SUMMARY NOTE

Present

Members
Professor Henry Kitchener (Gynaecologist, Manchester; Chair)
Ms Frankie Brown (Practice Nurse, Aylesbury)
Dr Laurence Brown (Consultant Pathologist, Leicester)
Mr Geoff Curran (Biomedical Scientist, Royal London Hospital)
Dr Karin Denton (Consultant Pathologist, Bristol)
Ms Kay Ellis (Cytologist, Sheffield)
Dr Shaun Firth (GP, Essex)
Ms Paula Lloyd-Knight (Patient Experience - National Cancer Action Team)
Professor Sue Moss (Centre for Cancer Prevention)
Mr Robert Music (Director, Jo’s Cervical Cancer Trust)
Professor Julietta Patnick (Director, NHS Cancer Screening Programmes)
Professor Amanda Ramirez (King’s Health Partnership)
Ms Janet Rimmer (NHS Cancer Screening Programmes)
Professor Peter Sasieni (Epidemiologist, Wolfson Institute)
Dr Christopher Sonnex (Consultant in Genitourinary Medicine, Cambridge)
Dr Jane Woyka (GP, Middlesex)
Mr Richard Winder (Deputy Director, NHS Cancer Screening Programmes)

Observers
Mr Bryan Rose (Welsh Assembly)
Dr Margaret Boyle (Northern Ireland)
Ms Isabel Zaman (Scottish Executive – by telephone)

Department of Health
Mr Stephen Atkinson (Cancer Policy Team)
Mr Tim Elliott (Cancer Policy Team)

Apologies
Dr Rosemary Fox (Welsh Assembly)
Mrs Moira Morris (Lay Person, Bromsgrove)
Professor Catti Moss (GP, Northants)
Mr Mahmood Shafi (Gynaecologist, Cambridge)
Ms Susan Vryenhoef (Cytologist, Nottingham)
1. Welcome and apologies for absence
   1.1 Committee members were welcomed to the meeting and apologies were read out as above.

2. Minutes of the last meeting held on 21st June 2012 and matters arising
   2.1 It was agreed that the HPV TaPS group should be asked to look into whether stratified mucinous intraepithelial (SMILE) lesions and cervical glandular intraepithelial neoplasia (CGIN) lesions should be included in the test of cure protocol.

3. Update on NHS Cancer Screening Programmes into Public Health England (PHE) and the future of the ACCS
   3.1 From April 2013, the NHS Commissioning Board (NHS CB) would be responsible for the routine commissioning of cancer screening programmes and dedicated PHE staff would be embedded within the NHS CB to support this process. Cervical screening would be commissioned to a detailed specification developed by PHE and agreed between DH and the NHS CB.
   3.2 The national screening programme co-ordinating team and all the Quality Assurance Reference Centres would become part of PHE. PHE would be responsible for the piloting and roll-out of new or extended screening programmes up to a point mutually agreed with the NHS CB at which they became part of routine specification. The DH would retain overall policy responsibility for cancer screening.
   3.3 The secretariat of the cancer screening committees, including ACCS, and the UK National Screening Committee would move to PHE from 1st April 2013, but that the DH would still have input on membership, agendas, minutes etc.

4. HPV issues:
   4.1 The following points were made:
      - The group voted in favour of including women aged 25 to 34 in the HPV TaPS pilots. This followed a detailed discussion of the concerns about high levels of HPV in women in this age range, the possibility of overtreatment and the possible impact on cytology clinics. Despite these concerns the majority of the group felt a pilot would be the best place to test out these issues.
      - Roll-out of HPV triage and HPV test of cure had been completed in all areas with the exception of South East London and a couple of areas in the West Midlands.
      - Professor David Salisbury (DH Director of Immunisation) had reminded the service that it was “vital” to ensure that details of the vaccination of young women are added to their future cervical screening records on the NHAIS (Exeter) System. A working group had also been established to look at the issue linkage of screening and vaccination data in the service.
5. Consultation on revised NHSCSP information materials
5.1 The consultation on the process to develop a new process for developing materials for the screening programmes had now been completed. The consultation, which had involved over 1000 responses from the public and professionals, had heard strong support for the ‘Consider An Offer’ approach, now being taken forward. The consultation found that people wanted: an invitation; to understand why they were receiving the invitation; information on the harms and benefits of screening; information on the process of screening; and for their ‘choice’ about participating to be clear. There was also much enthusiasm for user involvement and developing a tailored approach to different age groups, ethnic groups etc. The consultation findings had gone to the Cancer Screening Information Expert Panel.

6. UK National Screening Committee (NSC) consultation on recommendation to raise age of first invitation for screening to 25 in Scotland and Wales
6.1 The UK NSC had discussed the outcome of its consultation at its meeting on 13 November and it was expected that a final decision would be announced in December 2012.

7. Update on a potential new cervical screening IT system
7.1 Discussions were being held with Connecting for Health on the possibility of the EXETER system being used for the cervical screening programme. The future requirements of the IT system had also been flagged up to PHE and the NHS CB.

8. Action to tackle the falling participation of younger women aged 25 to 35, including an update on the STRATEGIC trial
8.1 Phase 1 of the STRATEGIC trial was underway and had begun piloting interventions.

9. Statistical reports, including the annual ONS/IC statistical bulletin and a paper on coverage over time
9.1 The 2011-12 Cervical Screening report had been published on 18 October by the Information Centre. The report appeared to indicate that around half of the additional women who had attended a screening appointment as part of the ‘Jade Goodey effect’ in 2009 had returned to be screened.
9.2 A paper on variations in coverage by age over time showed that coverage remained at about 82% or over between 1995 and 2000. After 2000, the rate drifted slowly back down to about 79% in 2008, and since it has risen slightly and fallen back again.

10. Updates:
10.1 The following points were made:
- Work was underway to ensure women received their first invitation at 24.5 years of age, as agreed by the ACCS.
- A focus group to test the idea of HIV discussions at cytology appointments was in the process of being established.
• As at the end of October 2012, 99.1% of women were receiving their results within 14 days, the highest monthly figure yet
• A paper on the protective value of a woman’s final screening appointment would shortly be published
• The Cancer Does Not Discriminate initiative had been working to raise awareness of the signs and symptoms of common cancers and to dispel myths around the disease and aspects of the service, such as cancer screening. Awareness activity had taken place with community groups in Leeds, Leicester, Nottingham and Birmingham. The final report on the campaign was anticipated in January 2013
• There was some delay in getting data for the audit of invasive cervical cancers.

11. Any other business
11.1 No further business was arising.

12. Date of Next Meeting – to be arranged
12.1 The Secretariat would advise committee members of the next meeting date in due course.

ACCS Secretariat December 2012