations are identified with particularly poor screening participation rates, including Aboriginal and some culturally and linguistically diverse (CALD) communities.

Screening participation rates in NSW may be improved by acknowledging the complexity of primary care delivery and the pressures on general practice, and working collaboratively to increase primary care engagement with screening.

There are a range of primary care organisations, such as the Royal Australian College of General Practitioners (RACGP), the Aboriginal Health and Medical Research Council (AH&MRC), and GP training organisations which may play an enabling role in the Strategy.

NSW screening participation rates,

**Breast**
- 51.2%
- Rank 7th of 8 states

**Bowel**
- 33.2%
- Rank 7th of 8 states

**Cervical**
- 57%
- Rank 5th of 8 states

References:
The NSW policy context

The Strategy has been developed to align with the objectives and priorities of the State Health Plan – Towards 2021 and the NSW Cancer Plan.

The Cancer Institute NSW, Division of Cancer Screening and Prevention is working towards the following goals of the NSW Cancer Plan:

- Goal 1: Reduce the incidence of cancer
- Goal 2: Increase the survival of people with cancer

In order to achieve these goals, the Division is working collaboratively to increase participation rates in the three screening programs. The NSW Primary Care Strategy for breast, bowel and cervical screening programs will build on this work.

NSW State Health Plan: Towards 2021

This Strategy aligns to the NSW State Health Plan, Direction 1: Keeping people healthy. In particular, section 1.5 of the plan, which focuses on helping people manage their own health through screening programs, immunisation programs and community and consumer education.

Priorities for Aboriginal and CALD communities are outlined in the following strategic plans:

- NSW Aboriginal Health Plan 2013–2023
- NSW Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012–16

A major priority for the Ministry of Health, in relation to primary care engagement, is strengthening the relationship between Local Health Districts (LHDs) and the recently-formed Primary Health Networks (PHNs).

The NSW Cancer Plan

The latest NSW Cancer Plan was released in April 2016.

This new plan continues to focus on initiatives to promote the early detection of cancer through the breast, cervical and bowel cancer screening programs. Bowel cancer has also been identified as a priority in the NSW Cancer Plan.

Activities outlined within the NSW Cancer Plan have an explicit focus on improving cancer outcomes across the State and lessening the gap for groups within the community who experience poorer cancer outcomes. It provides the opportunity to strengthen existing partnerships between the Cancer Institute NSW and its stakeholders, as well as to develop new partnerships.

Primary care providers will play a pivotal role in achieving the goals of the NSW Cancer Plan. The Cancer Institute NSW’s website (cancerinstitute.org.au) provides links to the prioritised actions of the NSW Cancer Plan, and will contain regular updates on the plan’s achievements.
The Commonwealth and national agency context

Whilst this strategy focuses on screening activity within NSW, the programs sit within a broader national context. Key issues at a national level are outlined below.

**National Cervical Screening Program (NCSP): The Renewal (from May 2017)**

The NCSP will undergo significant changes, known as the Renewal. Changes include the test itself, the screening interval and age range. Implementation of the change will occur from 1 May 2017. More detail is provided on page 32.

**Primary Health Networks (PHNs)**

PHNs were established in July 2015 by the Federal Government. PHNs have national performance indicators they are required to report against. Among these indicators is a need to show increased participation in screening for cervical, breast and bowel cancer.

**Aboriginal Community Controlled Health Services**

Aboriginal Community Controlled Health Services (ACCHSs) play an important role within the primary healthcare system, with specific expertise in delivering primary care to Aboriginal communities. ACCHSs deliver comprehensive, culturally-appropriate models of care that differ from mainstream general practice.

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 shapes the work of ACCHSs in addressing cancer screening. Health checks and cervical screening are currently national key performance indicators for all ACCHSs receiving funding from the Commonwealth Department of Health. There is potential for health checks to be broadened to include referrals and promote the need for breast and bowel screening.

It is recognised that a cohesive approach among key stakeholders, including the AH&MRC and ACCHSs, is required to ensure an integrated service delivery model that supports the work being undertaken in relation to the broader ‘Closing the Gap’ strategies. This is also the case for strategies focusing on increasing participation in breast, bowel and cervical screening among Aboriginal people.
2. Key drivers for a primary care strategy

Participation in screening

Low screening participation rates, with little change in performance over time, is a key driver for developing this Strategy. An environmental scan of evidence and early consultation with stakeholders reinforced the need for a consistent strategy to engage with primary care, particularly PHNs and general practice. Figure 1 shows age-standardised participation rates in NSW for cervical screening from 2004–2005 to 2013–2014, and for breast screening from 2004–2005 to 2014–2015. Statewide data is available for bowel screening from 2009–2010.

Fig 1 | NSW participation rates by screening program, 2004/05–2014/15

* From 2008, people aged 55 and 65 were invited to participate in bowel screening. Fifty-year-olds were included from 2010 and 60-year-olds from 2013.

Data sources:
- Bowel screening data supplied by the Department of Human Services.

Current issues

Following a review of available evidence (refer to Appendix 1) and consultation with stakeholders, the following challenges and issues were indentified.

Roles and accountabilities\(^{1,2,3}\)

- The breast and bowel screening programs were introduced at Commonwealth and State levels, with a reported lack of GP involvement in the development of both. This has contributed to a lower sense of connection and ownership by GPs, as well as some negative perceptions of the programs.
- Communication between Commonwealth, State and local primary care providers appears to be inconsistent. This contributes to a lack of clarity around roles (leadership, accountability, priority) at all levels of the system, as well as a misalignment between the expectations of the different components of the system.
- The cervical screening landscape is complex and involves a wide range of providers, including GPs, non-government organisations (NGOs), LHDs, and pathology laboratories.
- While provision of cervical screening is an item for GPs on the Medicare Benefits Schedule (MBS) and is embedded as a primary care service, there are GPs who choose not to do Pap smears for cultural or business reasons, but do not necessarily refer women to other suitable services.
Current issues (cont.)

Messaging about population-based screening

- Formative research found that some GPs are not clear on the difference between population-based and risk-based screening, and are therefore unable to articulate the benefits and evidence for screening.
- Among GPs there is a lack of clarity around how to access bowel and breast screening for their patients; hence, the messages provided to patients about the programs are likely to be unclear or inconsistent.
- There is a lack of clear messaging about planned changes to cervical screening through the Renewal, and indications that there is an existing erroneous assumption amongst HPV-vaccinated women that they do not require screening.

Access and equity

Certain population groups tend to be under-represented in screening populations, which may be due to one or more of the following:

- Low levels of health literacy
- Locational disadvantage
- Cultural or language issues
- Socioeconomic disadvantage
- Aboriginal or Torres Strait Islander origins
- Personal history that creates anxiety about certain screening activities

Primary care infrastructure

- Currently, the willingness of primary care providers to engage in promoting the importance of breast and bowel screening is variable; as is the capacity, capability and infrastructure in primary care to identify eligible patients and collect data on breast and bowel screening referrals.
- Not all practices use existing capability to track cervical screening results and reminders for women.
- There are concerns regarding patient privacy and information sharing from some parts of the sector, which can limit opportunities to improve coverage at a population level. Identifying and following up patients who are eligible for screening in a systematic manner without primary care commitment and enabling infrastructure is difficult. This is further complicated by some patients having multiple GPs.
- There are currently no financial or performance target incentives in primary care specific to breast and bowel screening. The 45 to 49-year-old health check—a preventive health MBS item that could potentially provide an incentive to support increased GP activity for breast and bowel screening referrals—does not align with the eligible age ranges for either program.
- Practice payments to increase the use of practice nurses in cervical screening are not currently available. Not all practices choose to offer cervical screening, or do so at an additional charge.

Private screening

There are currently a number of people who are screened in the private sector on the recommendation of their GPs. This applies to breast and bowel screening. The actual number/proportions are not formally monitored or reported. Privately screened results are not collected on the state or national registers. Some of the reasons identified for recommending the use of private screening include:

- a belief that public screening is of lower quality than private screening
- inconsistency between evidence-based guidelines and the availability of FOBTs through the NBCSP (an issue of quality and compliance with evidence)
- reporting back to GPs on outcomes is rapid and often electronic through private providers.

---

1. Information based on stakeholder feedback.
3. Urbis, BreastScreen NSW: Formative research with GPs and practice staff: Literature Scan (2014), Cancer Institute NSW.
Analysis of the evidence (refer to pages 22—23) and the current issues identified by stakeholders highlighted the critical success factors required for the Cancer Institute NSW to achieve increased primary care involvement in the screening programs, and therefore improve screening participation rates.

3. The critical success factors

Enablers

- Systems for monitoring GP recommendations to screen at the practice level; manual systems can work until electronic systems are in place.
- Relationships are critical in engendering practice changes in primary care providers.
- Quality collaboratives are a good means of engaging primary care providers in practice change.
- PHNs have a key role to play in encouraging and supporting GPs to recommend screening and by monitoring practice populations.
- Practice Incentive Programs can be strong enablers for GPs and practice nurses where there is an existing interest in screening.
- Health workers and nurses (including practice nurses) can play a key role in cervical screening in helping address gender and cultural barriers.
- Specific expertise within and models of care provided by ACCHSs, enables delivery of culturally-appropriate primary health care to Aboriginal communities.

Establishment of an appropriate governance structure that promotes integration of cancer screening and primary care services

Consultation with general practice to determine the support needed to achieve higher screening rates

Identification of suitable primary care clinical champions at a state and local level

Consideration of the day-to-day operation of primary care practices when implementing strategies. Provide supporting tools and education to enable a smooth transition to the desired way of working - ‘making the right thing to do the easiest thing to do’

Creating a partnership approach to working with primary care to improve participation in screening

Maintaining a focus on Aboriginal populations to achieve equity of outcomes for Aboriginal and non-Aboriginal people in NSW

Enhancing current capability to actively monitor performance and promote quality improvement

Establishment, coordination and evaluation of a program to encourage and support primary care engagement in screening
4. Translating opportunities to strategies

Key opportunities

Through an environmental scan and consultation with stakeholders, a number of opportunities for action were identified. These are grouped into 3 areas of strategic action:

1. Developing partnerships with primary care (PHNs and primary healthcare professionals).
2. Building system capability and capacity.
3. Building knowledge and a learning environment.

Detail for implementing these opportunities is provided on the following pages.

- Engage multidisciplinary primary care team members in program development
- Establish formal linkages with PHNs to support performance reporting and targets
- Engage with consumers to understand context, including local issues affecting individual screening decisions
- Establish roles and functions within the Cancer Institute NSW to support engagement with primary care
- Support links between GPs and NGOs/LHDs to address populations with poor access to screening
- Support increased use of practice nurses for cervical screening
- Establish strong links with RACGP NSW faculty to support a quality improvement framework
- Maximise clinical record software to drive performance improvement
- Make greater use of CALD and ACCHS health workers to target hard-to-reach populations
- Work with Commonwealth, PHNs and local integrated demonstrator sites to pilot innovative primary care-led local bowel screening initiatives
- Produce clear statewide messages on the Cervical Screening Program’s quality and purpose, and on the Renewal
- Use information and data to generate interest and performance improvement
- Establish clinical forums to spread a consistent message
- Establish linkages with primary care academic researchers
- Create learning opportunities and resources for primary care providers
- Develop general practice leadership capability at all levels of the system
The opportunities and critical success factors noted earlier provide the basis for the development of the Strategy’s framework.

Figure 3 illustrates the framework of the Strategy. The foundation strategies will be critical to the successful implementation of the Strategy. Overall, the Cancer Institute NSW will ensure effective engagement with primary care providers, PHNs and primary care industry associations to implement the Strategy.

Implementation planning will need to ensure alignment with national programs and strategies in order to leverage opportunities and minimise conflict.

The following pages outline the rationale and key elements for each of the strategic action areas. Some actions contribute to more than one strategic action area.

PHNs will be engaged as partners at an early stage of development.
Fig 3 | Framework for the Strategy

PRINCIPLES UNDERPINNING THE STRATEGY

Knowledge-based learning and development
Equitable access
People-centred
Continuous quality improvement

FOUNDATION STRATEGIES

1. DEVELOP PARTNERSHIPS WITH PRIMARY CARE
1.1 Establish the Primary Care Program
1.2 Establish a Primary Care Advisory Group
1.3 Build a quality framework for screening in primary care
1.4 Develop evaluation framework for the strategy

2. BUILD SYSTEM CAPABILITY AND CAPACITY
2.1 Foster clinical leadership
2.2 Drive an integrated approach to delivery of screening programs
2.3 Work with PHNs to support achievement of PHN screening targets

3. BUILD KNOWLEDGE AND A LEARNING ENVIRONMENT
3.1 Support primary care workforce development
3.2 Support implementation of evidence-based guidelines and pathways
3.3 Establish a performance and reporting framework for PHNs and practices

4. BREAST
4.1 Improve the communication of information between SASs and GPs about women participating in the program
4.2 Support partnerships between SASs, PHNs and other service providers
4.3 Develop breast screening information resources including clear statewide messages targeted to:
   – different population groups
   – primary care health professionals
4.4 Utilise expertise held in SAS teams to provide local education and training to primary care
4.5 Develop an evaluation framework for locally-driven GP engagement strategies through SASs

5. BOWEL
5.1 Work with the Commonwealth to develop a local NSW approach to bowel screening, which has primary care in a key role
5.2 Work with NBCSP to pilot primary care-led dissemination of kits to priority populations
5.3 Develop bowel screening information resources including clear statewide messages targeted to:
   – different population groups
   – primary care health professionals
5.4 Work with LHDs to review and improve access to colonoscopy

6. CERVICAL
6.1 Support the increase in the number of cervical screening tests undertaken by practice nurses to address gender and cultural issues
6.2 Support education in nursing and Aboriginal Health Worker workforces to facilitate or undertake quality screening
6.3 Support nurses, GPs and other health workers to develop innovative local approaches to removing barriers for under-screened/never-screened women
6.4 Support primary care providers to identify under-screened and never-screened women (especially young women) and help them with appropriate messaging to offer opportunistic screening or self testing where appropriate (post implementation of the Renewal)
6.5 Support GPs to stay positioned as experts on cervical screening
6.6 Develop messages for primary care providers on the Renewal, emphasising the need to maintain current screening levels and providing upskilling activities

INCREASED PARTICIPATION IN SCREENING
## Principles underpinning the Strategy

<table>
<thead>
<tr>
<th>People-centred</th>
<th>Equitable access</th>
<th>Knowledge-based learning and development</th>
<th>Continuous quality improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engage with consumers</strong></td>
<td><strong>Acknowledge the social determinants of health</strong></td>
<td><strong>Use data and evidence to inform strategies</strong></td>
<td><strong>Partner with PHNs</strong></td>
</tr>
<tr>
<td>Engaging with consumers is important. PHNs have active Community Advisory Committees that can help inform local implementation of the Strategy.</td>
<td>Improving screening rates in under-screened and never screened populations requires an acknowledgement of the social determinants of health and the barriers to access that can result.</td>
<td>Improving data access, use and quality underpins the success of the Strategy. Evidence generated by data can inform improvements in screening rates.</td>
<td>PHNs, as regional primary healthcare organisations are critical partners in implementing the Strategy.</td>
</tr>
<tr>
<td><strong>Understand the local context</strong></td>
<td><strong>Use locally appropriate strategies, especially when working with Aboriginal communities and CALD communities</strong></td>
<td><strong>Increase health literacy in screening</strong></td>
<td><strong>Setting aspirational targets drives improvement</strong></td>
</tr>
<tr>
<td>What works in one location may not work in another—local context is important to implementing the Strategy.</td>
<td>Aboriginal communities know what works locally and should inform the local implementation of the Strategy. Different language and cultural groups require tailored approaches to the implementation of the Strategy.</td>
<td>Addressing health literacy supports informed decision making by consumers with regards to screening.</td>
<td>Cancer screening is a national performance indicator for PHNs and for the Cancer Institute NSW. Agreed aspirational targets for improvement can reinforce this.</td>
</tr>
</tbody>
</table>
### Develop primary care partnerships

1.1 Establish the Primary Care Program  
1.2 Establish a Primary Care Advisory Group

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful implementation of the Strategy will be a complex process with multiple internal and external stakeholders. Therefore, a robust program and project management framework is required.</td>
<td>Establish a primary care leadership and coordination function within the Screening and Prevention Division of the Cancer Institute NSW to support the implementation of the Primary Care Strategy and related work across the Institute.</td>
</tr>
<tr>
<td>Primary care practitioners are best placed to advise on what strategies will work within primary care.</td>
<td>Establish a Primary Care Advisory Group to include membership from the following groups and disciplines:</td>
</tr>
<tr>
<td>Relationships are critical in engendering practice changes in primary care providers.</td>
<td>- GPs (including Aboriginal and CALD)</td>
</tr>
<tr>
<td>The creation of an advisory group signals the importance of the partnership approach and recognition by the Cancer Institute NSW of the need to work with primary care.</td>
<td>- Practice managers (AAPM)</td>
</tr>
<tr>
<td>There is evidence to support the use of partnerships to shift from individual care models to system thinking.</td>
<td>- Practice nurses (APNA)</td>
</tr>
<tr>
<td>Partnerships between professionals, and across sectors, have been shown to strengthen the capacity of organisations to improve individual population health and reduce health risks.</td>
<td>- NGOs (Family Planning NSW/LHD Women's Health Services)</td>
</tr>
<tr>
<td>Primary care stakeholders identified improving communication channels between BreastScreen NSW and GPs as important.</td>
<td>- Aboriginal health</td>
</tr>
<tr>
<td>There was limited GP involvement at Commonwealth and State level in the development of breast and bowel screening programs, resulting in negative perceptions. GPs have expressed a sense of dislocation from breast and bowel screening programs, particularly bowel screening.</td>
<td>- PHNs</td>
</tr>
<tr>
<td>Not all GPs are offering cervical screening.</td>
<td>- RACGP</td>
</tr>
<tr>
<td>The Primary Care Advisory Group will:</td>
<td>- Primary care researchers (GP academics)</td>
</tr>
<tr>
<td>- oversee the refinement of the quality framework for primary care and the evaluation framework for the Strategy</td>
<td>- Consumers</td>
</tr>
<tr>
<td>- provide advice to support establishment of work programs to implement strategies</td>
<td></td>
</tr>
<tr>
<td>- provide advice on future screening strategies</td>
<td></td>
</tr>
<tr>
<td>- provide advice regarding monitoring and evaluation of the Strategy</td>
<td></td>
</tr>
<tr>
<td>- providing a gateway to the Cancer Institute NSW for primary care on screening matters.</td>
<td></td>
</tr>
</tbody>
</table>
1.3 Build a quality framework for screening in primary care
1.4 Develop evaluation framework for the strategy

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A quality framework supports a system-wide quality improvement approach to increasing screening rates and forms the basis of an improvement plan. It also:</td>
<td>• The quality framework should not replicate but align with existing national bowel, breast and cervical cancer quality frameworks and standards. It should include:</td>
</tr>
<tr>
<td>– frames the work to be undertaken to increase screening rates, shifting from a compliance approach to a quality approach</td>
<td>– a clear definition and description of the roles and accountabilities of agencies and providers</td>
</tr>
<tr>
<td>– provides a strategic direction that converts a diverse range of potential activities into a systematic approach and coherent work program.</td>
<td>– a set of underlying principles for bowel, breast and cervical screening in NSW</td>
</tr>
<tr>
<td>• There are indications that a quality improvement approach aligns with the professional values of primary care providers (e.g. as observed in participation in primary care collaboratives).</td>
<td>– evidence-based guidelines for practice</td>
</tr>
<tr>
<td>• It signals the intent of the Cancer Institute NSW to constructively support system-wide improvements in screening rates, and acknowledges that a proactive approach to quality improvement is required to achieve Institute priorities.</td>
<td>– quality performance indicators and targets</td>
</tr>
<tr>
<td>• It provides an opportunity for the Institute to agree and confirm with primary care stakeholders:</td>
<td>– process for performance monitoring and reporting</td>
</tr>
<tr>
<td>– the principles that underpin the screening programs</td>
<td>– a system for data collection and timely feedback on PHN and practice performance</td>
</tr>
<tr>
<td>– the key quality elements that will be necessary</td>
<td>– an evidence-based approach to the development and implementation of initiatives, including evaluation</td>
</tr>
<tr>
<td>– the platform required to support improvement.</td>
<td>– guidelines for evaluation of screening initiatives</td>
</tr>
<tr>
<td>• Evaluation provides essential feedback on the success (or otherwise) of strategy elements and provides necessary input to guide possible changes to the strategy.</td>
<td>– alignment with other components of the cancer pathway (e.g. diagnosis and treatment).</td>
</tr>
<tr>
<td>• Establish a work program with RACGP, AH&amp;MRC, APNA, AAPM and other peak organisations to support the quality improvement framework.</td>
<td>• Align with:</td>
</tr>
<tr>
<td></td>
<td>– Cancer Institute NSW quality frameworks and other jurisdictional quality frameworks</td>
</tr>
<tr>
<td></td>
<td>– AMAC population-based screening framework.</td>
</tr>
<tr>
<td></td>
<td>• Develop an evaluation framework.</td>
</tr>
</tbody>
</table>
2.1 Foster clinical leadership

### Rationale
- Clinical leaders can act as catalysts for change within their sphere of practice (e.g. location or profession).
- Clinical leaders exert influence in the wider community, particularly in CALD communities.
- GPs have demonstrated they are more receptive to messages delivered by a respected clinician.

### Key strategy elements
- Engage a primary care clinical champion at the Cancer Institute NSW level, and regional clinical leaders at the PHN level.
- Establish a work program with PHNs and PHN Clinical Councils to:
  - identify and foster primary care leaders/clinical champions/mentors at a regional level
  - identify and foster CALD community clinical leaders
  - provide support for PHNs to work with existing education providers, or develop educational opportunities for practice nurses and managers
  - identify relevant existing clinical forums to spread consistent messages.
- Use existing BreastScreen NSW SAS clinical coordinator forums to foster clinical leadership and share knowledge.
- Provide access to mentoring and support for identified lead clinicians.
- Engage with the RACGP and Clinical Excellence Commission (CEC) on developing clinical leadership.
- Foster and support clinical leadership within the Aboriginal primary healthcare workforce by working with AH&MRC and ACCHS.

2.2 Drive an integrated approach to delivery of screening programs

### Rationale
- Currently, there is a lack of clarity around roles and accountabilities for components of the screening pathway; particularly for bowel and breast screening.
- The degree to which different players relate to each other is currently variable across regions. There is a disconnection between some GPs and NGO/LHD services providing cervical screening.
- There is regional and local variability in screening activities, which are not attributable to demographics or geography.
- With the creation of regional PHNs, there are opportunities to build integrated regional approaches.

### Key strategy elements
- Work with PHNs, NGOs, LHDs, AH&MRC, ACCHSs and the Primary Care Advisory Group to define roles, accountabilities and points of connection.
- Identify and support a lead Health Pathways project that includes bowel, breast and cervical screening for inclusion in local cancer pathways.
- Support development of primary care collaboratives that deliver local integrated approaches to screening.
- Promote effective use of existing cancer-specific communication vehicles for GPs and cancer care providers to discuss clinical and non-clinical queries, receive updates and educational events.
2.3 Work with PHNs and other primary care providers to achieve screening targets

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PHNs are regional primary healthcare organisations, with a critical role in engaging with primary care providers to support improved performance delivery and population-based health outcomes.</td>
<td>Establish a joint work program with the NSW PHNs, the AH&amp;MRC (and other relevant primary care peak bodies) that includes:</td>
</tr>
<tr>
<td>• The PHN mandate includes supporting general practice development.</td>
<td>• reviewing the capability of common practice software with practice management system vendors and practices to facilitate where possible:</td>
</tr>
<tr>
<td>• The Commonwealth has established participation as a performance indicator for:</td>
<td>• screen prompts and reminders</td>
</tr>
<tr>
<td>– PHNs in bowel, breast and cervical screening</td>
<td>• electronic reporting</td>
</tr>
<tr>
<td>– ACCHS for cervical screening</td>
<td>• electronic referral</td>
</tr>
<tr>
<td>• Understanding performance at a practice level is critical; however, there are currently practice level data and reporting shortcomings that PHNs are well situated to address; for example:</td>
<td>• using clinical audit systems for audit and risk stratification</td>
</tr>
<tr>
<td>– patient flags have been identified as enablers to improve screening recommendations in primary care, but not all practice software is set up/has the capability to do this.</td>
<td>• identification of data points to measure outcomes</td>
</tr>
<tr>
<td>– accurate practice level reporting on screening referrals, attendances and outcomes is not routinely available in primary care practices, but this information is critical to creating a baseline, and improving referral rates.</td>
<td>• supporting shared approaches to improving referral rates between PHNs, NGOs and LHDs (SAS for breast cancer)</td>
</tr>
<tr>
<td>• PHNs that have developed from Medicare Locals already have established relationships with local practices (to varying degrees), which often includes support for data quality and practice software.</td>
<td>• providing PHNs with regular performance reports at the most granular level possible</td>
</tr>
<tr>
<td></td>
<td>• supporting PHNs to establish local primary care collaboratives that improve screening participation</td>
</tr>
<tr>
<td></td>
<td>• building expertise within PHNs—providing information on clinical evidence, guidelines and pathways</td>
</tr>
<tr>
<td></td>
<td>• engaging with the health needs analysis work of the PHNs and LHDs to inform issues for bowel, breast and cervical screening.</td>
</tr>
</tbody>
</table>
## Build knowledge and a learning environment

### 3.1 Support primary care workforce development

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Formative research has demonstrated varying levels of understanding among GPs around the</td>
<td>• Work with training providers to develop education programs that support general practice, ACCHS and CALD providers. This should include FPNSW, RACGP, GP training providers, academic GP units and clinical schools, AH&amp;MRC, the Agency for Clinical Innovation and possibly the Health Education and Training Institute.</td>
</tr>
<tr>
<td>role of population screening.</td>
<td></td>
</tr>
<tr>
<td>• There is an opportunity to make better use of practice nurses and other practice staff roles</td>
<td></td>
</tr>
<tr>
<td>and skills.</td>
<td></td>
</tr>
<tr>
<td>• There is local expertise held in SASs on breast screening, assessment and diagnosis.</td>
<td></td>
</tr>
<tr>
<td>• Family Planning NSW (FPNSW) is contracted to provide upskilling training to GPs and nurses.</td>
<td></td>
</tr>
<tr>
<td>• Priority populations, and people under-screened and never screened require targeted approaches.</td>
<td></td>
</tr>
</tbody>
</table>

### 3.2 Support implementation of evidence-based guidelines and pathways

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evidence-based guidelines and standards exist.</td>
<td>• Review current bowel, breast and cervical screening guidelines for currency and relevance to primary care.</td>
</tr>
<tr>
<td>• There are various local Health Pathways being developed; some of which include screening.</td>
<td></td>
</tr>
<tr>
<td>• One of the biggest challenges in building an evidence base is supporting its translation into</td>
<td>• Work with clinical champions to develop and/or identify accessible information and general practice resources that can support evidence-based protocols (e.g. flowcharts, pathways posters, flags on practice software).</td>
</tr>
<tr>
<td>everyday practice.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide regular updates on evidence and guidelines to PHNs and AH&amp;MRC for practice development.</td>
</tr>
<tr>
<td></td>
<td>• Foster information sharing opportunities (e.g. through state forums and conferences).</td>
</tr>
</tbody>
</table>
### 3.3 Establish a performance and reporting framework for primary care

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
</table>
| - Screening coverage rates at a practice or PHN level aren’t easily available so it is difficult for primary care practices to measure and understand their own performance. | - Work through the Primary Care Advisory Group to establish a process for developing practice-level targets and reporting that aligns with the Quality Framework and includes:  
  - ensuring robust, accurate and timely (granular) data is easily available to PHNs and practices (preferably in real time)  
  - providing regular reports to PHNs on screening performance in their region, broken down to the smallest permissible and available denominator. |
| - GPs respond well to opportunities to improve performance if they are supported by relevant local data. However, it is challenging to engage in performance improvement without measurement. | - Review capacity of common practice software with PMS vendors and practices to enhance the capability of practice software to include:  
  - screen prompts and reminders  
  - electronic reporting  
  - electronic referral. |
| - Some practices have implemented manual data collection and are monitoring their performance internally. | - Pending electronic information, support development of manual systems, by using experiences of lead practices. |
| - There is not a systematic process to support GPs in developing and monitoring practice-specific targets for screening rates. | - Work with PHNs and Aboriginal health services to use clinical audit systems for audit and continuous quality improvement. |
| - | - Use Primary Care Collaboratives to build screening practice into everyday business. |
### 4.0 Develop specific strategies to enhance the role of primary care in breast screening

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
</table>
| • Breast screening is perceived as a separate service and GPs find it difficult to refer directly to Screening and Assessment Services (SASs) or receive information in return. | 4.1 Improve the communication of information between SASs and GPs about women participating in the program.  
  • Consider development of an electronic referral form for breast screening and online booking.  
  • Develop a GP ‘Hotline’ for screening enquiries and referrals.  
  • Investigate the option of providing results to GPs electronically.  
  Strengthen existing processes, and reinforce to GPs and women the importance of women identifying their GP to receive screening results. |
| • Where women do not actively identify a GP when screened, their GP may not get screening results. | 4.2 Facilitate and support partnerships between SAS, PHNs and other service providers as part of the joint program of work with PHNs.  
  Support PHNs in building a SAS role into a model Health Pathway for breast cancer. |
| • SASs have a key role to play in the implementation of local strategies. | 4.3 Use expertise held in SAS teams to provide local education and training to primary care within a consistent statewide approach.  
  In particular, reinforce the role that practice nurses play and integrate education into what is available locally. |
| • SASs hold technical and clinical expertise on screening, assessment and diagnosis. | 4.4 Develop breast screening information targeted to:  
  • different population groups  
  • primary care health professionals.  
  Produce clear statewide messages on program quality and purpose.  
  Develop and share evidence-based information on screening program benefits. |
| • Formative research indicates variability in the degree to which GPs understand the difference between population screening and diagnostic screening. | 4.5 Develop an evaluation framework for local SAS primary care engagement strategies. |
| • There is variability in local primary care engagement activities and these have not been rigorously evaluated. |
### 5.0 Develop specific strategies to enhance the role of primary care in bowel screening

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bowel screening is perceived as a national service with little or no connection to local GPs.</td>
<td><strong>5.1</strong> Work with the Commonwealth to develop a local NSW approach to increasing participation in bowel screening, which involves primary care playing a key role.</td>
</tr>
<tr>
<td>• Reportedly, there are patients who are accessing private FOBT through ‘over the counter’ bowel screening tests or through privately-initiated tests by their GP. This is partly due to the issue above, and partly because of misalignment between best practice and current NBCSP scheduling.</td>
<td><strong>5.2</strong> Work with NBCSP to develop and pilot primary care-led approaches to the dissemination of FOBT kits to priority populations.</td>
</tr>
</tbody>
</table>
| • The Cancer Institute NSW works with the Commonwealth and is aligned with the national program, but also seeks to address current gaps in the program. | **5.3** Develop bowel screening information resources targeted to:  
  • different population groups  
  • primary care health professionals. |
| • Stakeholders report that the instructions and process for the FOBT kit are dense and not easily understood. | **5.4** Produce clear statewide messages on program quality and purpose. Develop and share evidence-based information on screening program benefits. |
| • Formative research indicates variability in the degree to which GPs understand the difference between population screening and diagnostic screening. | **5.5** Support PHNs and LHDs to work on colonoscopy access redesign and strategies (potentially through Health Pathways, primary care collaboratives or state-level MOUs for access to colonoscopy). |
| • There is a perceived risk that public colonoscopy follow-up will not be available if there is an increase in referrals as a result of positive FOBTs. |
### 6.0 Develop specific strategies to enhance the role of primary care in cervical screening

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key strategy elements</th>
</tr>
</thead>
</table>
| • Provider characteristics are a key influence in women choosing to screen or even having access to screening. This is especially true in rural and remote areas; with Aboriginal and Torres Strait Islander women; and women from some CALD backgrounds.¹ | **6.1** Support increase in the number of cervical screening tests undertaken by practice nurses to address gender and cultural issues.  
**6.2** Support education in nursing and Aboriginal Health Worker workforces to facilitate or undertake quality screening.  
Explore expansion of supervised remote mobile follow-up on screen-detected abnormalities. |
| • There has been a reported drop in the number of young women seeking screening, possibly due to an erroneous belief they are fully protected by the HPV vaccine.  
• NGOs, such as FPNSW and LHD Women’s Health and Sexual Health Services play a key role in accessing women who do not go to a GP for screening (including rural, CALD and Aboriginal and Torres Strait Islander women who are under-screened or never screened). | **6.3** Support nurses, GPs and other health workers to develop innovative local approaches to removing barriers for under-screened/never screened women, including cost barriers.  
Assist general practices to address cultural and organisational barriers.  
Continue to engage with and support NGO and LHD primary care providers who are implementing innovative approaches for women who do not access GPs for cervical screening. |
| • There is evidence, supported by stakeholders, that opportunistic screening is still an effective way to ‘capture’ unscreened women who present to primary care for other reasons. | **6.4** Support primary care providers to identify under-screened and never screened women (especially young women) and help them with appropriate messaging to offer opportunistic screening. |
| • Stakeholders are describing some confusion about the Renewal and what it will mean for practice change and how they can explain it to their patients. Guidelines are not yet available. | **6.5** Support GPs to stay positioned as experts on cervical screening (cytology or HPV) and to deliver credible messages to their patients in the lead-up to, and implementation of, the Renewal, through skills updates and communication tools.  
**6.6** Develop locally-relevant messages for primary care providers on the Renewal, emphasising the need to maintain current screening levels and providing upskilling activities. |

---

¹ O’Connor M, Murphy J, Martin C, O’Leary J & Sharp L. Motivators for women to attend cervical screening: the influential role of GPs, on behalf of the Irish Cervical Screening Consortium (CERVIVA), Family Practice, 2014, Vol. 00, No. 00, 1–8.
Appendix 1: Summary of the evidence for interventions in primary care

Client-oriented interventions

Client-oriented interventions are those that could be delivered by primary care providers in the primary care setting to increase community demand and access to cancer screening services.

Client-oriented interventions include the following:

- **Group and one-on-one education**: Encouraging and motivating participants to seek screening and addressing anxiety before screening. Recognising and validating women’s concerns about personal screening, such as cervical and breast, and referring to other appropriate services if necessary.

- **Small media**: Universal and targeted videos and printed materials, such as brochures and newsletters, used to inform and motivate people to be screened.\(^1\)

- **Client feedback and reminders**: Text (letter, postcard, email) or telephone. Letters are most effective on the practice letterhead and endorsed by the patient’s own GP.\(^2\)

- **Reducing out-of-pocket costs** and minimising economic barriers to screening.\(^2\)

- **Reducing structural barriers**: Identifying interventions that address non-economic burdens/obstacles that impede access to screening, such as distance, time, administrative barriers, setting, practitioner gender and language barriers.\(^2\)

- **Offering self-testing** (cervical screening test) to specifically identified populations of under-screened or never-screened women.

Evidence is strongest for GPs to deliver one-on-one education; however, demand pressures can restrict the GPs’ ability to provide this. Practice nurses have been shown to deliver statistically-significant improvements in screening rates through one-on-one education, with no significant difference found between patients receiving education from the GP or nurse.

---

As cancer screening improves, primary care has a pivotal role in facilitating uptake, which can be enhanced using audit and feedback systems, office prompt systems and general practitioner endorsement.\(^{—Emery et al, 2013}\)
Primary care provider-oriented interventions

Primary care provider-oriented interventions are those that support and enable primary care providers to participate in screening programs. The following provider-oriented interventions are supported by evidence.\(^3,4,5\)

- Academic detailing and training for GPs and other primary healthcare professionals. This includes professional development workshops and targeted, individual practice-based education.
- Assisting GPs with the knowledge, resources and office systems to better manage screening.
- Provider reminders, such as a note in the patient’s clinical notes or an automated pop-up message. Using embedded multiple screening reminders simultaneously in patient management and decision-support systems has also been found effective.
- Opportunistic offers of cervical screening to under-screened women who attend practices for other reasons.
- Provider audits and performance data to monitor and evaluate performance of the practice/GP on the screening rates of their patients.
- Information systems, such as a patient registry database, connecting patients who are due or overdue for screening with GPs.

There are also a number of interventions with insufficient evidence for recommendations. However, some of these are contemporary interventions with promising futures. For example:

- decision aids assist shared decision-making and patient education
- web-based patient services aid discussion of screening options with patients
- planned care visits for prevention and screening as part of a chronic care model, taking a ‘proactive’ approach to preventive service delivery.

---

6. Information based on stakeholder feedback.
Appendix 2: Information about the cancer screening programs

Background

Although the breast, bowel and cervical screening programs are national cancer screening programs, there are differences in their structure and delivery as described within these appendices. The Strategy is designed to address system issues common to all three, as well as the key differences between the programs.

Promotional resources are developed for each screening program to inform and encourage participation among the community, underpinned by marketing and recruitment strategies specific to each program.

Campaigns may run across different media (print, radio, TV, digital), supported by public relations activities. These marketing and recruitment strategies will complement activities within the Strategy.

We really need to work out how to engage under- and never-screened women through GP engagement.

An environmental scan and early consultation with stakeholders with an interest in primary care engagement, screening delivery and/or specific screening programs, also identified program-specific issues, which are listed in the following appendices.
Breast screening

The BreastScreen Australia screening program is jointly-funded by Commonwealth, State and Territory governments, delivered by each jurisdiction according to National Accreditation Standards, and supported by individual policies and procedures.

The program actively recruits women aged 50–74 to have free mammograms biennially. This is done by an invitation letter when a woman turns 50, followed by a reminder letter every two years.

The Cancer Institute NSW is responsible for coordinating the national breast screening program within NSW. This is done through the BreastScreen NSW State Coordination Unit under the management of the Cancer Institute NSW. It is delivered by nine Screening and Assessment Services (SAs) located within, and managed by, Local Health Districts (LHDs).

There are currently 43 BreastScreen sites and 16 mobile vans visiting approximately 166 locations in NSW, according to need.

**Participation**

Participation in BreastScreen NSW is below target (as at October 2015). Allowing for data irregularities due to structural changes in LHDs, there has been little change in breast screening participation rates over time.

NSW’s participation rates are lower than the national average for, and rates are lower than most other states.

**Interface with primary care**

A GP referral is not required. If a woman provides BreastScreen NSW with her GP’s details, he/she will be provided with details of her results and will be kept updated on her progress through assessment and diagnosis. If a woman does not provide her GP’s details, there may be no communication between the program and the GP.
The involvement of GPs in breast screening is partly shaped by the decision of the individual to provide GP information to the provider at the time of screening and assessment. GPs are not required to follow up on suspicious mammograms identified through the BreastScreen program, as this is part of the service provided by SASs. There is variability in the extent to which primary care providers actively encourage women to screen and monitor re-screening. There is also variability across the region in how each SAS interprets and enacts their role in marketing and recruitment.

Specific issues for breast screening include:\(^1,^2\)
- variability in local approaches to GP engagement
- differences in SAS protocols in relation to informing GPs
- lack of an evidence-based approach to the development, implementation and evaluation of local initiatives.

---

1. Based on stakeholder feedback.
2. Urbis, BreastScreen NSW: Formative research with GPs and practice staff: Literature Scan (2014), Cancer Institute NSW.
Appendix 2b: About the National Bowel Screening Program

Bowel screening

The National Bowel Cancer Screening Program (NBCSP) was initiated by the Commonwealth Government in 2006 in partnership with State and Territory governments. As at 2016, the NBCSP actively recruits Australians turning 50, 55, 60, 64, 65, 70, 72 or 74 to take part. With the shift to biennial screening, which is consistent with NHMRC guidelines, by 2020 residents aged 50–74 will be invited to screen every two years.

Participants are sent a free faecal occult blood test (FOBT) screening kit. Instructions are provided with the kit and the sample is collected at home. Invitations to participate in the program are linked to Medicare or Department of Veterans Affairs’ information. Results obtained via the NBCSP are recorded on a national register, while private screens or patient-initiated screens, such as from over-the-counter kits, are not.

The Cancer Institute NSW has an accountability (but currently no operational role) in the NBCSP, which is administered by the Department of Human Services (Medicare Australia) and the Department of Health through a single national registry. Plans are underway to take up the Participant Follow-up Function from NBCSP in July 2016. The overall goals of the Cancer Institute NSW, as outlined in the NSW Cancer Plan, are to reduce the incidence of cancer, and improve the survival and quality of life for people living with cancer in NSW.

Therefore, during the life of the Strategy, the Institute will seek to align with the NBCSP but, as biennial screening will not be fully implemented in this time, it will also be seeking strategies that encourage FOBT in accordance with NHMRC guidelines.

Participation

NSW bowel screening participation rates are also low, and below the national average as at 31 December 2014. Figure 6 illustrates the rates recorded in the National Registry from 2013–2014.

Participation is lowest in people aged 50 with a modest improvement in people aged 60 and 65 years. NSW rates of participation for all age groups is lower than all of the other states and territories, with the exception of Northern Territory.

The degree to which GPs and other primary care providers are encouraging individuals to screen and re-screen varies. Follow-up and referral to the GP by the national program for a positive result depends on the patient identifying the GP at the time of the FOBT. If the GP is not identified, he/she will not be advised of the patient’s FOBT result. There is variation in GP practice with regards to colonoscopy. For example, some GPs believe colonoscopy should be the first line of investigation, even if a patient has no risk factors or symptoms. Pharmacists and NGOs also provide FOBT tests.
Specific issues for bowel screening include:\textsuperscript{1,2}

- lower level of state involvement and access to patient level information for GPs
- a lack of GP confidence in the NBCSP ("We are on the periphery")\textsuperscript{1}
- use of FOBT and the difference between screening of asymptomatic patients versus investigation of symptomatic patients is not clearly understood
- the scheduling of the NBCSP is inconsistent with the guidelines
- there is a perception that public colonoscopy services are not accessible, or may not be able to manage additional demand arising from an increase in positive FOBTs.

\section*{Interface with primary care}

If a participant’s FOBT result is positive, he/she is asked to discuss this with their GP, who may recommend further tests (e.g. colonoscopy). Ninety-nine per cent of people participating in the NBCSP nominate a GP or GP practice to receive their result. If participants do not identify their GP, no health professional is contacted regarding the results. The NBCSP has identified the role of general practice to include:

- encouraging participation in screening
- assessing and referring patients with a positive result as clinically indicated
- identifying high-risk patients and referring for colonoscopy screening in accordance with guidelines.

\textsuperscript{1} Based on stakeholder feedback.
\textsuperscript{2} Murphy M, & Rose M. Bowel Cancer Screening: Health Professionals - Report of qualitative research, (2015), Cancer Council Victoria.
Appendix 2c: Information about the National Cervical Screening Program

Cervical screening

Cervical screening aims to prevent cervical cancer by detecting pre-cancerous changes in the cervix. The National Cervical Screening Program (NCSP) is a joint initiative of the Australian and State and Territory governments, and involves:

- encouraging all eligible women to enter and remain in the screening program
- ensuring optimal quality of Pap smears with training for those conducting the Pap smear
- ensuring optimal quality of Pap smear reading through a quality assurance program for laboratories
- ensuring appropriate follow-up of abnormal Pap smears through management guidelines
- providing an efficient system for notifying women of results from Pap smear providers
- providing recall and reminder systems to ensure adequate follow-up of women with screen-detected abnormalities
- maintaining women's participation in the program by encouraging providers to set up reminder systems and maintain cervical screening registers
- reporting on national performance measures and contributing to national cancer data.

The NCSP currently recommends that all women aged between 18 and 70 who have ever been sexually active have Pap tests every two years.

The NCSP is undergoing significant change, known as the Renewal. Further information is on page 32. The Cancer Institute NSW manages the NSW Pap Test Register, which has been in place since 1996. The Register sends reminders to women for overdue Pap tests, works with health practitioners to ensure patients have had follow-up care if they have an abnormal test result, keeps a history of test results, and assists in gathering information that will help improve our understanding of cervical cancer and its treatment.

In contrast to breast and bowel screening, cervical screening is undertaken as a clinical service by general practitioners and other primary care providers, including practice nurses, ACCHS, FPNSW, and LHDs’ women’s health and sexual health services. ACCHS, FPNSW and LHD services focus more on priority populations, and under-screened or never-screened women. A proportion of GPs will refer to specialist gynaecologist or women’s health clinics to conduct cervical screening rather than conduct the test themselves.

Primary care providers take a cervical smear during a consultation with a woman and the sample is sent to a pathology laboratory for cytology testing. Laboratories also access the patient history available through the Pap Test Register.

NHMRC guidelines exist for the management of cervical abnormalities, and standards for cervical cytology exist with the National Pathology Accreditation Advisory Council (NPAAC). The Pap Test Register provides a safety net by following up results in accordance with NHMRC guidelines.

Providers are responsible for notification of results to women, follow-up and referral to specialist services if required. Women receive a reminder letter from the Pap Test Register when they are due for their two-yearly Pap smear. Some providers also remind women.
Participation
In 2013–2014, the NSW age-standardised cervical screening participation rate was 57%. This is below the national average and below that of Victoria, Tasmania, South Australia and the ACT. Rates of screening by age show a similar pattern of screening participation across all states and territories. Participation appears lowest in under thirties and over sixties. Rates are lower in younger women, with NSW having the lowest participation for women aged 20–30 years. This may relate to an erroneous belief among women vaccinated for HPV that they are protected from cervical cancer.

As shown in Figure 8, there has been a decline in screening participation rates over the past decade. Across Australia, rates of participation have dropped by 3.2%.

Issues for cervical screening include:

1. Some GPs who choose not to screen due to lack of training; individual beliefs; time constraints; and financial, cultural or gender issues. This may disadvantage women in communities where there are no other options.
2. Not all GPs bulk bill for cervical screening, which creates a cost barrier for what can be an extended consultation.
3. Provider characteristics are a key influence in women choosing to screen or even having access to screening. GPs generally do best with willing and motivated women, whereas under-screened or never-screened women are a key target for FPNSW and the LHDs’ women’s health or sexual health services. Innovative approaches are being used to reach these groups.
Interface with primary care

The NSW Pap Test Register sends out an information pack to new doctors and operates an information line. GPs can initially be trained in taking Pap smears during their registrar training. Upskilling training for GPs and nurses is funded by the Cancer Institute NSW and delivered by Family Planning NSW. Not all GPs receive base training or upskilling. There is no register of those who have had training.
The National Renewal (from 1 May 2017)

The Renewal represents a significant change to the NCSP. The recommendations are that:

- a new Cervical Screening Test for human papillomavirus (HPV) should be undertaken every five years and will replace Pap tests. The liquid-based sample will be collected via an examination with a speculum and subsequent cytology undertaken on the same sample if HPV is detected.
- the screening interval will increase to five-yearly.
- cervical screening should commence at 25 years of age and women should have an exit test between 70 and 74 years of age. This differs from the previous Pap test screening age range of 18–69 years.
- women with symptoms (including pain or bleeding) can have a cervical test at any age.

Specific issues related to the Renewal include:

- primary care providers are unclear about the Renewal changes and the messages they should be providing to women about HPV testing (known as the Cervical Screening Test). Systems are not yet in place to operationalise HPV testing as per the Renewal procedures, (e.g. guidelines are not yet publicly available for the Cervical Screening Test and processes are not in place for providing reports back to primary care providers on HPV samples).
- some stakeholders believe GPs may be declining Pap smear training opportunities because of the proposed introduction of HPV testing.
- some providers are concerned women may be delaying having a Pap smear and will wait instead for the HPV test.

“We need to make sure people know there is nothing wrong with what we are doing currently, but that because of technical changes, we can now do this differently and pick up risks earlier”

1. Based on stakeholder feedback.
### Appendix 3: Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPM</td>
<td>Australian Association of Practice Management</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service</td>
</tr>
<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AH&amp;MRC</td>
<td>Aboriginal Health &amp; Medical Research Council</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
</tr>
<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
</tr>
<tr>
<td>FOBT</td>
<td>Faecal occult blood test</td>
</tr>
<tr>
<td>FPNSW</td>
<td>Family Planning NSW</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HETI</td>
<td>Health Education and Training Institute</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of understanding</td>
</tr>
<tr>
<td>NBCSP</td>
<td>National Bowel Cancer Screening Program</td>
</tr>
<tr>
<td>NCSP</td>
<td>National Cervical Screening Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NPAAC</td>
<td>National Pathology Accreditation Advisory Council</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>PMS</td>
<td>Patient management system</td>
</tr>
<tr>
<td>PN</td>
<td>Practice nurse</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practice</td>
</tr>
<tr>
<td>SAS</td>
<td>Screening and Assessment Service</td>
</tr>
</tbody>
</table>