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| **National Screening Advisory Committee (NSAC)** **National Screening Unit (NSU)** |
| **Minutes Wednesday 9 November 2016** |
| Venue | Ministry of Health, No. 1 The Terrace, Wellington  |
| Start time | 1000hrs |
| NSAC members present  | Professor Ross Lawrenson (Chair)Dr Jane O’Hallahan (Deputy Chair) Dr Carol AtmoreDr Joanne Dixon Professor Mark Elwood John Forman Dr Bryn Jones (from 1230hrs) Astrid KoornneefProfessor John McMillan Professor John PotterDr Deborah Rowe Professor Diana SarfatiDr Pat Tuohy  |
| Other attendees | **NSU** Anne McNicholas Dr Bronwyn Rendle Dr Kerry Sexton (Items 6 & 8) **Item 6. Abdominal Aortic Aneurysm Screening** Professor Justin Roake, *University of Otago, Christchurch* Dr Manar Khashram, *University of Otago, Christchurch* Dr Peter Sandiford, *Waitemata District Health Board* Dr Nisha Nari, *University of Otago, Wellington*  | **Item 7. BreastScreen Aotearoa**Dr Marli Gregory, *Clinical Leader***Item 8. National Cervical Screening Programme** Dr Margaret Sage  *Clinical Leader,*  |
| Apologies | Professor Jackie Cumming Dr Andrew Simpson |

| **Item** | **Subject and summary** |
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| **1.** | **Welcome, apologies and introductions** Ross Lawrenson welcomed the NSAC members, noting that Professor Mark Elwood is attending for the first time.  |
| **2.** | **Declaration of conflicts of interest (COI)**COI register tabled with no additions.  |
| **3.** | **Minutes of 6 July 2016** Confirmed as a true and accurate record. Moved by Deb Rowe. Seconded by Jo Dixon  |
| **4.** | **Correspondence tabled**1 September 2016 letter of resignation from the Chair Ross Lawrenson (effective at the end of 2016). The NSU thanked Ross for his substantial contribution over his nine years of membership of the committee and his excellent leadership as Chair. The Ministry has appointed Dr Jo Dixon as Chair. 11 July 2016 letter from the Chair Ross Lawrenson withdrawing NSAC membership of Associate Professor Brian Cox.  |
| **5.**  | **Actions from previous meetings** *Non-invasive prenatal testing (NIPT)* At its 6 July 2016 meeting NSAC considered options for inclusion of non-invasive prenatal testing (NIPT) as part of antenatal screening for Down syndrome, trisomy 18, and trisomy 13. The NSU is continuing to undertake policy development around the proposal and is yet to undertake public consultation. *National Cervical Screening Programme (NCSP)*Clarification was sought regarding responsibility for the prompt investigation of symptomatic women, especially for those aged 20-24 years. This issue is included in the NCSP Clinical Guidelines.  |
| **6.** | **Abdominal Aortic Aneurysm Screening (AAA) screening** The Chair noted that NSAC considered AAA screening in 2011. At that time, NSAC agreed that AAA screening met a number of the NHC screening criteria. These were that: * the condition is a suitable candidate for screening
* there is a suitable test - abdominal ultrasound
* there is effective, accessible treatment - elective repair
* there is high-quality evidence from randomised controlled trials that screening for men aged 65 to 79 years is effective.

However concerns existed at that time around the capacity of the health system to screen for AAA, maintain ongoing surveillance of those identified as at risk and to provide surgery. NSAC also identified the need for New Zealand population prevalence data and a cost-effectiveness assessment. It was noted that opportunistic screening is currently occurring, including some GPs undertaking ultrasound screening in their practices; and there was also a substantial amount of incidental AAA findings at the time of other investigations. In 2015 the National Health Committee (NHC) commissioned an assessment of the wider model of care for AAA. The NHC was disestablished in March 2016, prior to their consideration of the final version of the report. The report has been transferred to the NSU and was provided to NSAC for their consideration. To support NSAC’s considerations on AAA screening the following clinicians attended the meeting: * Professor Justin Roake, Vascular Surgeon and Clinical Director, Department of Vascular, Endovascular and Transplant Surgery, Christchurch Hospital.
* Dr Manar Khashram, Vascular Surgery Trainee, Christchurch Hospital.
* Dr Peter Sandiford, Clinical Director Health Gain, Auckland and Waitemata DHBs
* Dr Nisha Nair, Public Health Medicine Specialist and University of Otago Senior Research Fellow.

They gave presentations on AAA epidemiology, international screening and surveillance, NZ detection, management and outcomes, the Waitemata screening pilot in Māori men and women and cost-effective analyses. **Discussion included:*** the degree to which current relative centralisation of services would support a national approach to AAA screening
* potential impact of increased detection on surgical services, noting advice that there is currently no waiting list for surgery once an aneurysm is judged large enough for intervention
* NZ surgical outcomes are favourable compared with the UK
* harm of surgery in otherwise well with mortality between 1-2% for EVAR and 5% for open repair
* earlier identification creates the opportunity to intervene around other risk factors eg smoking (and would increase cost-effectiveness)
* prevalence appears to be higher in NZ especially for deprived populations and Māori
* the Waitemata District Health Board (DHB) pilot for Māori men aged 55-74 years (n=249) and Māori women aged 60-74 (n=193) in three general practices is to be extended in Māori men across the DHB and also to Auckland DHB, which will provide a more reliable estimate of prevalence in Māori men
* potential issue with a central agency led programme if specific ethnic groups were targeted noting the Waitemata pilot has targeted Māori with no adverse feedback to date
* there is very low AAA prevalence in Asian communities so some ethnic risk stratification likely required
* there were questions as to where responsibility for ongoing surveillance/recall would sit, with it currently being with vascular surgery teams
* there is already some experience in ongoing surveillance of high risk groups eg those with familial AAA
* workforce requirements with dedicated sonographers appearing to be the best approach, as implemented in the UK and the Waitemata pilot
* potential for a precision risk assessment within GP practice systems to identity those eligible for an AAA screen, with an algorithm currently under development
* there is reasonable confidence that the incremental cost-effectiveness ratio (ICER) estimate for a national AAA screening programme is below the NZ threshold of $45,000.
* consideration of benefits of an organised central programme versus changing the model of care eg incorporating AAA into cardiovascular risk calculations within general practice as usual practice and the ongoing surveillance/recall activities sitting with GPs
* the NHC report on AAA was regarded overall as a good report, but caution is required with some numbers eg the 200 deaths cited may be underestimate. It was noted that bowel cancer screening is being introduced with 1200 deaths per year currently occurring.
* observed that NHC considered materiality so tendency to look closely at large health issues, while conditions with smaller numbers will in fact cost a comparatively small amount to address
* noted that the Waitemata and Auckland DHBs extension of the Waitemata pilot in remaining Māori men aged 60-74 years and will also test a precision-based screening model for non-Māori
* while there were varying views as to whether there was sufficient evidence to support national AAA screening it was noted that the NHC had moved the argument a step closer with AAA screening offering the opportunity for a reasonable health gain at a reasonable cost
* overall there was general agreement that getting people screened was beneficial and that the next step was to identify how best to do this; critical barriers need to be examined eg sonography and surgical capacity
* the negative psychological impact of a person being told they have an AAA would need to be considered; this issue reflects the moral tension between population level screening and personal health
* acknowledged that deciding the design and targeting options for a national AAA screening programme would not be a fast process.

**Conclusion** The Committee 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
* target population
* priority of equitable delivery for Māori
* psychological harms to those diagnosed with an AAA who require ongoing surveillance
* consideration of options based around best clinical practice eg CVD risk assessment incorporating risk of AAA.
* opportunities to integrate case detection within GP practices, for example, GP access to AAA ultrasound screening
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| **7.**  | **BreastScreen Aotearoa – age extension**  The Committee considered the NSU’s proposal to commence work in relation to extending the eligible breast screening age range to 74 years. This step follows the International Agency for Research on Cancer (IARC) recent review of the international evidence and their conclusion that there is sufficient evidence that screening women aged 70-74 years by mammography reduces breast cancer mortality and that screening women aged 50 to 75 years is cost effective. The NSU noted that BreastScreen Aotearoa does not currently have the capacity to include women aged 70-74 years. The NSU will need to undertake an extensive analysis of the impact of changing the eligibility criteria including workforce and cost effectiveness. A key concern is the ability to maintain the 70% screening coverage target in the eligible population, and the ability to increase coverage in Māori from its current level of only 65%. **Discussion** While the potential gain for women aged 70-74 years was acknowledged, there were strongly expressed concerns about the lack of equity in the current programme with screening coverage levels for Māori women consistently below the coverage target of 70%. * Some members did not support the age extension. Instead they supported the prioritisation of achieving equity in coverage levels for Māori women currently eligible for screening as otherwise Māori would inevitably continue to suffer a higher mortality rate.
* The majority of members felt the policy work was required and that the resource implications should be made explicit for screening older women while at the same time achieving screening targets in younger Māori women. They believed that best practice should see screening offered to both groups with services for both resourced appropriately.
* It was noted that any policy work would include an assessment on the impact of age extension on equity.
* It was observed that getting older Māori women into screening could result in an increase in coverage for younger Māori women.
* It was also noted the some regions do currently reach the screening target and that the NSU should look closely at these regions to see what is working.

**Conclusion** Overall NSAC supported the NSU exploring expansion of the programme to women aged 70-74 years, with the strong caveat that the NSU must also prioritise addressing current equity issues alongside any future programme extension.  |

 **NSAC endorsements**

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| *1.* | Agreed  | The NSU will seek Ministerial approval to commence work to examine the impact on BreastScreen Aotearoa of extending the eligible age range to 74 years for New Zealand women |
| *2.*  | Agreed  | The NSU will explore options for the implementation of age extension within the New Zealand breast screening programme |
| *3.*  | Agreed | The NSU must also prioritise addressing current equity issues alongside any future programme extension |

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| **8.** | **National Cervical Screening Programme (NCSP) - update** Dr Jane O’Hallahan provided an update on implementation of the primary HPV screening including progress with the development of the clinical guidelines which are currently open to public consultation. Dr O’Hallahan also described the NSU’s scientific meetings held for the health sector during October in Christchurch and Auckland. These meetings were convened to provide details of the science underpinning the decision to adopt primary HPV screening. Approximately 100 people attended each meeting. Presenters at the meetings were Dr Jane O’Hallahan (NSU Clinical Director), NCSP science advisors Professor Karen Canfell (Cancer Council, New South Wales) and Associate Professor Dr Marion Saville (VCS Pathology, Australia), and NCSP clinical leaders Dr Margaret Sage and Dr Gary Fentiman. Dr Margaret Sage presented to NSAC on the decision by New Zealand, the UK, Europe and Australia to adopt primary HPV testing, in particular the rationale behind the decision not to adopt co-testing (performing a cytology test and an HPV test on all women). * Dr Sage summarised key literature showing the superior long term predictive value of HPV screening over cytology; explained how more than 95% of the clinical value of co-testing comes from the HPV test; and noted the downside of co-testing including substantially increased costs as everyone has two tests instead of 10-15% of screened women. The cost-effectiveness modelling using New Zealand data clearly demonstrated primary HPV testing to be highly cost-effectiveness and co-testing to be not cost-effective. These findings are in line with those from Australia and the UK.
* Co-testing provides only a small gain in sensitivity at the expense of considerable loss in specificity with referral to colposcopy if either test is positive. Additional colposcopies see increased anxiety, physical discomfort, time for investigation, potential for overtreatment and increased risk of future pre-term labour. It also results in complex management algorithms which compromise adherence to recommended screening and treatment pathways.
* Selective co-testing will be used as part of the investigation of women at increased individual risk, that is women who:
	+ have symptoms suspicious of invasive cancer;
	+ have a positive hrHPV screening test (any HPV type)
	+ have been treated for a high grade lesion (test of cure)
	+ are at greater clinical risk eg immune deficient.
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| **9.**  | **Cystic Fibrosis (CF) Carrier Screening** In response to a request from the Royal NZ College of General Practitioners, the Committee considered the addition of carrier testing for cystic fibrosis to the screening conditions recommended by the NSU. The NSU Antenatal and Newborn Screening team provided a paper summarising CF carrier screening, including international precedents for CF screening and a preliminary assessment against the National Health Committee screening criteria. In summary:* CF is included in the Newborn Metabolic Screening Programme. In 2014, 16 cases of CF were identified through newborn metabolic screening (the heal prick). Most children born with CF are born to parents who do not know they are carriers.
* only a very small proportion (about 2-5%) of all CF carriers are identified through newborn screening as a negative screening test result does not provide information about carrier status
* life expectancy for those with CF is expected to approach normal over the next 25 years due to increasing early treatment options
* CF carrier screening identifies individuals who are carriers of the most common CF causing mutations, and could detect the majority of carrier couples who are at risk of having a child with CF, enabling various reproductive choices; and it may enable earlier treatment for those with an affected foetus who choose to continue the pregnancy
* carrier testing is available free in New Zealand through regional Genetic Services for people with a family history of CF, partners of people with CF, and partners of CF carriers
* carrier testing is also available through GPs and private clinics at a cost. Information about uptake of this testing is not readily available. Additionally, direct to consumer genetic testing services advertise detection of carrier status for CF
* no country provides population based state funded CF carrier screening
* the UK National Screening Committee consideration of CF carrier screening has not resulted in a recommendation to screen all pregnant women
* fully funded population based CF carrier screening is unlikely to be achievable, or possibly desired, in New Zealand, and would not replace newborn screening for cystic fibrosis
* promotion of opportunistic screening that is currently available could compound inequity of access due to personal cost
* developments such as the rise of direct to consumer genetic testing, in the absence of pre- and post-test genetic counselling, reinforce the need for good public information to reduce the risk of confusion.

**Conclusion**The Committee concluded that it did not support population based CF carrier screening. **Action** The Chair will write to the Royal NZ College of General Practitioners advising them of the committee’s decision.  |

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| **10.** | **Bowel Screening Programme** * Following previous NSAC discussions related to bowel screening, particularly debate around screening modalities, recent publications were tabled for NSAC’s information including the following article which usefully summarises the international literature: Sarfati D, Shaw C, Mcleod M, Blakely T, Bissett I. Screening for colorectal cancer: spoiled for choice, NZMJ 2016;129 (1440):120-8.
* It was noted that the Bowel Screening Programme is now part of the NSU. A number of its work-streams reach across the NCSP and BreastScreen Aotearoa including those addressing IT needs, data warehousing and issues related to achieving equity in screening coverage and outcomes.
* NSAC members requested some clarification of its governance role in relation to implementation of the Bowel Screening Programme. The NSU will consider this issue prior to the next meeting.
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| **11.** | **Other business** * Noted upcoming International Cancer Screening Meeting, 19-21 June 2017 in Bethesda, Maryland, United States.
* Next NSAC meeting date: Wed 22 March 2017
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|  | The meeting closed at 1600hrs |