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| **National Screening Advisory Committee (NSAC)** **National Screening Unit (NSU)** |
| **Minutes Wednesday 22 March 2017** |
| Venue | Ministry of Health, 133 Molesworth St, Wellington  |
| Start time | 1000hrs |
| NSAC members present  | Dr Joanne Dixon (Chair)Dr Jane O’Hallahan (Deputy Chair) Professor Jackie Cumming Professor Mark Elwood John Forman Dr Bryn Jones (1000-1130) Astrid KoornneefProfessor John McMillan Dr Deborah Rowe Professor Diana SarfatiDr Andrew Simpson (1245-1330) |
| Other attendees | **NSU** Anne McNicholas Dr Bronwyn Rendle Dr Kerry Sexton  | **Item 5. National Bowel Screening Programme**Susan Parry, Clinical Director Stephanie Chapman, Programme Director Helen Gower, Principal Advisor Bronwen Chesterfield, Public Health Medicine Register **Item 6. BreastScreen Aotearoa**Maree Pierce, Manaqer Amanda Wynne, Acting Senior Portfolio Manager Jennifer Cox, Senior Service Development Analyst **Item 9. NSU Strategic Plan** Stephen Park, Senior Service Development Analyst  |
| Apologies | Dr Carol AtmoreProfessor John PotterDr Pat Tuohy |

| **Item** | **Subject and summary** |
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| **1.** | **Welcome, apologies and introductions** Jo Dixon welcomed the NSAC members.  |
| **2.** | **Declaration of conflicts of interest (COI)**COI register tabled.  |
| **3.** | **Minutes of 9 November 2016** Confirmed as a true and accurate record.  |
| **4.** | **Correspondence tabled**NSAC Chair’s 15 Dec 2016 letter to the Royal NZ College of General Practitioners regarding NSAC’s consideration of cystic fibrosis carrier screening at its November 2016. Genomic Health Alliance New Zealand’s 22 February 2017 letter to NSAC Chair advising of their establishment and providing a copy of their draft proposal for *“A Phased Introduction of Genomics into New Zealand Health Care”.* NSAC noted this area will be important to the NSU in the future, with a watching brief for now as implications in the short term relate to personal health services.  |
| **5.**  | **National Bowel Screening Programme (NBSP)**NSAC noted the following in preliminary discussion.* The NBSP is now located within the NSU. NSAC’s relationship with the NBSP is the same as other NSU programmes, for example, clinical governance and oversight of major programme changes or key decisions.
* Operational management and governance sits with the Ministry.
* The NSU’s Bowel Screening Advisory Group (BSAG) provides expert/technical advice. The NSU is currently reviewing BSAG’s membership to align with the different perspectives required as the national rollout progresses.
* A balance is required to avoid duplication between the considerations NSU expert committees and NSAC make, particularly those of a technical nature, while also ensuring NSAC’s oversight and governance role is maintained.
* NSAC provides an important mechanism for providing a layer of checks and balance, considering contrary views or public concerns, and asking questions others may not have considered when balancing the harms and benefits of screening initiatives.

**NSAC had expressed concern at its November 2015 and July 2016 regarding two areas.** * The reporting of faecal immunochemical test (FIT) results as a positive or negative screening result, rather than the actual FIT measurement, given the national programme cut-off differs from that used in the Waitemata DHB Bowel Screening Pilot (Pilot)
* Inequities in Pilot participation across ethnic and socioeconomic groups**.**

NBSP staff attended the 22 March 2017 meeting to respond in more detail to these concerns with their review including the following areas: * findings from the Final Evaluation Report of the Bowel Screening Pilot (01 August 2016)
* advantages of using the quantitative faecal immunochemical test (FIT) as the screening test
* current colonoscopy capacity including recent wait times reductions for symptomatic groups
* anticipated NBSP demand on colonoscopy services
* evidence underpinning selection of the NBSP FIT positivity threshold and eligible age range
* steps undertaken to improve equity in participation during the Pilot.

*FIT and its use in screening programmes internationally*NSAC considered a paper outlining the FIT and its use in screening programmes internationally, particularly when faced with constrained colonoscopy capacity. In summary: * Bowel screening programmes set the FIT cut-off values to align with their resources and circumstances.
	+ Consideration is given to factors such as the bowel cancer incidence, screening intervals, cost-efficacy, colonoscopy capacity, the balance between test sensitivity and specificity and the harms and benefits of screening.
	+ The FIT threshold and positivity level varies between countries.
	+ It is standard practice for screening programmes to test a range of FIT thresholds to identify which one best suits a programme. This step can be through a formal pilot where a programme threshold ultimately selected may be higher than the pilot’s, and also through ongoing evaluations of programmes already in place.
* Setting a higher FIT cut-off level is the most effective way to reduce colonoscopy demand, and results in higher-risk individuals being referred to colonoscopy.
	+ A low FIT threshold increases the detection of advanced neoplasia, but lowers the positive predictive value and specificity, with a higher number of colonoscopies performed to detect one case of bowel cancer. The increase in false positives is associated with increased harms such as unnecessary invasive procedures, adverse events following colonoscopy and increased anxiety.
	+ Increasing the cut-off decreases the number of colonoscopies and increases the detection rate amongst those having colonoscopies, improving the positive predictive value.
* A FIT positivity rate of between 5-8% has been suggested as optimal to minimise missed cancers and advanced adenomas.
	+ New Zealand’s threshold is similar to the Netherlands and is expected to give a similar positivity level of around 7%.
	+ The Australian screening programme also reports a positivity level of approximately 7% at their FIT cut-off.
	+ The UK countries are moving from a guaiac faecal occult blood test to FIT, but are using much higher FIT thresholds than New Zealand, resulting in positivity levels around 2%.
* Centrally managed bowel screening programmes universally report FIT results as positive or negative relative to a pre-set threshold.
	+ There will always be a need to set a positivity threshold, with a wider population gain outweighing individual benefit.
	+ As in all screening programmes false positives and negatives will occur.
	+ While knowledge that a FIT result close to the threshold may generate a higher index of suspicion for patients, the resulting demand on colonoscopy services, particularly for the asymptomatic sub-group, would overwhelm capacity and put the entire screening programme at risk.
	+ While programmes may record the numerical haemoglobin level from the FIT, this step is to allow ongoing programme assessment.
* The NSU will develop a clear plan and timetable to monitor outcomes during the phased introduction of the national programme.
	+ It will include reviews of colonoscopy capacity to ensure the programme can be adjusted to detect more cancers, including changing FIT cut-offs and lowering of age groups eligible for screening over time.
	+ In the longer term, international research and bowel screening programme evaluations are looking at more individualised screening strategies. These could see lower risk groups invited at longer screening intervals than every two years, more frequent invitations for high risk, or invitation to colonoscopy extended to those with consecutive FIT measurements just under the threshold.
* Programme information resources emphasise the importance of participating in each screening round and of anyone with symptoms suggestive of bowel cancer immediately seeking advice from their health professional.

The NBSP tabled advice received from the following international advisors endorsing the reporting of FIT results as positive or negative relative to a pre-set threshold:* Professor Stephen Halloran, Professor Emeritus, University of Surrey
* Dr Linda Rabeneck, Professor of Medicine and Health Policy, Management and Evaluation University of Ontario; and Vice President, Prevention and Cancer Control, Cancer Care Ontario
* Professor Ernst Kuiper, Professor of Medicine and CEO of Erasmus MC University Medical Centre Rotterdam.

*The NBSP and achieving equity*NSAC considered a NSU report “Equity Options Report for the Bowel Screening Programme”. The report included a literature review related to equity in bowel screening programmes, a review of evaluations for the bowel screening pilot regarding equity and recommendations to address equity across the NBSP. **Discussion** *Equity** Continued focus is required in this area and it must be a priority work area for the NBSP
* Disappointingly low coverage in round one of the Pilot for Māori and Pacific saw an increase in the Pilot’s focus and activities to improve equity in participation. However, while Pilot coverage is increasing for Pacific in the second screening round, it has remained unchanged for Māori; although it was noted that once recruited to the programme re-screening rates between rounds were similar across ethnic groups.
* Initiatives tested in the Pilot are being considered for the wider programme, eg, increased outreach and follow-up of non-participants, and allowing lab drop-off of specimens.
* Māori and Pacific coverage will be a focus of analysis as larger data sets become available during the Counties Manukau DHB rollout.
* The Chair of the NSU’s Māori Monitoring and Equity Group noted that the Group is impressed with the equity lense now across the NBSP. They are interested in future consideration of the eligible screening age range for Māori as more data become available from other regions.
* A shared focus and approach across all the NSU programmes is required to better address the equity issues common to them all.

 *FIT threshold / reporting of results* * The NBSP selected the FIT threshold based on information from the New Zealand Pilot and deliberations by the Bowel Screening Advisory Group.
* The NBSP will continue to monitor the FIT threshold level as the programme is implemented and data become available from other DHBs.
* International research is investigating more individualised approaches to future screening with potential to develop algorithms combining FIT results and a range of risk factors
* Consideration of the harms (colonoscopy is an invasive procedure) and benefits (early cancer detection) of screening are important drivers of decision not just resources.
* The slow growing nature of bowel cancers reinforces importance of messages for regular repeat screens and this advice will be a focus for the NBSP.
* Consideration was given to the Health and Disability Code: “*every consumer has the right to information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, including the results of tests*.”
* It was noted that it is standard practice to report FIT results as positive or negative relative to a pre-set threshold and this approach is a reasonable expectation for NBSP participants. Bowel screening programmes internationally report FIT results as positive or negative; and laboratories also report results from investigations of symptomatic patients this way, generally using a threshold set by the kit manufacturer.
* It was noted that there is substantial uncertainly and difficulty interpreting an individual measurement in an asymptomatic individual. It was considered unethical to undertake a screening test in asymptomatic individuals and to then provide the actual measurement knowing it was not possible to provide diagnostic services due to resource constraints, or to offer an invasive procedure when the risk of disease is known to be low. Also, the screening programme cannot disadvantage symptomatic patients by overwhelming colonoscopy services with screening of lower risk groups.
* An individual can request their FIT level under the Privacy Act. On the rare occasion where this may happen the NBSP will need to provide a standard statement along with the result to ensure consistent messaging for patients and GPs.

*Resource constraints* * Colonoscopy workforce capacity remains a key consideration. Three years minimum experience is required. Workforce complexity with gastroenterologists (who may also do general medicine) and surgeons who undertake colonoscopies also being required for other activities. Steps to increase capacity are continuing and include training opportunities for nurse endoscopists.
* At the FIT threshold and age range selected colonoscopy numbers will reduce by around 50% compared with the pilot and cancers detected will reduce by around 30%.
* In light of colonoscopy constraints, the possibility of offering three yearly screening was raised. Such options are being considered by UK researchers examining more tailored screening over consecutive rounds.
* DHBs have been advised of bowel cancer referral numbers anticipated following the first round of screening (based on the pilot results).

**Conclusion** NSAC noted: * their previous concerns regarding how FIT results would be reported were raised at a point when they did not have comprehensive information on the test
* this meeting’s focus on bowel screening has usefully clarified a number of areas with the NBSP providing robust explanations
* their appreciation of the NBSP’s work to date and the exhaustive challenges the programme has been required to consider and respond to.

**Actions** The NSAC Chair will write to the NBSP to advise that:* NSAC endorses the reporting of FIT results as positive or negative relative to a pre-selected FIT threshold.
* NSAC appreciates the NBSP’s rigorous approach to identifying the most appropriate FIT threshold, and that this process aligns with centrally managed programmes internationally where FIT thresholds are selected following consideration of local pilot results and colonoscopy capacity.

**NSAC Endorsements** **Agreed** * The NBSP will report FIT screening results as positive or negative relative to the FIT threshold

**Noted** * The NBSP will continue to monitor outcomes against a range of FIT levels and will assess options for adjusting the threshold and/or eligible age group as colonoscopy capacity increases
* That the NSU will maintain a watching brief of research and international developments related to individualised screening algorithms for bowel cancer
* NSAC will provide oversight of major changes to the bowel screening programme including changes to the eligible screening age groups and FIT positivity threshold
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| **6.**  | **BreastScreen Aotearoa: update**BreastScreen Aotearoa ManagerMaree Pierce updated NSAC on NSU’s investigation into the potential screening age extension and activities to improve equity. *Age extension** BSA staff attended the Parliamentary Review Committee preliminary consideration of a petition supporting a breast screening age extension to 70-74 year olds.
* NSAC has previously supported NSU investigating this area, with the strong caveat that every attempt is made to not compromise equity in screening uptake for those currently eligible.
* The BSA expects to complete an impact analysis by October this year. This analysis will assess the impacts if a decision was made to increase the age range. No decision has been made at this stage.
* The analysis will include a focus on equity including potential negative impacts on Māori and Pacific Island coverage, those unscreened or not screened within the last five years as well as the ability to maintain current overall coverage.
* Modelling of volumes will be used to assess impacts on the workforce and treatment pathway.
* NSAC noted co-morbidities should be considered in the modelling as this may affect the numbers able to move to treatment. This aspect is important for Maōri as co-morbidities are likely to be present earlier for this group.
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|  | *Equity** Regular monitoring of coverage is used to drive improvement initiatives. Latest reports indicate a reduction in re-screening rates for Māori. The NSU is looking into why rates have reduced.
* The NSU recently reviewed its “Support to Services Programme” and contracts have been shifted to a wider range of providers. The NSU is to evaluate the effectiveness of these changes.
* A cancer screening hui was held September 2016 with around 200 attendees. It provided the opportunity to show case local initiatives. Māori and Pacific caucuses provided valuable feedback to the NSU.
* National contracts are held with eight providers. New contracts from January 2018 will move to a results/outputs based model with the funding model incentivising achievement of results. Equity will be a key outcome for these contracts.
* Health promotion/social marketing activities: a new website is being developed and a facebook presence is to be established, with consultation with Māori and Pacific completed.
* DHB Annual Plans: these include a Māori Health Plan. The NSU gives a strong steer on what it expects DHBs to include eg co-operation with primary care with data matching to identify women who are eligible for the programme but are not involved, especially priority group women.
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| **7.**  | **Abdominal Aortic Aneurysm (AAA) screening: update**At its 9 November 2016 meeting NSAC agreed support in principle for a national programme to screen for AAA. The Committee supported further exploration of how a national programme could be implemented, with options to include its operation under the NSU. Areas requiring further exploration included: * cost effectiveness, workforce capacity, the target population, the priority of equitable delivery for Māori and consideration of options based around integrated case detection within GP practices and GP access to AAA ultrasound screening.

Dr O’Hallahan advised she had recently met with Dr Peter Sandiford at Waitemata DHB regarding extension of their AAA screening pilot; and with Drs Doone Winnard and Wing Cheuk Chan at Counties Manukau DHB to seek their views on AAA screening. * The pilot extension will operate in Waitemata and Auckland DHBs and will now include Māori women as well as Māori men
* Counties Manukau DHB are not participating in the pilot as they do not believe the low number of AAA deaths in Māori justify this initiative being prioritised over other more pressing health needs in their community and other options for accelerated Māori health gain.

**Actions** The NSU will maintain a watching brief of the pilot extension and will also review opportunities with Otago University to complete the preliminary cost-benefit analyses presented at NSAC’s 9 November 2016 meeting.  |
| **8.**  | **Non-invasive perinatal testing (NIPT): update**At its 16 July 2016 meeting NSAC supported the NSU plans to undertake consultation on the proposal to add NIPT to the current antenatal screening pathway as a contingent screen after a women’s combined screening indicates an increased risk for Down syndrome, trisomy 18, and trisomy 13. The NSU planned to identify the preferred risk threshold (1:300 or 1:1,000) following further consideration of cost-effectiveness analyses, feedback from public consultation, and advice from the Antenatal screening for Down syndrome and Other Conditions advisory group (DSOC). Wide stakeholder consultation has not been undertaken to date. Some members of DSOC have suggested that this step is not necessary as they regard the introduction of NIPT as a quality improvement initiative. NIPT is a more accurate screening test with fewer false positives and false negatives, thereby reducing the number of invasive diagnostic tests (amniocentesis).DSOC is also giving further consideration to the option of moving directly to the universal offer of NIPT rather than the originally envisaged stepwise change of moving first to contingent testing. Some health provider groups have also expressed a preference for universal offer of the test. DSOC has not reached a consensus on the preferred approach. It was noted that the UK announced in January 2016 that it will be undertaking an evaluative implementation of contingent NIPT testing before proceeding to its nationwide roll-out from 2018. The NSU will continue consideration of policy options for potential implementation of NIPT either as a contingent or universal test.  |
| **9.**  | **New Zealand Health Strategy and the NSU 2017-2022** The NSU Strategic Plan was last updated in 2010. A new plan is being developed to align with the New Zealand Health Strategy which outlines the high-level direction for the health system through to 2026. As with the previous New Zealand Health Strategy, the underlying guiding principles include acknowledging the special relationship between Māori and the Crown under Te Tiriti o Waitangi, and the need for equitable access and active partnership and collaboration.The NSU plan will align with the New Zealand Health Strategy’s five central themes: people-powered, closer to home, value and high performance, one team and smart system.NSU staff leading the development of the NSU plan attended the NSAC meeting to outline the key themes that are emerging through early discussions with staff and stakeholders, and seek NSAC’s views. NSAC members offered feedback for consideration. The NSU will provide a fuller draft as it nears completion. |
| **10.** | **Other business** Next NSAC meeting date: Wed 26 July 2017 |
| The meeting closed at 1530hrs |