Cancer Research UK response to the UK National Screening Committee consultation: HPV as a primary screen for cervical cancer - November 2015

Summary
Cancer Research UK welcomes the opportunity to respond to this consultation. Cancer Research UK supports the adoption of human papillomavirus (HPV) testing as a primary screen within the cervical cancer screening programme. Introducing HPV primary testing would save more lives than the current liquid-based cytology. It is also a recommendation in the new cancer strategy for England, ‘Achieving World-Class Cancer Outcomes’, which both the NHS and the Government have committed to implementing.

Importantly, HPV as a primary screen is cost-saving once introduced, as a negative result gives longer lasting protection, meaning the standard interval between invitations can be extended (e.g. for women aged 25-49, from three years currently, to five years) which would reduce the number of screening rounds per participant across the screening period. Findings from the ARTISTIC trial showed up to an 18% reduction in annual screening-associated costs in unvaccinated cohorts and up to a 22% reduction for vaccinated cohorts, potentially saving tens of millions of pounds every year, depending on which screening strategy is adopted.

We acknowledge there are issues around IT and workforce (especially the cytology workforce) to overcome. However, the most important driver should be the prompt introduction of HPV primary testing to the programme, as this is in the best interest of both the finances of the NHS and more importantly, women’s health.

Pathway
Cancer Research UK advises that HPV negative women aged 25-49 are invited for screening every five years, as the Health Technology Assessment (HTA) cost-effectiveness analysis using real-life screening rates found this to be more cost-effective than invitation every six years and takes account of the time lag between screening invitation and attendance.

Cancer Research UK supports the rescreening of women identified as being at intermediate risk (i.e. HPV positive, but cytology negative) 12 months after their initial test, as the HTA review found this increased the effectiveness of HPV primary screening under all the scenarios considered.

Further information, including from the pilot, would be useful to establish the best possible pathways to manage intermediate risk women, particularly with regard to the impact of testing for specific high risk HPV types (HPV-16 and 18) and referring to colposcopy sooner for those women who test positive.

It will also be important to monitor compliance with early recall among this group of women in the screening programme and if necessary investigate ways to improve compliance and, ultimately, health outcomes.

Lastly, with women vaccinated in the catch-up cohort now reaching screening age, it will be important to gather information on cervical screening outcomes and impact among vaccinated women to ensure a good balance of harms and benefits, as well as cost-effectiveness, is maintained for this group.
Workforce and Infrastructure Issues
Workforce and issues with reconfiguring laboratory infrastructure will need to be addressed as a priority as part of the implementation. It is important to appreciate that extended uncertainty for cytology staff will generate instability in the workforce and may exacerbate capacity difficulties.

Managing declining demand for cytology services will need to take into account ongoing ambition to increase coverage and uptake. Efforts to increase awareness and uptake of cervical screening should be supported through ensuring there is capacity in the cytology workforce to meet this demand.

Detail on the test itself
There are a number of approved tests which may be used to test for HPV DNA. Whilst helpful that the National Screening Committee will provide a specification, findings from the recent formal appraisal in Wales may help, as will considerations around bulk purchasing balanced against local need.

IT system
We appreciate that the IT system must be fit for purpose, in order to make sure that women are being called and recalled appropriately, according to their test result and the correct interval.

However, we are concerned that timelines for procurement and piloting of a new system will unnecessarily delay the introduction of HPV as a primary screening test. It is frustrating that we have known for some years that the ‘IT systems which support cervical screening...are no longer fit for purpose’.vi

Commitment to and introduction of a fully-funded IT system must be included as part of the roll-out plans for HPV primary tests but should not delay its introduction.

As the pilot programme has managed to introduce HPV primary testing without an IT upgrade this could be used as an exemplar in the interim.

Finance
It should be noted that HPV as the primary screening test is cost-effective, and in absolute terms, will be cost-saving, due to the elongated interval for women who test HPV negative.

Roll-out Process and Timescale
The new cancer strategy for England stipulated that roll-out should commence by 2016 and full national coverage achieved by 2020.vii It is essential that roll-out is not stalled. We await information from the pilot to make a judgement on the detail of the roll-out, including whether this should be to all screening rounds, or take a more gradual approach.

Communications, Patient and Public Information
We understand that information has been produced for the pilot, and feel it would be important to have this reviewed and evaluated, ensuring that there is patient and public involvement and engagement during this process. Cancer Research UK would be happy to assist with this.
We would also like to note the information requirements for intermediate risk women as being of particular importance, with the need to carefully balance the need for women to comply with early recall against undue anxiety. We would also recommend that due consideration is given to safety-netting in the information provided, for example advising women experiencing symptoms to tell their GP without delay, rather than waiting for their recall appointment.

It is probable that there is low awareness of HPV and its role in cervical cancer as a sexually transmitted oncogenic virus. As yet unpublished results from the 2014 Cancer Awareness Measure show that recall of HPV as a cancer risk factor is 0.2% among women and recognition is 33.1%. We recommend that consideration is given to how to best improve awareness and understanding of this link, to enable informed participation in cervical screening without unintentionally increasing worry and concern.

Monitoring and data
A clear implementation plan, with timelines, should be made publically available in order to ensure full accountability of the screening programme. Data on coverage and uptake should be regularly published as part of the Public Health Outcomes Framework.

Cross-nation sharing
As the UK NSC provides advice to ministers and the NHS all 4 UK countries, it is important that learning is shared about implementation between the nations.

About us
Cancer Research UK is the world’s largest independent cancer charity dedicated to saving lives through research. The charity’s pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. In 2014/15, Cancer Research UK spent £434 million on research in institutes, hospitals and universities across the UK. The charity supports research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses. For more information, please contact Sara Bainbridge, Policy Manager, on 020 3469 6142 or sara.bainbridge@cancer.org.uk

---


iv Ibid.

v Ibid.

vi National Cancer Intelligence Network (2011) *An Intelligence Framework for Cancer*