The Association of Directors of Public Health Consultation Response

Prostate cancer screening consultation

Objectives and Scope

The UK National Screening Committee (UK NSC) has opened a public consultation on the findings from the Sheffield Centre for Health and Related Research (SCHARR) modelling study that estimated the clinical and cost effectiveness of various prostate cancer screening strategies, as submitted via the UK NSC's annual call, and to update the established recommendation on whole population screening.

About ADPH

ADPH is the representative body for Directors of Public Health (DsPH), and is a collaborative organisation, working in partnership with others to strengthen the voice for public health, with a heritage which dates back over 160 years. We also work closely with a range of Government departments, including DHSC and UKHSA, as well as the four CMOs, NHS, devolved administrations, local authorities, and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

ADPH aims to improve and protect the health of the population by:

- Representing the views of DsPH on public health policy.
- Advising on public health policy and legislation at a local, regional, national, and international level.
- Providing a support network for DsPH to share ideas and good practice.
- Identifying and providing professional development opportunities for DsPH.

ADPH response

We make the following observations in support of the draft recommendation:

The ethics of screening

- The benefits of screening are often overestimated, while the potential harms are often underestimated. For example, the impact of invasive biopsy and unnecessary treatment.
- As a result of policy, these harms can grow from individual experience to impacting entire populations.
- Screening can turn well people into patients, and this is very poorly understood. It means the ethical basis of screening is fundamentally different to the ethics of health care delivery. Therefore, the threshold for the risk/benefit of screening needs to be higher.
- Studies can encourage optimistic coverage that misrepresents actual findings, which can in turn shape public, policy, and clinical opinions on screening.

    - For example, positive headlines on mortality rates were circulated after the follow-up of the European Randomised Study of Screening for Prostate Cancer (ERSPC).
    - This study seemed to confirm a 'sustained reduction in deaths', stating a 13% relative risk reduction after introducing Prostate Specific Antigen (PSA) tests.[i]
    - However, the absolute risk reduction was 0.22%, reinforcing that the burden of diagnosis is rarely outweighed by its benefit.
    - The ERSPC also left out other important variables, like quality of life outcomes, which ignore the 'labelling effect' of diagnosis. This includes harms from overtreatment, such as experiences of impotence and incontinence.
    - Analysis from the ERSPC also shows little value in screening from the age of 70.[ii]
- Overpromoting early detection may also increase the risk of harm, where those otherwise living well could encounter harm from both the screening process and during treatment.
- Pushing for early detection may also increase diagnoses through case-finding without any concrete impact on health outcomes, which should remain the goal.
- Screening is often seen as just the 'test' part of diagnosis. However, screening should be understood as a comprehensive programme, which includes other aspects such as quality assurance and failsafe procedures.
- Screening ethics should be clearly explained to all audiences, extending beyond prostate cancer screening, and involve discussing potential negative impacts on those who are well.
- In addition to the UK NSC infographic, it would be useful to provide a plain English description of when individual screening is appropriate.

Shared decision-making

- If UK NSC were to recommend screening, it would leave too much work to shared decision-making.
- This would require significant resourcing and run the risk that under-resourcing could worsen harmful outcomes. Uneven resourcing across areas could also create a postcode lottery in screening quality, worsening health inequalities.
- The reliability of shared decision-making is often overestimated, particularly the ability of clinicians to understand and then communicate statistical probabilities in a complex system. This is critical to informed consent.

Men's health

- Arguably, the prostate's link to sex has often led to prostate health being thought of and treated as part of men's health, risking overshadowing other important determinants and conditions affecting men.
- There are other, more impactful targets for improving men's health. For example, addressing the negative health impacts that harmful products such as alcohol or tobacco have on men or prioritising the improvement of men's mental health.

TRANSFORM trial

- Proceeding with screening may significantly undermine the TRANSFORM trial, which will provide critical evidence to understand the risk/benefit balance of the contemporary screening question (PSA + MRI + genomic risk).
- Screening may cloud the results of the trial, affecting their validity and making them difficult to interpret.
- We agree that it is crucial that black men are well represented in the TRANSFORM trial, with Black British men two to three times more likely to receive prostate cancer diagnoses than white British men[iii] and twice as likely to die from prostate cancer.[iv]

Use of resources

- Spending money where there is insufficient evidence is unethical, displacing resources away from areas where there is clearer evidence of benefit and preventing us from finding out the ideal diagnostic mix for the men in the groups outlined.

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[i] Roobol MJ, de Vos II, Månsson M, Godtman RA, Talala KM, Den Hond E, et al. European Study of Prostate Cancer Screening — 23-Year Follow-up. N Engl J Med. 2025;393(17):1669–1680. https://www.nejm.org/doi/full/10.1056/NEJMoa2503223 [Accessed January 2026]

[ii] Cervoni E. PSA screening remains a probabilistic gamble. BMJ. 2026;392:s176. https://www.bmj.com/content/392/bmj.s176 [Accessed February 2026]

[iii] Dee EC, Todd R, Ng K, et al. Racial disparities in prostate cancer in the UK and the USA: similarities, differences and steps forwards. Nat Rev Urol2025;22:223-34. https://pubmed.ncbi.nlm.nih.gov/39424981/ [Accessed February 2026]

[iv] Butler EN, Kelly SP, Coupland VH, Rosenberg PS, Cook MB. Fatal prostate cancer incidence trends in the United States and England by race, stage, and treatment. Br J Cancer2020;123:487-94. https://pubmed.ncbi.nlm.nih.gov/32433602/ [Accessed February 2026]