

**National Screening Advisory Committee (NSAC)  
National Screening Unit (NSU)**

**Minutes Thursday 28 November 2019**

Venue	Ministry of Health, 133 Molesworth St, Wellington	
Start time	1000hrs	
NSAC members present	<p>Dr Jo Dixon (Chair)          Dr Jane O'Hallahan (Deputy Chair)          Dr Carol Atmore          Dr Karen Bartholomew          Professor Barry Borman          Pania Coote          Professor Jackie Cummings          John Forman          Astrid Koornneef          Dr Caroline McElroy          Professor John McMillan          Dr Deborah Rowe          Dr Caroline Shaw          Dr Pat Tuohy</p>	
Other attendees	<p><b>NSU</b>          Anne McNicholas          Principal Advisor</p> <p>Dr Bronwyn Rendle          Public Health Physician</p> <p>Dr Nisha Nair          Public Health Physician</p>	<p><b>Item 7: Equity in Screening</b>          John Whaanga, Deputy Director-General Māori Health, Ministry of Health          Jason Moses, Manager, Crown Relations, Māori Health, Ministry of Health          Dr Kerry Sexton, Public Health Physician, NSU          Toby Regan, Manager Screening Insights and Analytics, NSU</p> <p><b>Item 8: Silicosis screening</b>          Catherine Epps, WorkSafe NZ (co-chair of Dust Diseases Task Force)          Dr Richard Jaime, Principal Advisor, Office of the Director of Public Health, Ministry of Health</p> <p><b>Item 9: Updates</b>  <b>Well Child Tamariki Ora (WCTO) review</b>          Alison Hussey, Principal Advisor, WCTO Review</p> <p><b>Screening in pregnancy: rheumatic heart disease; syphilis</b>          Niki Stefanogiannis, Deputy Director Public Health</p> <p><b>Lung cancer screening: cost-effectiveness</b>          Dr Sue Crengle, University of Otago (via teleconference)</p>
Apologies	Professor Mark Elwood	

Item	Subject and summary
1.	<p><b>Welcome, apologies and introductions</b></p> <p>The Chair thanked Deb Rowe (previously Chair of the NSU's Maori Monitoring Equity Group (MMEG) for her contribution to NSAC, and welcomed the new MMEG Chair Pania Coote to NSAC. The Chair also thanked Caroline Shaw who is standing down from NSAC after a two-and-a-half-year membership.</p>
2.	<p><b>Declaration of conflicts of interest</b></p> <p>Conflict of interest register tabled.</p>
3.	<p><b>Minutes of 25 July 2019</b></p> <p>Amended and confirmed as a true and accurate record.</p>
4.	<p><b>Matters arising from the minutes</b></p> <p>Re-emergence of congenital syphilis - update provided (see item 10)</p>
5	<p><b>Correspondence</b></p> <p>Nil</p>
6.	<p><b>Terms of reference annual review</b></p> <p>Amended by addition of membership expertise to include primary care and health services delivery.</p>
7.	<p><b>Equity in screening</b></p> <p>At its April and July 2019 meetings NSAC proposed that it dedicate a session to look at equity across the NSU programmes. At this 28 November meeting NSAC examined equity, primarily for the NSU cancer screening programmes, with a number of presentations provided by Ministry staff.</p> <p><u>Te Tiriti o Waitangi Framework and Māori Health Action Plan.</u></p> <p>John Whaanga (Deputy Director-General, Māori Health) opened the session and explained the current reconsideration of the direction of the Māori Health Directorate in relation to Māori Health and Te Tiriti o Waitangi responsibilities, including how a proposed Treaty Framework would look in the Māori Action Plan currently under development.</p> <p>At the centre of the proposed Ministry framework is the Te Tiriti preamble, the three articles and the additional oral declaration protecting Māori customs and beliefs. The accompanying Ministry functions and goal for each area (expressed in terms of mana) are as follows:</p> <p>Article 1: Stewardship (Mana Whakahaere - good Government)</p> <p>Article 2: Iwi/Māori Health development (Mana Motuhake - unique and indigenous)</p> <p>Article 3: Equity focus (Mana Tangata - fairness and justice)</p> <p>The Declaration: Protect Mātauranga Māori (Mana Māori - cultural identity and integrity)</p> <ul style="list-style-type: none"> <li>• And then 8 priority areas for action <ul style="list-style-type: none"> <li>○ Māori / Crown relations</li> <li>○ Māori Health Development</li> <li>○ Māori leadership</li> </ul> </li> </ul>

- Accountability frameworks
- Cross sector action
- Workforce
- Quality systems reflect good practice
- Clear evidence of performance

- There are three clear important areas: decision makers (Māori want to be here); driver of services that are appropriate and safe; and addressing racism and discrimination.
- Currently identifying 10-15 things that need to be done over a five-year horizon, and has been seeking feedback throughout. A national hui is proposed to assess where we want to be 25 years out.
- Ministry must lead by example and question whether it is meeting its equity and Māori health responsibilities. There is a consensus on why, but a need to lift performance – to identify how we do it and how we monitor it.
- The general public view of equity is in terms of allocative equity. However, need to treat different people differently. Need to show inequities in a way that people can understand and appeal to, given the general understanding of fairness. What is fair is a starting point.
- Simple personal stories of inequity resonate.

John Whaanga and Jason Moses (Manager, Crown Relations, Māori Health) provided an overview of the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) initiated in November 2016.

- The Inquiry is hearing claims concerning grievances relating to health services and outcomes of national significance for Māori (noting it is largely about Government practice across the board and health inequity).
- There are approximately 220 claims (including from individuals and wider iwi) covering a range of issues relating to the health system and specific health services and outcomes including: health equity; primary health care; disability services; mental health; and alcohol, tobacco and substance abuse.
- The Inquiry consists of three stages:
  - Stage One inquired into the legislative and policy framework of the primary health care system, with key findings relating to the lack of compliance with Te Tiriti including inequitable health outcomes and institutional racism. Legislative, policy and operational recommendations were made, with changes to health legislation proposed to increase focus on equitable outcomes and obligations under Te Tiriti.
  - Stage Two is structured in two parts covering three priority areas. Part one will focus on Māori with disabilities, and Part two on Māori mental health (including suicide and self-harm) and issues of alcohol, tobacco, and substance abuse.
  - Stage Three will cover remaining national significant issues and eligible historical issues.

#### NSU development of its equity policy

The areas under consideration include:

- the problem definition
  - there are inequities in access and outcomes across all screening programmes
  - inconsistent definition of “priority” populations across programmes
  - tension between health need and health gain for the total population, sub-populations, and individuals
  - limited new resources
  - potential principles for deciding priority populations
- considering both access and outcomes, but giving more weight to outcomes
- population level approach, not individuals
- considering intersectionality / “and” not “or”

- special considerations for group with access issues eg Asian populations, disability, LGBTQI+.

*Discussion included*

- There should be one priority, that is, reduce inequity in outcome. How you achieve this is the next step, for example, increase access to address outcome.
- Will be harder to argue population level versus individual equity when individualised risk algorithms apply to decide screening eligibility.
- Whole of population approach does not necessarily work for all people or groups.
- Principles for identifying priority populations need to be clear.
- Having a priority means identifying where to put effort and resources to get outcomes you want, identifying what trade-offs you allow to achieve the priority.
- While equity within a programme is the focus, noted lack of equity for those whom screening is not yet funded, or if a programme improvement is not supported or funded - raises question of whether it is better at a high level to consider establishing a new programme or instead concentrate on improvements to current programmes.
- Questioned whether any new screening programme should be implemented until current programmes are equitable.

National Bowel Screening Programme (NBSP) - evidence for age extension for Māori

In February 2019 the Ministry hosted a hui with Māori health sector experts to review the evidence and look at what changes could be made to the programme to increase outcome equity. At previous meetings the NSU provided NSAC with an overview related to the hui's highest priority recommendation that "the age range for bowel screening should be extended to 50 years of age for Māori men and women". NSAC supported the hui's recommendation.

NSAC considered the evidence for age extension in more detail at this 28 November 2019 meeting including the following areas.

*Support for age extension stems from*

- Evidence that colorectal cancer screening from 50 years of age is safe and effective.
- If sufficient colonoscopy capacity existed, the NBSP would have been implemented for the 50 to 74 year age group.
- A commitment to striving for equity of outcome from each our programmes.
- A desire that the NSU does not increase inequity through its programmes.
- A view that the NSU should act now where it can.
- An understanding of what is practical to achieve over what timeframe.

*Known inequities in colorectal cancer (CRC) outcomes pre-date the NBSP*

- Despite a lower incidence in Māori (age-sex-standardised rates for 2002-2006 were about 1/3<sup>rd</sup> lower), mortality from CRC was similar to non-Māori.
- Māori had significantly lower odds than non-Maori of being diagnosed at a localised stage and higher odds of being diagnosed at a distant stage.
- There are better survival chances if CRC is detected early.

*The key difference in parameters between the Waitemata DHB pilot and the NBSP*

- The pilot eligible age range was 50-74 years versus 60-74 years for the NBSP.
- The pilot screening faecal immunochemical test (FIT) threshold was  $\geq 75$  ng Hb/ml buffer versus  $\geq 200$  ng Hb/ml buffer for the NBSP.

*In 2017, the Bowel Screening Advisory Group acknowledged that the NBSP did not provide outcome equity for Māori.*

- At that time the Advisory Group did not recommend a lower screening age as cancer registration data (to the end of 2013) showed Māori had a lower incidence of colorectal cancer compared to non-Māori (although the mortality rates were similar).
- The Advisory Group was also concerned that widening the age range would significantly stretch colonoscopy services.

#### *CRC screening impact on health inequalities*

Equity of outcome within a screening programme is best measured through a composite measure such as QALYs (quality adjusted life years). Modelling of NZ data has been undertaken by Otago University (McLeod et al, 2017. *Cancer Epidemiol Markers Prev*; 26(9):1391-1400).

- This modelling showed that a CRC screening programme with biennial FIT testing in the 50 to 74 year age group would:
  - produce health gain for both Māori and non-Māori
  - would be cost-effective for both Māori and non-Māori
- BUT**
  - per capita health gains would be less for Māori than non-Māori
  - inequalities in quality adjusted life expectancy (QALE) for Māori compared with non-Māori would be increased.
- The key drivers of the inequitable benefit from screening were:
  - lower CRC incidence in Māori
  - lower life expectancy in Māori
  - lower Māori participation in screening.

Of these drivers, participation in screening is the only factor the NSU has direct influence over. However, despite a focus on equal participation by ethnicity, DHBs have struggled to achieve this.

#### *Hui with Māori health leaders*

The Ministry hosted hui in February 2019 reviewed the current evidence and looked at what changes could be made to the NBSP to increase outcome equity.

- Cancer registration data, released since the Bowel Screening Advisory Group's earlier considerations of equity, shows an increase in new bowel cancer cases in Māori, with incidence now similar to non-Māori.
  - The 2017 age standardised rate for Māori was 37.3 per 100,000 and for non-Māori 39.8 per 100,000
  - The CRC rate for Māori is potentially trending upwards.
  - At the time of the hui, the total number of bowel cancer registrations for 2017 was 3,011 with 1,268 deaths due to bowel cancer in 2016. Of these, 219 bowel cancers and 81 deaths were in the Māori population.
- Māori have a much higher proportion of CRC diagnosed before 60 years age for which there is no opportunity to be screen detected.
  - Approximately 38 percent of CRC occur in Māori before 60 years of age compared with around 16 percent in non-Māori.
  - Approximately 20 percent of CRC occur in Māori between 50 and 59 years of age compared with around 10 percent in non-Māori.

The hui recommended lowering the eligible screening age for Māori. This step was demonstrated to have a larger impact on the detection of CRC than lowering the FIT threshold.

#### *Colonoscopy capacity*

Colonoscopy capacity was a key driver of the previous decision to narrow the age range from the pilot to the NBSP ie to start screening at 60 years instead of 50 years.

- Recent modelling of the impact of age extension indicates it would see around a doubling in the number of CRC cases detected in Māori (60 additional cases) annually.

- It would require approximately 750 colonoscopies (about a 10% increase in total colonoscopies for the programme).
- The impact will be larger for DHBs which have a high Māori population. For example, assuming 60% coverage across all ethnicities and age groups, initial modelling indicates that:
  - Counties Manukau DHB would see around a 10% increase in the total number of screening colonoscopies required (85 colonoscopies additional to the 820 required for the 60-74 years age group)
  - Tairāhiti DHB would see around a 20% increase (25 colonoscopies above the 110 required for the 60-74 years age group)
  - Canterbury DHB would see around a 5% increase (55 colonoscopies above the 1300 required for the 60-74 years age group).

*Discussion included*

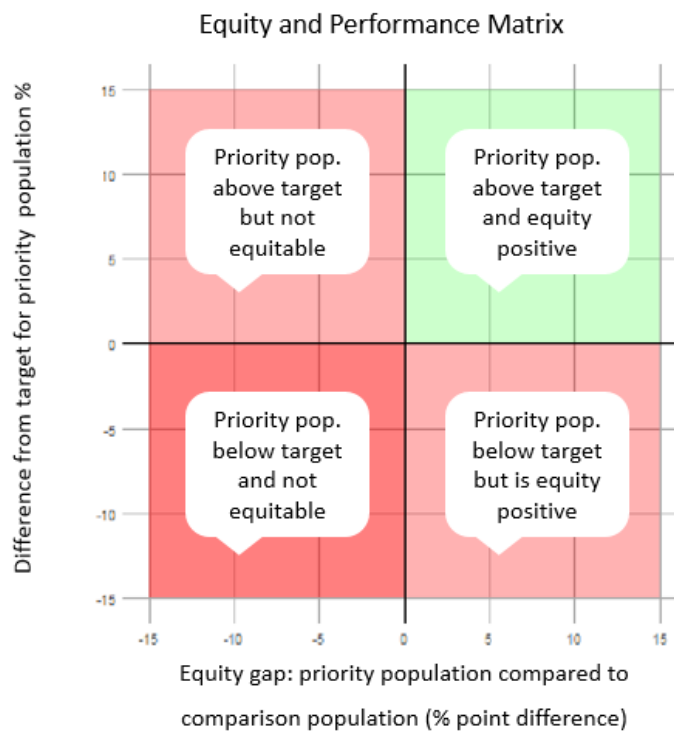
- Without a change to the screening age range, inequity for the current programme will increase, and with the trends in Māori CRC incidence it may worsen further again.
- Questioned whether achieving an increase in screening coverage for Māori to 60 percent would achieve equity.
  - Modelling shows that achieving equal participation by ethnicity will not achieve equity of outcome. To achieve this outcome would require screening coverage reaching approximately 73% in Māori, while holding back non-Māori to around 58 to 60%.
- NSAC Terms of Reference include the responsibility and obligation to address Māori inequity (The Terms of Reference state that NSAC provides expert advice that is founded on a number of principles including that "national screening programmes will achieve equitable access to the screening pathway and equitable outcomes for all population groups").
- CRC age distribution for Pacific is similar to Māori, with age extension for this group also under consideration.
- Given Māori incidence is now similar to non-Māori, framing up the rationale for age extension requires consideration of the impact of screening - with the modelling assessment of the impact on QALYs providing important supporting evidence.
- If Māori do get CRC they do worse than non-Māori, so addressing the treatment pathway is also important - but earlier screening remains necessary to improve outcomes.
- NSAC's role is to make an evidence-based recommendation (consistent with their terms of reference). While their recommendations are based on their evaluation and expert consideration of the proposed change, it is recognised that the ultimate decision to proceed is political.
- There is clearly a strong case for age extension for Māori and it is a Treaty of Waitangi obligation.
- Noted that lung cancer screening is likely to provide substantial equity health gains for Māori. It is a potential future programme that NSAC will actively consider as the evidence base grows. However, any implementation of lung cancer screening is an undetermined (some/many) number of years away. In contrast, addressing health inequities through lowering the bowel screening age is something that can be done now.

The NSU's development of the Equity and Performance Matrix

The NSU had developed an equity and performance matrix which it intends to apply across its programmes.

- Health services that are failing to meet performance targets are considered to be underperforming.
- Health services that result in equity gaps for different populations must also be considered to be underperforming.
- Both situations may occur simultaneously.

- The matrix provides a visual picture of any 'equity gaps' that exist as well as 'how effectively' health services are being delivered for a population against a defined target.



- Any measure that has a target can be adapted to be incorporated into the matrix and the dimension of equity can also be adapted to help demonstrate a particular issue, be it ethnicity, deprivation, sex, rurality etc. The key feature is the quadrant that the provider or service falls within.

**Recommendations**

**NSAC noted**

- Its commitment to providing advice that supports the Ministry meeting its obligations under the Treaty of Waitangi to achieve access and outcome equity for Māori in the National Bowel Screening Programme.
- The requirement under its terms of reference to provide advice that addresses equitable access and outcomes for all population groups.
- The epidemiological evidence for lowering the screening age for Māori.
- That lowering the screening age for Māori would be the first stage in lowering the age for all the population.

**NSAC endorsed**

- The National Bowel Screening Programme lowering the eligible screening age for Māori to 50 years in order to support achieving outcome equity for bowel cancer screening.

**8. Screening for accelerated silicosis**

Representatives from WorkSafe New Zealand and the Ministry of Health's Office of the Director of Public Health attended the meeting to seek advice on the screening principles that might apply to potential case finding for lung disease in asymptomatic people who have been exposed to respirable crystalline silica (RCS).

- Accelerated silicosis is a preventable occupational lung disease occurring in workers as a result of being exposed to RCS from working with engineered stone during the manufacture and installation of bench tops.
- In New Zealand, the prevalence of silicosis is unknown.
- WorkSafe issued a safety alert in August 2019 to raise awareness of the risks to those working in the engineered stone industry.
- A cross-agency Dust Diseases Task Force has been established to determine a coordinated response for workers at high risk of exposure to RCS and the approach to case finding.
  - Case finding is not believed to have been done previously in New Zealand for an emergent occupational disease.
  - Agreement is still being reached on whether or not to actively case find asymptomatic individuals exposed to RCS.
- WorkSafe is working with the Ministry of Health and ACC to set up a self-referral process for workers who consider themselves at high risk of exposure. It is also determining on-going appropriate health monitoring.
- Diagnosis is not straightforward. It requires high resolution CT findings and a good clinical history (including occupational exposure history). There is largely clinical agreement on the type of testing required to identify potentially affected individuals, with a clinical pathway being developed.
- There is currently no known treatment that alters the course of the illness.
- The advice, management and follow up for asymptomatic workers with a diagnosis of silicosis on CT is still to be decided, although there is likely agreement on advice to stop work that exposes the worker to RCS. It is possible no active management may be available or required but follow-up will be. Appropriate management and follow up may be determined by the responsible clinician, likely a respiratory physician.
- WorkSafe is identifying and inspecting work sites, issuing enforcement notices where effective control practices are not being met and reinforcing health and safety messages.
- Given the inadequate controls seen in a number of businesses, WorkSafe anticipates finding confirmed cases if active case finding is undertaken. Based on the Queensland experience, around 17% of all workers tested are expected to be diagnosed with silicosis.
- In Australia there is state-by-state variation in the response based on agency structures. Queensland has been the most proactive in case finding with organised case finding starting in October 2018. The Australian Federal Government is initiating a nationwide co-ordinated response, although not nationwide case finding

*Discussion included*

- *Latency of condition:* short latency (1-10 years after exposure) compared with, for example, asbestosis. Pathology present while asymptomatic, making assessment through primary care challenging.
- *Case definition:* is not clear cut, particularly in asymptomatic.
- *Reason for early identification:* to provide potential early treatment, to remove exposure, to change way lead life
- *Workplace mitigation:* NZ is identifying employers/workplaces & scale (130 to date & all visited): provision of education, safety alerts and enforcement.
- *Level of confidence re work place mitigation:* likely achievable if apply safety protocols, especially with wet cutting, but individual's knowledge of right gear varies eg respirator fit
- *Whether use of stoneware should still be allowed:* all stone is imported, and still early in understanding - difficult to ban; consideration required of loss to consumers vs harm to those processing the stone. In interim, starting to identify various mitigation levers.
- *Screening Criteria*
  - Silicosis case finding is the approach considered to date (with a cohort defined already)
  - If case finding is viewed as screening, then arguably it would not meet the screening criteria
  - However, criteria are useful to apply (especially if there is a treatment or primary intervention) but their strict application is not necessary.



	<ul style="list-style-type: none"> <li>○ Criteria useful if follow-up for a length of time required - enabled by a good register</li> <li>○ Maybe useful to use a broader approach and view less as a screening programme and more as an occupational and health safety work programme, and use some screening, some surveillance (as at risk and need monitoring) and some occupational health principles, noting a research component is also required.</li> <li>● <i>Register</i> <ul style="list-style-type: none"> <li>○ Intention for use of register not clear: whether it is for <ul style="list-style-type: none"> <li>▪ screening</li> <li>▪ identifying those exposed and/or seeking compensation,</li> <li>▪ monitoring/evaluation</li> <li>▪ collecting details for research</li> </ul> </li> <li>○ Research is important as it is a new issue.</li> <li>○ The rationale for establishing a surveillance system differs to that for a register and requires a specific approach.</li> <li>○ Registers are easy to set up but hard to run (the asbestosis register has similar goals but does not operate well).</li> <li>○ A register is likely needed, but an all-encompassing approach makes it more difficult to operate.</li> </ul> </li> <li>● <i>Ethics</i> <ul style="list-style-type: none"> <li>○ Known workplace hazard so an effective way of contacting people is important as is an effective diagnostic test, with consideration required of harms and benefits of diagnostic procedures. For example, the impact on individuals through the screening pathway including from incidental findings.</li> <li>○ A predominantly young male workforce is affected so different from the general population.</li> <li>○ Equity issue with poor outcomes not evenly distributed - is a manual labour workforce with low pay and high turn-over.</li> <li>○ Approximately 550 people are employed in the NZ engineered stone industry with potentially 50-80 current employees having been exposed to RCS.</li> <li>○ Active case finding is important as no other reliable way to find those affected – must be supported by a standardised approach and protocols including informed consent.</li> <li>○ NZ Medical Council advice would be useful, for example identifying what people should understand before they are screened.</li> </ul> </li> </ul> <p><b>Action:</b> WorkSafe NZ will update NSAC on progress in 12 months' time</p>
<p><b>9.</b></p>	<p><b>Update - rheumatic heart disease (RHD) in pregnancy</b></p> <p>An Auckland University study indicates that around 1/500 in Maori women have RHD in pregnancy, 1/200 for Pacific and 1/15,000 for non-Maori and non-Pacific. Around 10-20% of these cases are unidentified prior to pregnancy.</p> <p>A preliminary assessment is being undertaken of the potential gains of RHD ultrasound screening for pregnant Māori and Pacific women during the routine 18-22 week antenatal screen, with the aim to identify RHD earlier and improve outcomes. A Counties Manukau DHB Registrar will likely undertake this assessment. It will include consideration against the New Zealand's National Health Committee screening criteria. If it is judged that the screening criteria are met this topic will come back to NSAC for consideration.</p> <p><i>Discussion included</i></p> <ul style="list-style-type: none"> <li>● RHD screening in pregnancy would be unlikely to meet the screening criteria for example, absence of a randomised control trial, and suggested development of a research strategy to fill the evidence gaps the assessment may identify.</li> </ul>

<p><b>10.</b></p>	<p><b>Update - congenital syphilis / third trimester screening</b></p> <p>The Ministry's recently developed the National Syphilis Action Plan. It has four action areas:</p> <ul style="list-style-type: none"> <li>• prevention and health promotion</li> <li>• testing and management</li> <li>• antenatal care</li> <li>• surveillance and monitoring</li> </ul> <p>The Ministry is supporting work in the prevention of congenital syphilis, including the development of maternal syphilis guidelines by the New Zealand Sexual Health Society to provide guidance on re-testing for syphilis during pregnancy and ensure consistency in syphilis management pathways in each region.</p> <p>They are considering screening in the third trimester of pregnancy with options including universal (as with first trimester screening) or targeted (by risk). These options will be costed and surveillance will also be included in the considerations.</p> <p>Noted that not all women are being screened during the first trimester, and not all labs have the syphilis lab test request "bundled" with the routine antenatal screen request. It is unknown what proportion of positive screens are adequately followed up.</p> <p><i>Discussion included</i></p> <p>Improved monitoring and evaluation of first trimester screening is required. An alternative approach to first trimester screening would be to establish a full screening programme with comprehensive monitoring and active failsafe mechanisms.</p> <ul style="list-style-type: none"> <li>• Equity is an issue with a large proportion of affected babies Māori</li> <li>• If universal third screening is recommended, that is a new screening programme, it must come back to NSAC for consideration, including with a cost-benefit assessment.</li> </ul>
<p><b>11.</b></p>	<p><b>Update - Well Child Tamariki Ora (WCTO) Review</b></p> <p>The Ministry is undertaking a review of the WCTO programme, including a health contact workstream established to develop an integrated framework of universal wellbeing contacts for the pregnancy to 24 years of age life-course. The initial focus of the Review is on 0 to 5 years of age. The Ministry commissioned the Ministry of Business Innovation and Employment (MBIE) national research programme "National Science Challenge <i>A Better Start E Tipu Rea</i> to manage a series of rapid evidence reviews.</p> <p>At its July 2019 meeting, NSAC considered aspects of the WCTO Review, particularly the rapid evidence reviews. NSAC's advice included that the reviews should be consistent in approach and include all the screening criteria, and that equity criteria should be a threshold component for any new programme.</p> <p>The WCTO Review team provided NSAC with the October 2019 draft evidence review, and updated NSAC on progress.</p> <ul style="list-style-type: none"> <li>• The Ministry has now commissioned MBIE to grade the evidence reviews using the United States Preventive Services Task Force (USPSTF) grading approach. However, this work is likely to be challenging given its retrospective application across the reviews and the insufficient systematic approach between the different reviews.</li> <li>• The review team may likely move towards a five year plan/improvement program, noting the need for clinical leadership and workforce development, and also a technical advisory group to look at evidence for a programme and potential changes to screening tools.</li> </ul> <p><i>Discussion included</i></p> <ul style="list-style-type: none"> <li>• The Better Start's foreword notes the criteria for a screening programme includes the requirement that there is an effective and accessible intervention, and that screening therefore should not be offered if there is no benefit to those being screened.</li> </ul>

	<ul style="list-style-type: none"> <li>• It is important to get it right when establishing whether there should be a screening programme – and the evidence from the reviews indicates it is far too early to say.</li> <li>• The screening aspect of the current WCTO programme are not well recognised, and moving the screening tests to meet formal screening criteria is a huge shift.</li> <li>• Over ambitious scope of the evidence reviews with a need to do a smaller number well.</li> <li>• Only some components should or could be configured as a screening programmes and there is a failure to initially scope what could potentially be screening programmes eg early vision screening.</li> <li>• Some components should clearly be configured as a screening programme in a formal sense, for example, hearing and vision within the B4 School Check.</li> <li>• Substantial issues with performance of current screening tools, for example, neurodevelopmental screening tools used in very deprived areas such as South Auckland; and that there are better tools now available in areas such as hearing that improve ability to screen children, for example, those with autism</li> <li>• Equity is important with current programmes, with gaps remaining between Māori and non-Māori with mainstream providers.</li> </ul> <p><b>Action:</b> WCTO review team to update NSAC annually</p>
<p><b>12.</b></p>	<p><b>Update - lung cancer screening cost effectiveness equity re-analysis</b></p> <p>At its July 2018 meeting, NSAC considered lung cancer screening as part of its annual work programme review, including the University of Otago’s Burden of Disease Epidemiology, Equity &amp; Cost Effectiveness Programme (BODE3) cost effectiveness modelling.</p> <p>Karen Bartholomew updated NSAC on the work of an Auckland research group on lung cancer screening (led by Dr Sue Crengle). There are three parts to the research programme, a cost-effectiveness equity review, focus groups &amp; survey, and a planned demonstration trial using low dose computerised tomography (LDCT).</p> <ul style="list-style-type: none"> <li>• The Auckland group’s review of the BODE model originally used to assess cost-effectiveness of lung cancer screening identified errors in the model which impacted on that original assessment.</li> <li>• After amending the BODE model, the analysis indicated that screening would be cost-effective for Māori. Further analyses could be done, for example, integrating smoking cessation into the model which would improve cost-effectiveness further.</li> <li>• The BODE team have undertaken a review of their model and advise that their study outcomes have changed, with a shift towards lung cancer screening being cost-effective.</li> </ul> <p>To date international cost effectiveness analyses have produce variable results. However, the increasing sensitivity and specificity of lung cancer screening, particularly in relation to improved nodule management pathways, will directly impact on reducing costs and harms, with these improvements occurring quickly over time.</p> <p>Australia is currently undertaking a one-year long enquiry examining the evidence for lung cancer screening, cost-benefit and the delivery phase / national framework for a screening programme.</p> <p><b>Action:</b> NSAC will reconsider lung cancer screening at its April meeting, including analyses undertaken by the Auckland and BODE teams.</p>
<p><b>13.</b></p>	<p><b>Update - pulse oximetry screening (POS)</b></p> <p>At its November 2018 meeting, NSAC concluded that there is likely sufficient evidence for the introduction of POS through a nationally-led quality improvement programme, and that the NSU should encourage and support the development of a national POS guideline.</p> <p>The NSU is making good progress with development of the guideline, supported particularly by Dr Elza Cloete (Liggins Institute). A Steering Group has been established and has met.</p>

	<p>Membership comprises a number of sector and academic experts and includes Māori and Pacific representation. A consultation process is planned, and development of national resources is required.</p> <p>Key Issues remain around how to achieve consistent implementation of a guideline, including in rural areas, as well as the extent of monitoring and evaluation required.</p> <p><i>Discussion included</i></p> <ul style="list-style-type: none"> <li>• Consistent implementation would be supported by including POS in the Well Child Health book, specifying how and when it should be done</li> <li>• Importance of working through directors of nursing/midwifery at the DHB level.</li> <li>• Antenatal and newborn screening area is very busy and the package of activities likely needs to be reviewed again to ensure a specific and robust programme along the lines of a well-women and baby screening programme.</li> </ul> <p><b>Action:</b> NSAC will consider the POS pilot's published results and final report during 2020.</p>
<p>14.</p>	<p><b>Update - National Cervical Screening Programme (NCSP) change in cervical screening starting age to 25 years</b></p> <p>In March 2018 NSAC endorsed the cessation of screening in women aged 20 to 24 years. A strong evidence base shows that the harms of screening this age group outweigh the benefits. International guidelines recommend against screening women under 25, and a number of other countries have implemented these recommendations.</p> <p>The change in the screening start age was implemented during November 2019 as practice management system (PMS) technology updates were progressively implemented across primary care.</p> <ul style="list-style-type: none"> <li>• Changes have also been made to the NCSP Register to enable tracking of women.</li> <li>• A media campaign is planned for the New Year and will include messages about the ongoing importance of screening in the context of HPV vaccination.</li> <li>• The NSU is providing additional advice to primary care about the pathway for women under 25 who have already started screening versus those who have not.</li> <li>• The NSU is also considering a national notification process for women as they approach 25 years of age.</li> <li>• Transitional monitoring indicators have been established.</li> </ul> <p><i>Discussion included</i></p> <ul style="list-style-type: none"> <li>• The importance of community care providers and incorporating Māori health providers and support to screening services.</li> <li>• Concerns remain about the broader issue of identifying women not enrolled with primary care. Resolution of this issue is dependent on the NCSP register activities being moved across to the National Screening Solution, the population-based screening register that will ultimately support the NCSP (the NBSP is its current focus).</li> <li>• There are risks created for women turning 25 years if the transition to the National Screening Solution is delayed, as it provides the ability to identify/invite those women who are not enrolled with primary care.</li> <li>• Need for additional communications to primary care, for example, GP colleges, practice nurse and Maori health professional organisations</li> </ul>
<p>15.</p>	<p><b>Meeting Dates for 2020</b></p> <ul style="list-style-type: none"> <li>• Wed 1 April</li> <li>• Wed 17 June (Auckland)</li> </ul>

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|  | <ul style="list-style-type: none"><li>• Thurs 19 November</li></ul> Meeting closed at 1600hrs. |
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