UK National Screening Committee (UK NSC)

Note of the meeting held on the 28 February 2018

at

Park Plaza London

This meeting provided recommendation on the following conditions;

- Biotinidase deficiency in newborns
- Elevated blood lead levels in children aged 1-5 years
- Chlamydia in pregnancy
- Thyroid dysfunction in adults

Members

Professor Bob Steele	Chair
Claire Bailey	Lead Clinical Nurse Specialist in breast screening, SW London
Professor Roger Brownsword (TC)	School of Law, Kings College London
Professor Alan Cameron (TC)	Consultant Obstetrician at Southern General Hospital, Glasgow
Dr Paul Cross (TC)	Consultant Cellular Pathologist, Queen Elizabeth Hospital Gateshead Health NHS Foundation Trust

Ms Eleanor Cozens	Patient and Public Voice (PPV)
Professor Gareth Evans	Consultant in Genetics Medicine, St Mary's Hospital, Manchester
Jane Fisher	Patient and Public Voice (PPV)
Professor Alastair Gray	Director at the Health Economics Research Centre, Nuffield Department of Population Health and Professor of Health Economics at the University of Oxford
Ms Hilary Goodman	Operational Manager of Antenatal Services/Screening at Hampshire Hospitals Foundation Trust
Professor Chris Hyde	Public Health Specialist, University of Exeter
Dr Anne- Marie Slowther	Reader in Ethics, University of Warwick
Dr Graham Shortland	Consultant Paediatrician, Cardiff and Vale University Health Board, Noah's Ark Children's Hospital for Wales and Executive Medical Director, Cardiff and Vale University Health Board, University Hospital for Wales

Observers;

Ms Natasha Alleyne	Department of Health Screening Team, Emergency Preparedness and Health Protection Policy Global and Public Health Group
Dr Hilary Angwin	Chair of Fetal Maternal and Child Health Group (FMCH)
Dr Carol Beattie (TC)	Senior Medical Officer, Northern Ireland

Dr David Elliman	Clinical lead for Newborn Infant Physical Examination and Newborn Blood Spot, PHE
Dr Ros Given – Wilson	Chair of the Adult Reference Group (ARG)
Dr Nick Hicks (TC)	National Co-ordinating Centre for HTA
Dr Sharon Hillier	Director of Screening Division, Public Health Wales
Charles O'Hanlon	National Screening Service, Republic of Ireland
Dr Heather Payne	Senior Medical Officer for Maternal and Child Health, Welsh Government
Dr Sue Payne (TC)	Scottish Government

Secretariat

Professor Anne Mackie	Director of Programmes - UK National Screening Committee
Zeenat Mauthoor	Secretariat
Mr John Marshall	UK NSC Evidence Lead
Dr Cristina Visintin	UK NSC Senior Evidence Review Manager
Paula Coles	Senior Information Scientist
Mrs Jo Harcombe (TC)	National Lead for Stakeholder Information and Profession Education and Training

Elizabeth Andrade	Secretariat Support Officer

Presenters

Professor Richard Martin	University of Bristol
Professor Jenny Donovan	University of Bristol
Professor Freddie Hamdy	University of Oxford
Dr Matejka Rebolj	Queen Mary University

Apologies

Ms Christine Cook	NHS England
Dr Hilary Dobson	Consultant Radiologist and Deputy Director of the Innovative Healthcare Delivery Programme, University of Edinburgh
Professor Stephen Duffy	Director of the Policy Research Unit in Cancer Awareness, Screening and Early diagnosis and Professor of Cancer Screening, Centre for Cancer Prevention, Wolfson Institute of Preventive Medicine
Dr Greg Irving	GP
Dr John Holden	Joint Head of Medical Division, Medical and Dental Defence Union of Scotland
Ms Sarah Manson	Scottish Government
Mrs Margaret Ann Powell	Patient and Public Voice

Dr Ailsa Wight	Deputy Director Emergency Preparedness and Health Protection, Department of Health

Welcome and Introductions

1. Professor Steele welcomed all to the meeting. A round of introductions was initiated for newly appointed members, Dr Anne- Marie Slowther and Claire Bailey who fulfil the role of ethicist and nurse on the UK NSC.
2. The Chair asked members to provide an update on any new declarations of interest which may be relevant to this meeting. No conflicts were raised.

   Apologies were noted.

Minutes and Matters arising

3. The minutes of the October 2017 meeting were confirmed as a true and accurate record and would be uploaded as final on the webpage.

   Seven action points were identified from the October meeting;

   (action3a) Directors Update- SCID

   Chair's Action to be appended to Minutes of the meeting as the consultation on SCID closes after the UK NSC meets- *Completed and is available on the website*

   (action3b) Directors Update- Update on Screening for Iron Deficiency anaemia in children under five years of age

Recommendation on screening for Iron Deficiency anaemia in children under five years of age to be appended to minutes – *Completed. This was not recommended, papers are available on the webpage.*

(action 3c) Informed Choice

UK NSC members wishing to attend the presentation of the HTA report to contact Zeenat Mauthoor – *The HTA Presentation was held on the 7 February*

(action 3 d-). Presentation on Bowel Optimisation report

The confidential report to be shared with ARG and for the UK NSC Secretariat to draft a paper to support a public consultation. This would be shared with members for their comments before the document was shared more publically – *The UK NSC is now publicly consulting on this. Consultation closes on the 7 April*

3f. Ethics Task Group Update

Ethics report to be added to the UK NSC February agenda- as the group have only met once it was agreed that an update should be given at the June meeting instead once the group had something more substantial to present. John M informed the Committee that the ethical considerations of reflex testing would be discussed at its upcoming March meeting.

4a. Screening for CMV

The UK NSC Secretariat to arrange meetings with necessary stakeholders about taking research forwards and signposting where necessary – The secretariat had met with a stakeholder and are preparing a workshop, later this year focusing on research.

4b-c. Screening for Human T- Cell Lymphotropic Virus (HTLV) in pregnancy

The UK NSC Secretariat to contact the NCHR and

The UK NSC Secretariat to do an evidence map before undertaking another regular review of the condition- *This was ongoing*

***Director's* Update**

Prof Mackie gave an update on the following

Update on Screening for Severe Combined Immunodeficiency (SCID)

3.1 Following the October UK NSC meeting, a positive recommendation was made by the Committee supporting a practical evaluation of SCID using PCR to be undertaken in the NHS before a final recommendation is made. The UK NSC was informed that a ministerial decision is now awaited.

Update on Bowel optimisation

3.2 The UK NSC opened up public consultation on bowel optimisation on the 7 January. Consultation will close on the 7 April. It is expected that a recommendation will be made at the June meeting.

Annual call for topics

3.3 The UK NSC ran a call for new screening topic proposals between 6 September and 6 December 2017. The campaign received the following four submissions; the outcome of each submission was agreed and noted by the UK NSC

i. Screening proposal for early Keratoconus

The proposal is to test for early keratoconus in children and young adults with Down's syndrome.

It was agreed that this proposal falls outside the UK NSC's remit of whole population screening programmes.

ii. Screening proposal for increased risk of stroke in children aged 2-16 with sickle cell disease (SCD)

The proposal is to diagnose those children with SCD who are at a higher risk of stroke and to offer early intervention

The Evaluation group agreed that this was outside the remit of the UK NSC but acknowledged that it was part of the existing care pathway for children diagnosed with SCD.

iii. Screening proposal for Auditory Neuropathy Spectrum Disorder (ANSD) as an extension to the current Newborn Hearing Screening Programme (NHSP)

The proposal is for an additional hearing condition to be added to the existing screening programme.

It was agreed that although this was not a new topic it was a programme modification as described by the evidence review process and so would be handled in the prescribed manner

iv. Screening proposal for endometrial cancer

Although this is a new topic the evidence available does not support population screening

Prostate Screening

3.4 The Committee acknowledged the renewed interest in prostate cancer following recent media stories of various high profile personalities having recently been diagnosed with prostate cancer. Prostate screening is not a recommended population screening programme in the UK however the Prostate Cancer Risk Management Programme (PCRMP) was established to ensure that men considering a PSA test are given information concerning the benefits, limitations and risks associated with having a test. Prof Mackie informed the Committee that it is keeping abreast of the developments in prostate cancer, including the upcoming publication of the CAP trial as well as a proposal to run a scoping workshop later in the year ahead of the upcoming review.

Action 3b: Members of the UK NSC to email Zeenat M to express an interest in the prostate workshop

Lung cancer

3.5 Prof Mackie informed the Committee of the ongoing interest in lung cancer with proposals to offer testing to high risk individuals, such as the Manchester initiative recently announced by NHS England. The UK NSC continues to keep abreast of research and developments in this area.

Action 3c: Prof Mackie to keep the UK NSC up to date with developments in the area

Informed Choice

3.6 This Task and Finish group was brought together to address recommendations following the Science and Technology Committee's Health Inquiry; to come to an agreed definition of 'informed choice' and to develop a mechanism by which to share best practice in screening information provision across all programmes in the UK.

3.7 Following the public consultation Ms Fisher informed the UK NSC that a significant change was made to the report which uses the word "personal" when defining informed choice. The reason for this, and supported by the group, was that the previous term of "personalised" may be misinterpreted as being tailored to the individual rather than reflecting the autonomy of the individual. The Chair acknowledged and thanked the group for all their hard work to develop best practice guidance for all to use and looked forward to future screening information being better aligned with this. The UK NSC approved the final documentation and for its publication on the website.

Action 3d: Secretariat to discuss and confirm the working arrangement for the guidance database with the four countries

Presentation of CAP study

3.7 The confidential presentation following the CAP study was provided by Profs Martin, Donovan and Hamdy.

Fetal Maternal and Child Health Screening

FMCH Report

4. Dr Angwin summarised the discussions and outcomes from the January FMCH meeting.

4.1 Reflex testing was discussed at length with the group agreeing it should be ethically evaluated by the ethics group at its upcoming meeting in March with a view to be brought to the June UK NSC meeting for further discussion.

4.2 The Chair informed the UK NSC that this would be Dr Angwin's last Committee meeting, having successfully been appointed as the National lead for Screening Quality Assurance Service. The Chair and the Committee thanked Dr Angwin for all her hard work and support and wished her the best in her new role.

4.3 The Chair confirmed that an expression of interest would be circulated amongst the four countries in the coming weeks to provide suitable nominees for the independent role of Chair of FMCH.

Infectious Disease in Pregnancy Screening Programme- Triage review

4.4 The UK NSC undertook a triage review within the infectious disease in pregnancy screening programme (IPDS) to see whether there was any published peer-reviewed evidence which suggests that screening for HIV, Hepatitis B or Syphilis should be stopped or that screening causes harm.

4.5 The triage process follows the 'red flag' mechanism to see if further work is needed following three questions being examined: Is there evidence about:

- screening programme cessation
- the harms of screening for the condition in question

- the balance of harms and benefits of screening for the condition in question

4.6 This process was previously used in the 2017 triage review process for the five blood spot conditions; PKU (phenylketonuria), CHT (congenital hypothyroidism), MCADD (medium chain acyl-CoA dehydrogenase deficiency), Sickle Cell Disease and CF (cystic fibrosis).

4.7 The triage reports for IPDS found that there was no evidence to suggest that screening should be stopped. Following a public consultation comments were supportive of the recommendation for screening for IPDS to continue. The UK NSC noted that there was a suggestion that Hepatitis C be added to the existing screening programme. Mr Marshall informed the Committee that the review of evidence for Hepatitis C would be looked at this year as part of the three-yearly cycle.

4.8 The UK NSC was informed that before further reviews was undertaken on the evidence which underpinned existing screening programmes, the triage review process would be evaluated. The outcomes of the evaluation would then be reported to the reference groups and to the UK NSC to ratify its use wider.

Action 4a: Secretariat to evaluate the triage process before proceeding to review the evidence for the remaining screening programmes

Screening for Biotinidase deficiency in newborns

4.9 Biotinidase deficiency is an inherited disorder which leaves the body unable to recycle the vitamin biotin. This vitamin is needed to help keep skin, liver the nervous system as well as hair and eyes healthy. Ms Coles explained to the Committee that there are two forms of Biotinidase deficiency;

i. Profound- where the deficiency means the body works at less than 10% of its normal level. Without treatment this can cause problems with the nervous system, affecting vision and hearing loss as well as seizures.

ii. Partial- being a milder form where the deficiency means that the body works at 10%-30% of the normal level. Without treatment children may be prone to infection, suffer skin rashes and hair loss

4.10 Treatment for this condition involves taking biotin supplements throughout life. This form of treatment is highly effective with no known side effects.

4.11 The UK NSC last reviewed screening for Biotinidase deficiency in 2012 screening was not recommended.

4.12 The 2017 review looked at four key questions based on the areas of uncertainty identified from the previous review. These were;

- what is the prevalence of Biotinidase deficiency in the UK
- what is the natural history of profound and partial Biotinidase deficiency
- whether a screening test cut off has been identified
- what the treatment outcome is for people with either type of Biotinidase deficiency

4.13 The review found that there was no new evidence that would justify a change in the current recommendation not to screen. This was because the prevalence of the condition remains unknown in the UK and that international comparisons varied considerably. Additionally treatment for the condition is straightforward with all cases detected being treated immediately with biotin. This means that from a screening

perspective we do not know which cases can be left not requiring treatment and which ones do need treatment, nor is the optimal treatment period clear.

4.14 The review document was sent to 12 stakeholders directly from whom two comments were received. The UK NSC's attention was drawn to the paper highlighted by Genetic Alliance UK which had been excluded. Ms Coles informed the Committee that although this paper had been highlighted during the consultation, the paper was not considered for inclusion in the current review since its publication fell outside the period covered by the literature search. Ms Coles confirmed that pending its relevance to the key questions, the paper may be considered for inclusion in the next evidence review

4.15 The UK NSC supported the recommendation that a whole population screening programme for Biotinidase deficiency in newborns should not recommended

	Criteria	Met / Not met
The condition		
1	The condition should be an important health problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the association between the risk or disease marker and serious or treatable disease.	There is still no UK incidence/prevalence data available
The Test		
4	There should be a simple, safe, precise and validated screening test.	The optimal threshold is not known and this is different to the current blood spots that are screened for as Biotinidase is an enzyme deficiency

The intervention		
9	There should be an effective intervention for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to wider benefits of screening, for example those relating to family members, should be taken into account where available. However, where there is no prospect of benefit for the individual screened then the screening programme should not be further considered.	As most children are treated at diagnosis, RCTs or comparative studies comparing treated and untreated populations are not available

Screening for Elevated Blood Lead Levels in Children aged 1- 5 years

4.16 Small consumptions of lead over time can build up and cause health problems in young children whose growing bones and organs absorb lead more than adults. In today's society the risk of lead poisoning is very low as there have been systematic efforts to remove lead from everyday items, such as in paint, petrol and food containers. However this does not mean that there is no exposure at all with some buildings still having lead pipes.

4.17 The UK NSC last reviewed the evidence for elevated blood lead levels in 2012 and concluded that screening should not be recommended. The reasons included; that the prevalence of the condition was low, there were various ways to stop children from having elevated blood lead levels, that the test considered at the time missed a lot of children (false negatives) and that there was no threshold to indicate what a safe blood lead level was.

4.18 The review aimed to address the uncertainties from the previous review. However the 2018 review found that there was no new evidence to address the concerns related to; prevalence, the screen test and how well treatment works in children identified through screening.

4.19 The review was sent to five stakeholder organisations and six comments were received. The overall comments echoed concern over the effects of elevated blood lead levels in children but acknowledged that there was a lack of data to understand how common this condition is in the UK.

4.20 The Committee queried whether venous blood sampling could be an acceptable population screen test in the UK as suggested in the consultation and whether this had been considered. Ms Coles clarified to the Committee that this had been looked into. The venous blood test as used in the US is not used as a population screen test but is offered as a targeted test for high risk children. The Centers for Disease Control and Prevention (CDC) emphasised that the use of the venous test as a whole population screen test may not be comparable to that of targeted testing. The Committee noted the feedback and concluded that the test was not a suitable for use in a national screening programme.

4.21 The UK NSC expressed support that the recommendation for a systematic population screening programme for elevated blood levels in children aged 1-5 years is not recommended.

	Criteria	Met / Not met
The condition		
1	The condition should be an important health problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the	There is still no UK incidence/prevalence data available

	association between the risk or disease marker and serious or treatable disease.	
The Test		
4	There should be a simple, safe, precise and validated screening test.	Venous testing has not been used as a population screen test
The intervention		
9	There should be an effective intervention for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to wider benefits of screening, for example those relating to family members, should be taken into account where available. However, where there is no prospect of benefit for the individual screened then the screening programme should not be further considered.	No studies were identified that assessed interventions for reducing levels of blood lead in lead-exposed children

Screening for Chlamydia in Pregnancy

4.22 Chlamydia is one of the most common sexually transmitted infections (STI) in the UK often not presenting with any symptoms and can so go undetected. Dr Visintin explained to the Committee that it is unclear, so far, what effects an untreated chlamydia infection has on pregnant women or on pregnancy and baby outcomes. However, there are some reports that the infection may be the cause of premature rupture of membranes and chorioamnionitis (an intrauterine infection within the womb). If not treated before birth, the infection can be transmitted to newborns

during vaginal birth. In neonates it is difficult to estimate the burden of infection because infected infants are usually asymptomatic. However some babies may present with symptoms such as, conjunctivitis (an infection of the eyes) and respiratory infections. In this case, the baby can usually be treated successfully with antibiotics.

4.23 The UK NSC last reviewed screening for Chlamydia in pregnancy in 2011 and recommended that screening should not be offered. At the time there was conflicting evidence that chlamydia infection has an effect on pregnancy outcomes.

4.25 The 2017 review looked at five key questions focussing on the; test, consequences of chlamydia infection in pregnancy and the harms of antibiotics in the unborn baby. One of the key questions (What is the impact of untreated chlamydia infection, during pregnancy, on pregnancy outcomes in the UK?) was undertaken as a systematic review. The reason for this was that the previous review had reported that there was conflicting evidence on a range of pregnancy outcomes which made it difficult to evaluate the impact of the infection. A systematic review process was used to try to more accurately gauge the impact of the infection across a range of outcomes, which included; pre-term birth, premature ruptures of membranes, low birth weight, pre-eclampsia, miscarriage, re-infection rates and stillbirth and neonatal death. The review found that there was conflicting evidence from the RCTs and prospective comparative studies included in this review that untreated chlamydia results in poorer outcomes for pregnant women, with results reported for the same outcome by two or more studies often contradictory. Moreover, the volume of the evidence was very limited, and a meta-analysis was not considered possible by the reviewers. Again the Committee noted that more research is needed in this area to clarify if the infection has any effects on pregnancy outcomes.

4.26 The UK NSC acknowledged the four submitted consultation comments which agreed with the review's findings and reaffirmed the recommendation that a systematic

population screening programme for chlamydia in pregnancy should not be recommended

4.27 There was a discussion about the recent review undertaken by the United States Preventive Services Task Force (USPSTF). Dr Visintin informed the Committee that the USPSTF review looked at the effectiveness of screening women up to 25 years of age for gonorrhoea and chlamydia in reducing maternal complications and improving newborn outcomes. However the review found no new studies since its previous review which was undertaken in 2001

	Criteria	Met / Not met
The Test		
1	The condition should be an important health problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the association between the risk or disease marker and serious or treatable disease.	No new evidence was presented which looked at the burden of disease in the UK
The intervention		
9	There should be an effective intervention for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to wider benefits of screening, for example those relating to family members, should be taken into account where available. However, where there is no prospect of benefit for the individual screened then the screening programme shouldn't be further considered	No new evidence
The screening programme		
11	There should be evidence from high quality randomised controlled trials that the screening programme is effective in reducing mortality or	No new evidence

	morbidity. Where screening is aimed solely at providing information to allow the person being screened to make an "informed choice" (such as Down's syndrome or cystic fibrosis carrier screening), there must be evidence from high quality trials that the test accurately measures risk. The information that is provided about the test and its outcome must be of value and readily understood by the individual being screened.	

Adult Screening

Adult Reference Group

5. Dr Ros Given-Wilson, Chair of the ARG, summarised the discussions at the January meeting. A public consultation on screening for Chronic Obstructive Pulmonary Disease (COPD) would open in March. Information on this would be made available at; https://legacyscreening.phe.org.uk/copd

HPV modelling work

5.1 Mr Marshall reminded the Committee that in 2016 the UK NSC made a recommendation which was supported by the Minister, that HPV would become the primary screening test in the cervical screening programme, replacing liquid based cytology.

5.2 HPV is the cause of cervical cancer and the course of the disease from infection to cancer is now better elucidated. Since then discussions have focussed on what the screening intervals should be, with experts suggesting that the current three years intervals for women 25-64 could be extended.

5.3 The following were proposed by the Advisory Committee on Cervical Cancer (ACCS) for a major modification to the programme:

- HPV negative women to have a screening interval of five years
- HPV positive and cytology negative women to have a 12 month surveillance interval
- Consideration of whether detecting some higher risk sub types of HPV ("genotyping") should be used to guide colposcopy referrals in the surveillance pathway

5.4 Mr Marshall explained to the Committee that a modelling exercise had been commissioned by the Cervical Screening Programme. This had been undertaken by a team within PHE and had reported in 2015. As there was no primary research evidence on extended screening intervals the UK NSC commissioned a review of published cost effectiveness models to provide context for the PHE work.

5.5 The UK NSC discussed the findings of the update and the Bains model. The work suggested that extending the intervals to five years would lead to a:

- decrease in the number of screening tests and no change in the number of colposcopies
- increase in the number of cases of CIN2+ and a decrease in disease
- reduction of £35million per year in health related costs

5.6 The Committee noted that there was uncertainty around the QALY gain/loss

5.7 Mr Marshall informed the Committee that the direction of the estimates provided by the Bains model were replicated other modelling exercises.

5.8 In regards to genotyping and the interval proposals, Mr Marshall invited Dr Matejka Rebolj to present her confidential report to the UK NSC, using data from the English pilot HPV sites.

5.9 The Chair thanked Dr Rebolj for her presentation and confirmed to the UK NSC members that a public consultation would be opened on a recommendation to introduce a national five year screening interval combined with a 12 month surveillance interval based on the Bains model and the modelling overview paper. The draft document would be shared with the committee prior to public consultation.

Screening for Thyroid Dysfunction

5.10 The thyroid gland produces a hormone called thyroxine which has a role in regulating the metabolism. If thyroid dysfunction occurs people may have an increased risk of developing heart disease, decreasing bone density or having a stroke.

5.11 Prof Mackie informed the Committee that a review of the evidence to screen for Thyroid dysfunction was done in 2013 with a recommendation that screening should not be offered. The Committee noted that the reasons for this were; there was a lack of agreement on what the normal range for the hormone level should be, how long treatment should be offered, some people return to normal levels without treatment and the harms of the treatments.

5.12 The 2018 review looked at three key questions; what the proportion of people who have the disease revert back to a normal without treatment, what the agreed blood test result would be for those who should and shouldn't have treatment and how effective treatment is and what the side effects are.

5.13 The review found that the evidence base was limited and not sufficient to meet the UK NSC criteria. The natural history of the condition remains unclear and there is not a defined test cut off threshold.

5.14 One response was received following the three month public consultation. This was from the British Thyroid Association (BTA) who agreed with the review's recommendation that screening not be introduced.

5.15 The UK NSC agreed to uphold its recommendation that a systematic population screening programme for thyroid dysfunction in the adult population should not recommended.

Criteria	Met/Not Met
The Condition	
1. The condition should be an important health problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the association between the risk or disease marker and serious or treatable disease	The natural history of thyroid dysfunction remains unclear
The Test	
1. There should be a simple, safe, precise and validated screening test.	Suitable test cut off thresholds have not been agreed
The Intervention	
9. There should be an effective intervention for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to wider benefits of screening, for example those relating to family members, should be taken into account where available. However, where there is no prospect of benefit for the individual screened then the screening programme shouldn't be further considered.	There is a lack of evidence to demonstrate the benefits of treatment for screen detected vs clinical presentation

Updates

NIHR NETSCC Update (for information)

The Committee noted the updates

SIGN Update (for information)

The Committee noted the updates

AOB

i. Information about members appraisals would be circulated in the coming weeks