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|  **National Screening Advisory Committee (NSAC)** **National Screening Unit (NSU)** |
| **Minutes Tuesday 13 October 2015** |
| Venue | Ministry of Health (MOH), Freyberg Building, 20 Aitken St, Wellington  |
| Start time | 10.00am |
| NSAC Members  | Professor Ross Lawrenson (Chair)Dr Jane O’Hallahan (Deputy Chair) Dr Carol AtmoreAssociate Professor Brian CoxProfessor Jackie Cumming (attendance item 7 only)Dr Bryn JonesAstrid Koornneef Professor John McMillan Dr Deborah Rowe Associate Professor Diana SarfatiDr Pat Tuohy  |
| Ministry of Health Attendees | **NSU National Cervical Screening Programme**Anne McNicholas Helen Colebrook. Programme ManagerDr Bronwyn Rendle Dr Gary Fentiman, Clinical Leader  **National Services Purchasing**  Stephanie Chapman, Project Director  |
| Other Attendees | **Item 7: Cancer Research Division,** **Cancer Council, New South Wales** Professor Karen Canfell, Director Dr Megan Smith  |
| Apologies | **NSAC members** John Forman, Dr Joanne Dixon, Dr Andrew Simpson  |

| **Item** | **Subject and summary** |
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| **1** | **Welcome, apologies and introductions** Ross Lawrenson welcomed the NSAC members, noting the addition of Professor Jackie Cumming to the Committee will bring expertise in health economics.  |
| **2** | **Declaration of Conflicts of Interest (COI)**COI register tabled with no additions. * The Chair advised members should declare any Ministry of Health contracted work held.
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| **3** | **Minutes of 13 July 2015** Confirmed as a true and accurate record, subject to the addition under other business of the information provided by Brian Cox regarding results from the:* randomised introduction of bowel screening using FOBT in Finland
* assessment of breast density in the Netherlands breast screening programme.
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| **4** |  **Actions from 13 July 2015 meeting***Terms of Reference (TOR)** Tabled: National Health Committee decision-making criteria, noting those around value for money and materiality (following discussion at previous meeting about where consideration of costs and value for money sit).
	+ Noted also that ethical considerations related to a policy decision are not specifically stated in the NHC criteria
* Tabled: full version of NSU Quality Framework principles: noting the third principle related to equity has additional text specifying incorporation of the Treaty of Waitangi principles and the need to meet the needs of under screened populations (following discussion at previous meeting as to whether the NSAC TOR, which are the same as the headline Quality Framework principles, sufficiently acknowledge Māori needs)
	+ Deb Rowe will discuss with the Māori Monitoring Equity Group (MMEG) whether the current NSAC TOR are appropriate, with the additional text from the full version of the NSU Quality Framework principles acknowledged through a meeting note.

*Website* * NSAC information will now sit on the NSU website, with links retained to previous NSAC statements and publications on the MOH website
* Tabled: NSAC membership details to be included on the website. Members will email required changes to the NSU.
* Noted: NSAC minutes will be posted on the NSU website.

*Newborn Metabolic Screening Programme (NMSP)* * Tabled: examples of recently produced information resources for parents including newborn blood spot testing.

**Action**: Deb Rowe to report back on MMEG’s views on the TOR principle related to equity. **Action**: NSAC members will email required changes in membership details to the NSU.  |
| **5** | **HPV testing for primary screening in the National Cervical Screening Programme (NCSP)**This meeting’s purpose is to provide NSAC the evidence for primary HPV screening prior to their consideration of recommendations at the next NSAC meeting.*HPV project update* * Phase 1 of the project, with high level policy development, is progressing towards NSAC consideration in November 2015.
* The NSU anticipates seeking Ministerial approval in December 2015 to progress planning for implementation of primary HPV screening.
* The project structure includes a steering group and a technical reference group (TRG):
	+ The TRG is a 15 member group including Maori and Pacific representation, as well as the fields of pathology, colposcopy, cytology, medical science and general practice.
	+ Eight workstreams sit under the TRG, including IT, Clinical Guidelines, Equity, Research and Evaluation, and Workforce.
	+ Public consultation is currently underway on primary HPV. Feedback will be provided at the next NSAC meeting.
* Noted: the recommendations from the 2015 Parliamentary Review Committee report on the NZ cervical screening programmes related to prioritising the introduction of primary HPV screening.
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| **6** | **Gary Fentiman summarised the proposal to introduce primary HPV screening.** * Potential benefits included decreases in cervical cancer and mortality, better detection of risk of precancerous cervical cell changes, providing an effective test for HPV vaccinated and unvaccinated women, increased screening intervals, less subjective interpretation of tests, NZ maintaining a programme consistent with international best practice, and potentially improved cost-effectiveness.
* Strategies considered by the effectiveness modelling and economic evaluation, particularly the optimal strategy (2a), that is:
	+ 5 yearly HPV screening in women aged 25-69 years with partial genotyping for HPV 16/18 and direct referral to colposcopy; and cytological triage of other oncogenic types and direct referral of cytology high grades in this group to colposcopy
* Consideration of strategy 2c (retaining cytology in the 20-29 age group) given emerging indication of possible higher incidence of screen detected cancers in the 20-24 year age group in the NZ setting.

Discussion included:*Screening women age 20-24 years* * International evidence is that the harms outweigh the benefits of screening women aged under 25 years, with no impact on cancer mortality; the WHO does not recommend screening in this age group.
* Most screening programmes in other countries already exclude this age group or are moving towards their exclusion.
* The incidence of screen detected cancers in the 20-24 year age group in the NZ setting may differ from international patterns.
* Further analyses of NZ data is required to inform consideration of screening changes for this age group.
* Noted that model does not simulate the NCSP but impact of a policy on a group of women born in 1997.

*Self- sampling** While there is potential to improve screening equity through offering self- sampling to under-screened populations, there are concerns this approach risks creating a second tier of health service if test quality does not match that for specimens collected by health professionals.
* Substantial work remains to evaluate options for self-sampling, with the NSU developing a research programme in this area
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| **7** | **Karen Canfell and Megan Smith summarised their effectiveness modelling and economic evaluation (videoconference). Areas covered included the:*** International evidence on primary HPV screening.
	+ Allows risk stratification based on the test results eg hrHPV 16/18.
* Vaccine impact on screening in Australia.
	+ 77% decrease in HPV prevalence in 18-24 year olds from 2005-7 to 2010-2011, in line with modelled predictions; and fall in cervical high grade precancerous abnormalities (CIN2/3).
* Renewal of National Cervical Screening Programme in Australia with 2017 transition from 2-yearly conventional cytology in women 18-20 to 69 years, to 5 yearly HPV screening in women 25-70 years.
	+ Decision underpinned by modelling which considered 132 screening algorithms to identify optimal strategy.
	+ 5 yearly screening with partial genotyping from age 25 is predicted to be both life year and (potentially) cost saving and is the most favourable approach for unvaccinated and cohorts offered vaccination
	+ Relative improvement in cervical cancer incidence and mortality compared to the current screening programme of at least 13-15%, and up to 22% if retain an end-age of 70 years.
	+ A large increase in colposcopies is not predicted because by 2017 women aged ≤ 36 years will have been offered vaccination in Australia.
* The Compass trial.
	+ Large scale RCT of five yearly HPV vs 2.5 yearly LBC screening in women 25-69 years in Victoria.
	+ PiIot recruited 5000 women; main trial commenced Jan 2015 & will recruit 121,000 women.
	+ Primary end point based on CIN3+ detection at five year exit testing.
	+ Objectives are to quantify HPV 16/18 prevalence rates by age compared to pre-vaccination measures; characterise colposcopy rates after transition to primary HPV screening; and assess screening round PPVs for CIN2+ and CIN3+ in HPV-screened women.
	+ Compass is running 2-3 years ahead of their programme renewal so will feed into safety monitoring.
	+ NZ study arm of Compass trial, using the Australian preferred screening strategy, is operating as a service evaluation project eg laboratory time and motion study. Recruitment complete (N=500).
* Effectiveness modelling and economic evaluation of primary HPV screening in New Zealand. The modelling objectives were to:
	+ Determine a set of possible strategies, ie clinical pathways, suitable to the NZ context.
	+ Evaluate life time effects (cancer incidence, mortality) resource utilisation (colposcopy referral) and cost effectiveness of each strategy.
	+ Identify optimal cervical screening strategy in the context of HPV vaccination, for NZ.

Model platform: dynamic model, extensively validated across multiple countries; incorporated NZ data with test characteristics consistent with systematic review and validated against NCSP data; evaluated 4 main strategies and 4 variants for each (16 strategies). The optimal strategy was 2a (primary HPV for 25-69 years). Compared to rates in the current programme: * cervical cancer incidence reduced 15% in unvaccinated and 12% in vaccinated
* cervical cancer mortality reduced 16% in unvaccinated and 12% in vaccinated
* colposcopy referrals increased 15% in unvaccinated and 1% in vaccinated.

Strategy 2c: LBC for 20-29 years with HPV for 30+ years (as for 2a) was also discussed in light of indications of possible higher NZ incidence of screen detected cancers in the 20-24 year age group. Compared to rates in current programme: * cervical cancer incidence reduced 2% in unvaccinated and 0.3% in vaccinated
* cervical cancer mortality reduced 2% in unvaccinated and 0.3% in vaccinated
* colposcopy referrals increased 1% in unvaccinated and reduced 7% in vaccinated.

Discussion included: * Possible reasons for the size of difference in effect between 2a and 2c, given HPV screening occurs in the 30+ age group in both strategies.
	+ Explanation included the model reflecting international evidence i.e. a very small impact on outcomes from screening in those < 25 years; and the jump in incidence seen in the late 20s /early 30s (hence most European countries start screening at 30 years).
* Consideration of transition for the 20-24 year age group, with LBC retained for this age group until further data analyses is available and also until higher HPV vaccination coverage is reached
	+ It was suggested that the NSW team could undertake re-modelling with NZ specific data factored in for 20-24 age group.
	+ However, re-modelling will likely provide effectiveness measures similar to 2a (as in this model very early screens have no effect); but there will be an increase in colposcopies.
* Inclusion of 70-74 year age group. Australian modelling demonstrated discharge from programme when aged in the 70s had better outcomes, although it was more cost effective when aged in the late 60s. The Australian programme recommends an exit test between 70-74 years given the 5% mortality decrease compared to stopping at 65; and they judged that the screening programme had to be there for older women.
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| **8**  | **National Cervical Screening Programme: changing the Primary Laboratory Test 2015 - Public Consultation Paper**NSAC comments: *Question 1. Other pathway options NCSP should consider?* Investigate continuing LBC for 20-24 year age group (as per current programme) with primary HPV screening from age 25 years. * Consider running effectiveness modelling with this approach, and include NZ incidence and mortality data so have confidence with the model in terms of raising the screening starting age to 25 years.
* Public feedback is also likely to suggest re-consideration for this age group, also noting the risk of adverse publicity if screening is not offered to 20-24 year olds and a rare case of cervical cancer death occurs in this age group (recent media coverage of such cases has occurred in the UK).
* Consideration of harms of colposcopy in 20-24 age group is also required eg over-treatment, evidence of increased risk of premature births, anxiety of repeated recalls.
* Clear outline of harms vs benefits by age, especially 20-24 year age group would be useful.

Consideration could be given to reviewing how the model manages different age cohorts given there are intergenerational differences in risk, ie, look at modelling different generations versus modelling just the 1997 cohort. * However, it was also noted that the vaccinated and unvaccinated groups do provide different age ranges, so changing this approach will likely not change the results.

The NSU noted that it had already requested some additional modelling for Maori; and also cancer stage and incidence by five year age groups. *Question 2. Further research suggested?* * Investigation of reasons for low vaccination coverage and the extent of associations with parental attitudes eg not supporting vaccination as child not yet sexually active.
* Consider increasing the framing of vaccine as anti-cancer versus anti-HPV infection to reduce negative associations with STIs.
* Emerging evidence was noted of vaccine benefit in older age groups if HPV negative, with a request that the immunisation team consider modelling this scenario.
* Consideration of information needs and interaction between health professional and patient regarding meaning of a positive hrHPV test

*Question 3. Are there higher risk groups who require a shorter screening interval than 5 yearly?* * Yes: immune-deficient or immunocompromised groups, noting such groups would be covered in the clinical guidelines as per current practice
* Consideration should also be given to socially vulnerable groups, eg those who have suffered child abuse or have had a background of Child Youth and Family Services care, with increased risk of early sexual debut and infection with HPV at a young age. Such groups could be covered by the clinical guidelines.
* Given variation in genotype prevalence in different countries, eg HPV52 is more common in Asia, consideration of different LBC triage pathways for some immigrant populations may be warranted.

*Question 4. Exit test between ages 69-74?** Worth considering given increases in length of life, and also the Australian programme modelling demonstrates a 5% reduction in mortality with age range extension to 70-74 years.

*Question 5. Temporary increase in colposcopy numbers manageable?** Noted that colposcopy numbers will increase 15% in unvaccinated women during the first screening round, as prevalent cases are detected. These figures would drop on the second round, and with increasing immunisation coverage.
* NZ is already seeing a drop in age groups eligible for HPV vaccination.
* Exit test at age 69-74 years is unlikely to affect volumes.
* Issue is not lack of workforce, but how best to organise current workforce.

*Question 6. Suggested strategies for eliminating inequalities in screening** Inequities occur in all areas of the screening pathway, not just coverage eg colposcopy timing.
* Cost of visit to primary care for a smear may be mitigated in the future by self- sampling (once method is validated).
* Equity in provision of smears for disabled women is important with reports that health professionals see them as asexual.

*Question 7. Issues related to self-sampling?* * Self-sampling in on the horizon and is potentially good for the programme once the test has been shown to be reliable, as it reduces costs and will likely improve acceptability.
* As well as a vaginal sample, self-sampling includes options for urine collection eg the Fast HPV Voch trial currently underway overseas.
* It is important that all modalities are of an equivalent standard, with concerns that a two tier system will develop if a less reliable test is introduced for groups currently under-screened eg Māori.
* It was noted that the current programme must maintain expectations of reducing inequity.

*Question 8. Approaches for invite and recall of women* * GPs currently send first invite and NCSP register sends reminder at three months where invite fails (for those already on the NCSP register). Given 95% of population is registered with a GP this approach is generally successful.
* However, barriers exist as there is lack of information available to Independent Service Providers (ISPs) on women who are not screened, and ISPs have limited ability to refer these women to another provider if needs be.
* Noted that the smear taker is recorded on the register so there is potential to review CIN rates in the “outreach” groups and compare rates of CIN in smears taken by GPs.
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| **9** | **Other business** Meeting dates proposed for 2016 * Wed 16 March
* Wed 6 July
* Wed 16 November
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|  | The meeting closed at 4.00pm. |