

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

Minutes Wednesday 21 March 2018

Venue	Ministry of Health, 133 Molesworth St, Wellington	
Start time	1000hrs	
NSAC members present	Dr Joanne Dixon (Chair) Dr Jane O'Hallahan (Deputy Chair) Dr Karen Bartholomew Professor Jackie Cumming (1000-1430) Professor Mark Elwood John Forman Astrid Koornneef (1200-1530) Professor John McMillan Dr Pat Tuohy	
Other attendees	NSU Anne McNicholas Principal Advisor Dr Bronwyn Rendle Public Health Physician	Item 4: National Cervical Screening Programme (NCSP) Dr Julia Scott, Public Health Medicine Registrar, NSU Item 7: Antenatal and Newborn Screening Programme Dianne Callinicos, Programme Manager Moira McLeod, Programme Leader Julia Jones, Analyst Item 8: Abdominal aortic aneurysm (AAA) screening Dr Nisha Nair, Public Health Physician, NSU
Apologies	Professor John Potter Dr Carol Atmore Dr Caroline McElnay Dr Deborah Rowe Dr Caroline Shaw	

Item	Subject and summary
1.	Welcome, apologies and introductions
2.	Declaration of conflicts of interest (COI) COI register tabled.
3.	Minutes of 15 November 2017 Confirmed as a true and accurate record. Matters arising: Noted that ACC would be made aware of the NCSPs move to implement prospective cancer case reviews.
4.	NCSP - cessation of screening in women under 25 years of age <ul style="list-style-type: none"> • NSAC endorsed the recommendation for the NCSP to change to HPV primary screening at its 18 November 2015 meeting. • NSAC endorsed the recommendation to cease cervical screening in women aged 20-24 years when HPV primary screening is introduced at its 6 July 2016 meeting. <p>NSAC and NCSP's HPV-Technical Reference Group (TRG) have previously reviewed the evidence supporting the decision to stop screening in women aged 20-24 years.</p> <ul style="list-style-type: none"> • International evidence shows that screening women aged 20-24 years has had little or no impact on rates of cervical cancer in this age group or up to age 30. • Investigating and treating common cervical abnormalities in young women, of which the majority resolve without treatment, can lead to over-treatment with associated risks. • International guidelines recommend against screening women under 25, and a number of other countries have implemented these recommendations. <p>The NCSP proposes changing the starting age for screening from 20 to 25 years before HPV primary screening commences, with the evidence base for this change strong and separate to the introduction of HPV primary screening.</p> <ul style="list-style-type: none"> • The current NCSP Register (NCSP-R) is unable to support the substantial changes needed for initiation of HPV primary screening. • A National Screening IT Solution (register) is being developed for the NCSP and other NSU programmes, in particular the National Bowel Screening Programme. • Full introduction of HPV primary screening will be postponed until this register is developed. • The NSU wishes to avoid delaying changing the starting age for cervical screening from 20 to 25 years as the harms of screening this age group outweigh the benefits. <p><i>Proposed pathways for change in screening age</i></p> <ul style="list-style-type: none"> • Women never screened should commence screening aged 25 years. They will then be managed on the current cervical cytology screening pathway until HPV primary screening is introduced. This includes two cytology tests one year apart, which has a similar level of sensitivity to a single primary HPV test. • Women under 25 years who have already been screened and received an abnormal result will continue with the current investigation and management pathway. • Women under 25 years who have already been screened and received a normal test result should discontinue screening until age 25 years. <ul style="list-style-type: none"> ○ The change for women with a normal result will require clear communication with primary care and consumers, but given the capability of the current NCSP-R, it may be challenging to implement at a register level. The NSU will further investigate how the register can support this particular aspect.

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	<p>Note. Women of any age with persistent abnormal vaginal bleeding should always have appropriate investigation and referral. The screening programme applies to asymptomatic women.</p> <p>Currently women are invited to commence screening by their general practice from age 20, and join the register after their first smear or colposcopy.</p> <ul style="list-style-type: none"> • At the end of June 2017, three year coverage for women aged 25-29 years was only 61.2% nationally, and substantially lower in Auckland at 47.9%. Coverage in older age groups ranges from 69.9-80.2% and overall coverage is 75%. The median age for commencing cervical screening is currently 26 years. <p><i>It is important there is minimal delay in women initiating screening at age 25.</i></p> <p>To support women to start screening at age 25 the NCSP proposes to centrally coordinate a proactive invitation to women to join the NCSP and attend their primary care provider to be screened.</p> <ul style="list-style-type: none"> • The invitation would be in addition to current primary care-coordinated invitations. • It would identify women by NHI prior to age 25 years and would send them a letter encouraging them to participate. • Repeated contact could be made with women in priority groups who do not join. • Details of this process are yet to be determined, and the NCSP will work with the register on a plan to achieve this. <p>The NCSP will develop a communications strategy for health providers and consumers about the proposed changes, including tailored messaging and mechanisms for priority groups. Achieving equitable access to and through the cervical screening pathway for all population groups is a key priority. Three year coverage for women aged 25-29 at June 2017 was lower for Māori (62%), Pacific (58%) and Asian (36%) women than for other women (72%).</p> <p>The NCSP will monitor cancer rates in the 20-24 and 25-29 year old age groups, and participation rates at age 25 years. The impact of the change on equity will also be monitored. The policy will be reviewed, and steps taken to increase participation rates, if any adverse impacts are identified.</p> <p>With the change to HPV primary screening, laboratories are already planning for reduced cytology testing. Cessing screening in under 25 year olds will potentially assist with workload issues as cytology staff numbers reduce in anticipation of primary HPV screening's introduction.</p> <p>The NCSP will work on the proposed changes over the next year, with the timing for implementation dependent on resourcing, as well as Ministerial approval.</p> <p><i>Discussion included:</i></p> <ul style="list-style-type: none"> • evidence on the in-effectiveness of screening in the under 25 age group is accepted • importance of HPV immunisation as key primary prevention strategy for cervical cancer • substantial concern that women must pay a GP consultation fee for cervical screening <ul style="list-style-type: none"> ○ NCSP is the only screening programme which requires a payment ○ impacts substantially on screening uptake ○ creates major inequities ○ increasing coverage requires a reduction in up-front cost and going forward there should be no cost ○ NSAC supported a strong position being taken on free screening, and suggested the issue be considered as part of the current primary care subsidy review • messaging is important: <ul style="list-style-type: none"> ○ should include: there is no evidence of benefit and there is evidence of harm (it is unethical to continue) ○ importance of front footing messaging as there is a risk of push-back from some providers and consumers, especially if perception of service removal

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	<ul style="list-style-type: none"> ○ needs to specifically address increasing coverage in Māori, Pacific and Asian • suggested PHO enrolment in under 25s may only be about 60%, with many women choosing to go elsewhere eg family planning, so this will complicate proposal for an additional (centrally led) invitation, but agree extra initiatives still required • questioned whether it would be practical to stop screening women under 25 who have already been screened and have a normal result • importance of consultation with primary care noted • noted that some members of TRG did not support the component of the proposed pathway for screening women under 25 on a case by case basis in the context of early sexual activity (as detailed in the draft HPV screening guidelines) and this issue will be re-assessed. <p>NSAC endorsements</p> <p>NSAC endorsed the TRG 7 March 2018 recommendations, noting that an emphasis on communications will be critical.</p> <table border="1" data-bbox="276 719 1437 1167"> <tr> <td data-bbox="276 719 336 824">1.</td> <td data-bbox="336 719 1437 824">Support in principle that NSU implement ceasing screening in women aged under 25 years prior to HPV primary screening implementation.</td> </tr> <tr> <td data-bbox="276 824 336 891">2.</td> <td data-bbox="336 824 1437 891">Support in principle the proposed pathways for women aged 20-25 years.</td> </tr> <tr> <td data-bbox="276 891 336 996">3.</td> <td data-bbox="336 891 1437 996">Support in principle that NSU explore a proactive invitation process for women prior to their 25th birthday.</td> </tr> <tr> <td data-bbox="276 996 336 1102">4.</td> <td data-bbox="336 996 1437 1102">Note that safety and equity monitoring and a wide-ranging communications strategy will be part of this transition project.</td> </tr> <tr> <td data-bbox="276 1102 336 1167">5.</td> <td data-bbox="336 1102 1437 1167">Note that equity is a primary consideration for this implementation.</td> </tr> </table>	1.	Support in principle that NSU implement ceasing screening in women aged under 25 years prior to HPV primary screening implementation.	2.	Support in principle the proposed pathways for women aged 20-25 years.	3.	Support in principle that NSU explore a proactive invitation process for women prior to their 25 th birthday.	4.	Note that safety and equity monitoring and a wide-ranging communications strategy will be part of this transition project.	5.	Note that equity is a primary consideration for this implementation.
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5.	<p>Pulse Oximetry Screening (POS) for Critical Congenital Heart Disease (CCHD)</p> <p>In July 2015 NSAC considered a preliminary assessment of POS of newborns for CCHD and plans for a pilot/feasibility study. NSAC was supportive of POS for CCHD, and the pilot, but was undecided as to which implementation approach would work best:</p> <ul style="list-style-type: none"> • a nationally led screening programme • a nationally led quality improvement programme • sector led implementation with screening framed as part of improvements in routine care. <p>In July 2017 NSAC considered preliminary results from the first 12 months of a POS feasibility study led by Dr Elza Cloete (Liggins Institute). The pilot was undertaken at:</p> <ul style="list-style-type: none"> • Auckland District Health Board (ADHB): Auckland City Hospital and Birthcare • Lakes DHB: Rotorua and Taupo Hospitals, and Turangi Maternity Unit • Counties Manukau DHB: Pukekohe, Papakura and Botany Maternity Units (not Middlemore hospital). <p>NSAC felt the POS feasibility study results to date were very encouraging, and was to further consider options for a national POS screening programme on completion of the pilot and an economic evaluation.</p> <ul style="list-style-type: none"> • The July 2017 meeting minutes noted that Wellington and Dunedin hospitals were in the process or had already adopted POS. • The minutes conclusions included that “<i>in the meantime efforts should be made to encourage the sector to implement POS as part of routine clinical care</i>”. <p>Dr Cloete has recently advised the NSU that the POS pilot is nearing completion with data collection concluding on 30th April 2018.</p>										

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	<ul style="list-style-type: none"> • Dr Cloete has asked if there has been any effort to encourage the implementation of screening as part of routine clinical care, as included in the July 2017 meeting minutes. • While most DHBs are likely to continue screening at the end of the pilot, the study team is concerned that the DHB which detected the most babies with CCHD has indicated it will wait for NSU recommendations before taking steps to introduce screening permanently. <p>The Cochrane Collaboration has just published a review of POS for CCHD (Plana M et al., Pulse oximetry screening for critical congenital heart defects. <i>Cochrane Database of Systematic Reviews</i> 2018, Issue 3).</p> <ul style="list-style-type: none"> • The review concludes POS is a “<i>highly specific and moderately sensitive test for the detection of CCHD with very low false positive rates. Current evidence supports the introduction of routine screening for CCHD in asymptomatic newborns before discharge from the well-baby nursery</i>”. <p><i>Discussion included:</i></p> <ul style="list-style-type: none"> • evidence is strong for use of POS within routine clinical practice • equity in provision of POS is of key concern • no specific steps have been take to encourage the sector to use POS in routine care since NSAC’s views were recorded in the July 2017 meeting minutes (publicly available on the NSU website) • Dr Pat Touhy noted he had discussed NSAC’s support for POS at a recent meeting of the Newborn Clinical Network; and that the Well Child / Tamariki Ora Programme Practitioner Handbook on the Ministry website discusses infant screening could be updated to mention POS, acting as a mechanism to action POS. <p>Conclusion</p> <ul style="list-style-type: none"> • NSAC’s Chair will write to the Ministry’s DDG, Service Commissioning and Dr Cloete to confirm NSAC’s support for the sector’s implementation of POS as part of routine clinical care. The Chair will also consider writing to the Royal New Zealand College of Obstetrics and Gynaecology and the College of Midwives. • NSAC will consider options for a national screening programme or a nationally led quality improvement programme over and above current sector led improvements in routine care on completion of the pilot and an economic evaluation.
6.	<p>Genomics</p> <p>Dr Joanne Dixon presented on genomics in healthcare (using genomic information about an individual as part of their clinical care) particularly in relation to screening. A key area discussed was the priority of informed consent.</p> <ul style="list-style-type: none"> • Informed consent is a critical aspect with new models required. <ul style="list-style-type: none"> ○ Tiered – differentiated consent with information divided into categories of traits or diseases, ○ Layered – essential information for all consumers (test purpose, suitability, limitations, follow-up, data protection, sources of independent information); and secondary information accessible for those who seek it (more details, personal significance, risk estimates), ○ Staged approach – take time for stepwise consent with informational and decisional phases. • Noted that the consenting process for non-invasive prenatal screening in the antenatal screening pathway will require close attention and will likely change compared with current steps.

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7.	<p data-bbox="260 208 1469 275">Antenatal and Newborn Screening Programme - Down syndrome and other conditions quality improvement programme: non-invasive prenatal screening (NIPS)</p> <p data-bbox="260 320 778 353">March and July 2016 NSAC meetings</p> <p data-bbox="260 387 1477 488">NSAC considered quality improvement initiatives focussed on screening for “Down syndrome and other conditions” as well as aspects of NIPS including cost-effectiveness, and legal and ethical implications.</p> <ul data-bbox="260 495 1477 864" style="list-style-type: none"> <li data-bbox="260 495 1477 689">• The NSU outlined their support for introducing NIPS as a contingent screen within the current screening pathway highlighting: <ul data-bbox="308 562 1374 689" style="list-style-type: none"> <li data-bbox="308 562 1129 595">○ the decrease in invasive diagnostic testing (amniocentesis) <li data-bbox="308 595 1347 629">○ the more reliable information and reduction in the number of false negatives <li data-bbox="308 629 1374 689">○ improved cost effectiveness (due to the substantial decrease in the number of amniocentesis procedures). <li data-bbox="260 696 1382 757">• Contingent screening is regarded as a step toward universal testing, allowing for a managed introduction and avoiding overburdening the health system. <li data-bbox="260 763 1477 864">• NSAC agreed that NSU would identify the preferred risk threshold for contingent testing (1:300 or 1:1000) following further consideration of cost-effectiveness analyses, feedback from public consultation, and advice from the Technical Working Group. <p data-bbox="260 898 906 931">Update on progress towards introducing NIPS</p> <p data-bbox="260 965 1422 1032">Public consultation is planned for mid-2018 and a cost modelling exercise is underway to support a 2019/20 budget bid.</p> <ul data-bbox="260 1039 1477 1375" style="list-style-type: none"> <li data-bbox="260 1039 1477 1205">• Recent performance improvements in current first trimester programme (primarily sonographer performance) has resulted in a possible increase in the detection rate amongst those screened from 78% to 87% (preliminary data to be confirmed). This improvement may impact on the risk threshold chosen for contingent NIPS with an update of the cost effectiveness analysis under consideration. <li data-bbox="260 1211 1442 1312">• Noted that the Netherlands initially implemented NIPS for high risk pregnancies in April 2014 (TRIDENT study). It has been offered to all pregnant women, with a co-payment, since April 2017 (TRIDENT 2 study). <li data-bbox="260 1319 1442 1375">• The UK is expected to provide NIPS as a contingent test for high risk pregnancies from mid-2018. <p data-bbox="260 1408 1062 1442">NSAC feedback on the draft NIPS consultation document</p> <p data-bbox="260 1476 1493 1677">In summary, NSAC regarded the current draft document as a technical consultation document. The public consultation document needs to emphasise that NIPS will improve the quality and reliability of information, helping those who choose to screen consider their options. The document should emphasise there will be less risk through the pathway as the need for invasive testing (amniocentesis) will reduce. The driver for change is the improved quality of NIPS over current first trimester screening, not because of economic evaluations.</p> <p data-bbox="260 1711 692 1744"><i>Public and technical consultation</i></p> <ul data-bbox="260 1751 1501 2016" style="list-style-type: none"> <li data-bbox="260 1751 1501 1852">• While NIPS introduction is essentially a quality improvement step, public consultation is important as it is a significant change: it requires a significant investment and is the first use of a genomic test in antenatal screening. <li data-bbox="260 1859 1449 1919">• Important to have both technical and public consultation documents as questions to the public are different, noting some groups will participate in both consultation arms. <li data-bbox="260 1926 1501 2016">• Developing the public consultation document requires an assessment of what a reasonable person would expect to be told about NIPS (as enshrined in the Health Privacy Code) and needs to ask what women want to know.

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	<ul style="list-style-type: none"> • Public consultation is about the proposal to add NIPS to the current screening pathway and emphasis would include: <ul style="list-style-type: none"> ○ the value of information for parents ○ the mother's conversation with the midwife ○ an element of public education such as: <ul style="list-style-type: none"> ▪ clarity that NIPS is only being considered for the trisomies T21, T13, T18 ▪ explanation of how the test works and how it provides increased test accuracy/certainty, and increased safety through the screening pathway with reduction in the number of pregnancies that will have invasive testing ▪ emphasis that screening is a choice, and that NIPS will provide better quality information that can help families consider their options and prepare for a baby that may be affected by T21, T13 or T18 ○ scenarios so that people can clearly see different pathway options ○ consideration of consent and data privacy issues: NIPS involves a genomic test so the document should include an explanation of what happens to the DNA and how the sequenced data is stored. • The technical document (for GPs, midwives, labs etc) would cover, for example, issues related to the threshold options for contingent testing and whether the highest risk group (risk 1:2 to 1:50) should continue to be offered amniocentesis. • The documents also require a whakapapa / Māori lense across them and must include a statement relating to Māori sensitivities: <ul style="list-style-type: none"> ○ noted that the Health Research Council funded Te Mata Ira research project explored Maori views on genomic research and biobanking for the development of culturally appropriate guidelines, and the NSU should consider their work in development of the consultation documents. • Stakeholders for consultation will include Down syndrome support groups. An academic theological perspective was also suggested. <p><i>Reflex testing</i></p> <ul style="list-style-type: none"> • The option of reflex testing was discussed as an approach that could reduce anxiety. <ul style="list-style-type: none"> ○ Taking a second blood test for the NIPS (following a first trimester high risk result) adds a delay and increased anxiety/burden for families. ○ Noted reflex testing options have been previously investigated and found to not be logistically possible (in NZ and overseas) because of laboratory constraints around specimen storage. ○ Also noted that the greatest delay currently is with specimens being sent overseas. <p><i>Cost effectiveness modelling</i></p> <ul style="list-style-type: none"> • An update of the NIPS cost effectiveness modelling is required to reflect the recently increased detection levels in routine first trimester screening as well as reduced test costs • The table on page 4 of the report on NIPS cost effectiveness was noted: it could usefully be included in consultation documents as it provides clarity around the impact of NIPS compared with current screening, particularly the reduction in amniocentesis procedures. • Cost effectiveness analyses do not and should not look at family and societal dollar costs of having a child with Down syndrome <p>NSAC also noted that:</p> <ul style="list-style-type: none"> • “Down syndrome and other conditions” screening is currently a quality improvement programme not a “screening programme”. • there should be universal offer of Down syndrome screening, but having no target for the uptake of screening is an important principle. • the purpose of Down syndrome screening is to provide information for parents and allow important choices. This approach is regarded as a sound framework. Offering screening, and support for decisions must not be judgemental or coercive.

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	<ul style="list-style-type: none"> The Down syndrome and other conditions quality improvement programme has recently established an equity working group and it includes two members from the New Zealand Down Syndrome Association.
8.	<p>Abdominal aortic aneurysm (AAA) screening</p> <p>Conflict of Interest: noted Karen Bartholomew's role as Manager of Waitemata/Auckland DHB AAA screening pilot/extension.</p> <p>NSAC has considered AAA screening previously including:</p> <ul style="list-style-type: none"> <i>9 November 2016 meeting:</i> 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: <ul style="list-style-type: none"> priority of equitable delivery for Māori consideration of options based around best clinical practice eg CVD risk assessment incorporating risk of AAA opportunities to integrate case detection within GP practices, eg GP access to AAA ultrasound screening cost effectiveness. <i>15 Nov 2017 meeting:</i> NSAC considered preliminary findings from the Waitemata and Auckland DHBs screening of Māori men and women, Waitemata DHB's preliminary testing of a precision screening tool (a risk prediction algorithm) with its potential integration into Primary Care CVD risk assessment, and a risk assessment approach suggested by the Vascular Society of New Zealand. <p>Dr Nisha Nair presented results from the University of Otago's Burden of Disease Epidemiology, Equity and Cost Effectiveness Programme (bode³) AAA cost utility modelling.</p> <p>The study looked at whether a UK-style AAA screening programme would be cost-effective in New Zealand. The bode³ study used the UK's Glover model and compared a one-off ultrasound scan for men aged 65 to no dedicated screening programme.</p> <ul style="list-style-type: none"> The target population was men aged 65 in 2011, followed for a lifetime horizon. The model counted Health gains in QALYs, health system costs in NZ\$ and the incremental cost-effectiveness ratio (ICER) in NZ\$ per QALY. Using the generally accepted ICER cut off of \$45,000 per QALY to indicate cost-effectiveness, the model found that a UK-style AAA screening programme in NZ is very likely to be cost-effective with a mean ICER of \$13,570 (lower limit \$6227; higher limit \$31,887). <p><i>Discussion included:</i></p> <p><i>Cost effectiveness modelling results</i></p> <ul style="list-style-type: none"> The analysis is strong with good evidence of cost effectiveness While the model indicates cost effectiveness, the range is wide, and the \$45,000 ICER cut-off is not what is necessarily applied in practice. The ICER threshold used by Pharmac is unknown; and there are other interventions/issues to be considered eg, budget/capacity/affordability The model is steady state, and does not capture set-up costs; up-front costs need to be affordable and are likely to be significant. Too many unknown inputs to use the cost-effectiveness model to look at the Waitemata CVD risk predictive tool in primary care. Noted that the US Preventive Task Force recommends one lifetime screen for men at age 65 only if they are smokers.

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	<p>The NSU introduced as a topic for discussion the extent to which, when considering recommending a screening programme such as AAA, NSAC should explicitly prioritise equity; and if they should compare a screening programme against other screening programmes or compare against different interventions including up-stream activities, eg smoking prevention vs AAA screening.</p> <p>The Committee expressed varying views around prioritisation, equity and AAA screening approaches, summarised below.</p> <p><i>Prioritisation</i></p> <ul style="list-style-type: none"> • In the context of screening, once there is strong validated evidence, the imperative is often to do something. However a major consideration is always cost and readiness. • Members had varying views as to whether NSAC is the place to make trade-off considerations: the Ministry holds the wider role of comparing a potential screening programme against other interventions, taking cost effectiveness further and looking at opportunity costs. The call on what is funded is outside NSAC remit. • PHARMAC now uses a range of assessment criteria (up to 15) in addition to cost, and it would be useful if they could present to the Committee on how this system is working. <p><i>Equity</i></p> <ul style="list-style-type: none"> • Equity is a critical aspect in looking at implementation options eg the impact on equity of centrally led population screening versus primary care led screening, and also when compared to other ways (apart from screening programmes) to reduce health inequities. • It may be important to weigh up a potential new programme against improving equity in another programme eg, starting AAA screening versus increasing cervical screening in Māori women. • Noted AAA prevalence is reducing (estimated about 4-8% about 15 years ago and now about 1.5-2%), with the fall associated with smoking reductions and improved CVD management. However, even as smoking prevalence plateaus, it will leave a reasonable number of AAA cases. • How you design the screening model will effect equity, noting that the Waitemata/ADHB AAA screening of Māori men and women is equity driven ie, by only screening Māori. • For AAA screening, question of how overall gains is balanced against equity concerns. Acknowledge majority of disease is in non-Māori, but AAA mortality rates are double for Māori. Yet cannot guarantee the impact of a whole of population AAA screening programme on AAA inequalities between Māori and non-Māori ie, a positive, neutral or negative impact. • The NSU's Māori Monitoring and Equity Group (MMEG) does not support a national centrally led AAA screening programme as they regard the opportunity costs as too high given other health priorities. There are about 200 AAA deaths per year and about 16 of these are in Maori. However, NSAC noted this is more deaths than currently occur from cervical cancer. • One option MMEG suggested was free ultrasound for Māori men through GP practice. <p><i>Waitemata DHB - risk based precision screening</i></p> <ul style="list-style-type: none"> • Concerns expressed about the potential for integrating the risk predictive tool (algorithm) into routine primary care cardiovascular disease (CVD) risk assessment. • The additional information required to make an informed decision to use this targeted approach compared to a population based one is substantial. We know much more about a population based AAA screening programme and relatively little about a targeted AAA screening programme based on risk prediction. • CVD risk assessment coverage varies considerably, and recent removal of the CVD risk assessment targets will likely reduce coverage; and there is recognition their

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	<p>implementation was not equity enhancing (Allen and Clarke. 2016. More Heart and Diabetes Checks Evaluation. Wellington: Ministry of Health).</p> <ul style="list-style-type: none"> • Adding a risk predictive algorithm/dashboard to the Patient Management System (PMS) is not easy & is expensive. • Validation of the algorithm and this approach is an outstanding & substantial issue. • It can be seen as essentially opportunistic screening at point of care, which is not a screening programme. • The National Health Committee conclusion (cited in the cover memo for this meeting) that the “targeted approach ie case finding through enhanced CVD risk assessment, is an efficient way to detect most people with AAA” overstates the case. However a separate calculation appears to indicate that screening people with 2% or more risk potentially excludes about 70% of the population and misses about 39% of AAA. • There are also concerns regarding evidence to support the cover memo’s statement that the “advantage of a targeted approach is that it is probably more cost effective and has a better benefit-risk ratio”. For example, the people in the targeted group are likely to have higher post-op mortality and morbidity compared to the low risk group as they will have other illnesses etc, and they probably also have a higher chance of over diagnosis due to these other conditions. • On one hand it was argued that AAA screening should be a primary care delivered programme, with GP practices the home of health care and the best place to concentrate efforts. However another view was that primary care capacity is a concern, and currently there is resistance to new CVD risk assessment guidelines. • A formal evaluation of the Waitemata/ADHB AAA screening of Māori men and women will be completed soon and will come to NSAC. <p><i>System capacity</i></p> <ul style="list-style-type: none"> • Further consideration of the ability to implement AAA screening is required against the screening criteria of system capacity. • The current ability of the NSU to deliver a new programme is severely compromised by current commitments, particularly implementation of the National Bowel Screening Programme and major changes across other nationally led screening programmes. <p>Concluding comments</p> <ul style="list-style-type: none"> • AAA is a suitable candidate as a screening condition given its population frequency, the likelihood of serious and life threatening presentation, and availability of effective life-saving effective intervention with early detection. • Ultrasound is an easy and non-invasive test that performs with high sensitivity and has a low false positive rate. • National guidelines and consensus are important to avoid the wide variation in practice. • A key challenge remains to decide which approach would best establish a high quality AAA screening programme with equitable access and outcomes. <ul style="list-style-type: none"> ○ A NSU led AAA population screening programme seems an unlikely outcome in the interim, given the resources required to establish such a programme, although this approach would more likely produce better outcomes, provide equitable access and outcomes and allow comprehensive quality assurance. ○ The NSU will explore the option of implementing AAA screening as improved case ascertainment in primary care (a free one-lifetime screen for men at age 65 years), possibly developed regionally and allied to vascular hubs. It was noted that the screening pathway for primary care would require development, and that there must be explicit steps to monitor and address equity through the pathway.

Item	Subject and summary
9.	<p>UK National Screening Committee</p> <p>Simon Hailstone, a Public Health Speciality Registrar with the UK National Screening Committee gave a presentation on the operation and scope of the UK Committee.</p> <ul style="list-style-type: none"> NSAC noted the UK's investment in implementation research and that it would be useful for the NSU to meet with NZ Health Research Council Chief Executive Officer to discuss prioritisation and decision making.
10.	<p>Programme updates</p> <p><i>National Bowel Screening Programme</i> The Terms of Reference for an Independent Assurance Review for the National Bowel Screening Programme have been released.</p> <ul style="list-style-type: none"> The Minister of Health is seeking assurance through an independent review about how well positioned the programme is for successful delivery, what changes might be required and what the Ministry of Health can learn to support the design and roll out of further national initiatives. The Health Quality and Safety Commission will provide project management and secretariat support to the review team. Professor Gregor Coster will lead the review team that includes Dr William Rainger, Professor Graeme Young and Dr Mary Seddon. The review team will also include input from a Public Health Medicine Specialist to provide expertise on population health systems and the impacts of these systems on the quality and safety of the roll out with a focus on future improvements. <p><i>The National Bowel Screening Programme rollout is progressing</i></p> <ul style="list-style-type: none"> Hutt Valley and Wairarapa DHBs commenced screening on 17 July 2017. Waitemata DHB transitioned from the pilot to the national programme on 1 January 2018. Southern and Counties Manukau DHBs will commence screening by 30 June 2018. The remaining 15 DHBs are scheduled to implement the programme between 1 July 2018 and 30 June 2021. <p><i>NCSP</i></p> <ul style="list-style-type: none"> The primary HPV self-sampling feasibility study in Auckland DHB has been completed. The full study in Māori, Pacific and Asian women will be rolled-out from April 2018. There are three study arms: mail out of invitation with self-sampling at home; clinic based invitation with self-sampling at the clinic; and usual care.
11.	<p>Other business</p> <p><i>Updated flexible sigmoidoscopy position statement</i></p> <ul style="list-style-type: none"> The Ministry plans to issue an updated position statement re-confirming the faecal immunochemical test (FIT) as the National Bowel Screening Programme's screening test rather than flexible sigmoidoscopy. The statement will note the support of the Ministry's National Bowel Screening Working Group, the Bowel Screening Advisory Group and NSAC. A draft position statement was provided to NSAC for consideration. The National Bowel Cancer Working Group is amending this version. Depending on timeframes, the final version will come back to NSAC or the Chair for signoff. <p><i>NSAC remaining meeting dates for 2018: Wednesdays of 25 July and 28 November.</i></p> <p>The meeting closed at 1530hrs.</p>