National Screening Advisory Committee (NSAC) National Screening Unit (NSU)		
Minutes Wednesday 25 July 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 Carol Atmore Dr Karen Bartholomew John Forman Astrid Koornneef Dr Caroline McElnay Professor John McMillan Dr Deborah Rowe Dr Caroline Shaw	
Other attendees	**NSU** Anne McNicholas Principal Advisor Dr Bronwyn Rendle Public Health Physician Dr Nisha Nair Public Health Physician Dr Emma Chuch Public Health Registrar	**Item 6: Lung Cancer Screening** Dr Richard Jaine, University of Otago **Item 7: Prostate Cancer Screening** Dawn Wilson, Manager, Cancer Services, Ministry of Health **Item 8: Screening Criteria** Dr James Harris, PHARMAC
Apologies	Professor Jackie Cumming Professor Mark Elwood Professor John Potter Dr Pat Tuohy	

Item	Subject and summary
1.	**Welcome, apologies and introductions**
2.	**Declaration of conflicts of interest** Conflict of interest register tabled.
3.	**Minutes of 21 March 2018** Amended and confirmed as a true and accurate record.
4.	**Correspondence tabled** • NSAC Chair correspondence to Dr Elza Cloete (Liggins Institute) and the Ministry of Health's Director Service Commissioning and Chief Medical Officer re pulse oximetry screening for critical congenital heart disease. • NSAC Chair correspondence with the Breast Cancer Aotearoa Coalition. • NSAC Chair correspondence with the Federation of Women's Health Councils.

5.	**NSAC work programme - overview**
	The overall work programme was noted.
	Discussion included:
	• potential role for NSU through partnership models or quality improvement initiatives in areas such as the B4 School Check programme and retinal screening in primary care
	• oversight role NSAC can provide across screening in a broader sense, while working within acknowledged resource constraints
	• the NSU's current contribution to quality improvement initiatives around maternity ultrasound because of its established expertise through Antenatal and Newborn Screening Programme
	• antenatal screening for infectious diseases (hepatitis B, HIV, syphilis), noting the national increase in syphilis incidence and recent cases of congenital syphilis
	  ○ the cases of congenital syphilis highlight the absence of a "failsafe" screening programme to stop babies getting congenital syphilis, with this situation viewed as unethical
	  ○ assurance is required that antenatal screening is achieving what is wanted
	  ○ the re-emergence of congenital syphilis exposes the lack of antenatal screening monitoring data with at least a lab–based surveillance framework required urgently alongside retrospective review to find out why the congenital cases occurred
	  ○ current imperative is a robust antenatal monitoring and oversight framework including for congenital syphilis, Hep B and HIV
	  ○ longer-term a comprehensive and systematic approach is required for antenatal and well child screening through the first five years of life, including a strong equity focus
	  ○ the broader child well-being work programme reflecting the Government approach around the first 1000 days of a child's life should include antenatal screening
	• gestational diabetes was also noted as part of a well-baby approach. NSAC has previously reviewed this area and will reconsider it following completion of two trials underway in Auckland.
	Actions
	• Karen Bartholomew to provide a report back on B4 School Check performance to inform NSAC considerations around scope of any potential role.
	• NSAC Chair to write to the Ministry expressing concern regarding re-emergence of congenital syphilis cases and the imperative of establishing a robust antenatal monitoring framework.

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6.	**NSAC work programme review - lung cancer screening**
	
	Additional information was provided on lung cancer screening as part of this year's review of NSAC's work programme.
	
	• Dr Richard Jaine presented the results of cost effectiveness modelling for lung cancer screening in New Zealand from the University of Otago's Burden of Disease Epidemiology, Equity & Cost-Effectiveness Programme (bode³).
	  ○ The researchers modelled biennial low dose computerised tomography (LDCT) screening applied to high-risk a population* over 20 years (2011 to 2031) among all estimated eligible New Zealanders alive in 2011, with a lifetime horizon or follow-up, compared to no screening (* high risk population defined as adults aged 55 to 74 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years).
	  ○ Based on a threshold of GDP per capita per QALY gained (ie NZ$45,000) LDCT screening is unlikely to be cost-effective for any sociodemographic group.
	  ○ The researchers also concluded that it is important to investigate the nuances of cost-effectiveness for certain populations; and that resources need to be maintained to reduce harm from lung cancer with current health gains through tobacco cessation related interventions.
	• NSAC noted that a recent HRC cancer screening research application proposes to examine whether risk prediction models underestimate lung cancer risk for Māori.
	• NSAC will not undertake an in-depth review of lung cancer screening within the next two years as it will await the UK National Screening Committee's next evidence review and final recommendations. The UK deliberations will follow analyses of the large Dutch-Belgian lung screening trial (NELSON) and the pooled data from the NELSON trial and the UK Lung Cancer Screening Trial (UKLS).
	
	Recommendation
	
	NSAC recommended that the NSU maintain a watching brief of international lung cancer screening developments.

7.	**NSAC work programme review – prostate cancer screening**
	
	Additional information was provided on prostate cancer screening as part of this year's review of NSAC's work programme.
	
	In May 2018 the US Preventive Services Task Force (USPSTF) released an updated prostate screening recommendation (replacing their 2012 Grade D recommendation which did not support routine prostate cancer screening).
	
	• The recommendation grade has increased to a "C" (moderate certainty that the net benefit of reducing the chance of death from prostate cancer is small in some men). However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction.
	
	• In summary, the USPSTF now recommends that:
	  ○ the decision for men aged 55-69 to be screened should be based on informed individual decision making and should consider a man's values and specific clinical circumstances
	  ○ clinicians should not screen men who do not express a preference for screening
	  ○ men older than 70 should not be routinely screened for prostate cancer as the potential benefits do not outweigh the harms (D recommendation).
	
	The UK National Screening Committee last reviewed prostate cancer screening in 2016. The UK Committee did not recommend universal screening of men for prostate cancer because:

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	• the major harms of treating men who incorrectly test positive outweighs the benefits • PSA is a poor test for prostate cancer with a more specific and sensitive test is needed • PSA is unable to distinguish between slow-growing and fast-growing cancers • the current evidence does not support a population screening programme using any other test. In March 2018 a large UK randomised trial published its findings: "*Effect of a low-intensity PSA-based screening intervention on prostate cancer mortality. The CAP randomized clinical trial" (JAMA, 2018:319 (9):883-895*). • The study findings do not support a single PSA screening test for population-based screening for prostate cancer. New Zealand's 2009 Parliamentary Select Committee Inquiry did not support a national screening programme, recommending a Prostate Cancer Awareness Quality and Improvement Programme. This Programme sits under the Ministry of Health's Cancer Services team. They recently commissioned the development and implementation of a: • public facing decision support tool designed for men (target audience is Māori and Pasifika), and their families and whānau regarding prostate cancer testing and treatment which aims to help men decide if a prostate check is right for them • separate guide and support for GPs and other primary care health professionals to ensure consistent clinical management of men and informed decision-making with patients on testing and treatment. It will sit within GP patient management systems. Dawn Wilson (Manager of Cancer Services, Integrated Service Design at the Ministry of Health) provided information on the development and recent launch of the public facing web based decision support tool (named Kupe). *Discussion included:* • substantial concern that the decision tool does not address the magnitude of the risks and harms of screening asymptomatic men • the necessity for a balanced consideration and presentation of the evidence base for prostate screening of asymptomatic men to ensure clarity in messages for this group • the importance of a clear separation of advice for symptomatic and asymptomatic men • the text provides contradictory and confusing information and uses language that is unlikely to be easily understood by or connect with target audiences • NSAC's definitive position that there is a lack of evidence of benefit from universal screening of asymptomatic men, noting the recent UK CAP study results • the need for the input of population level screening expertise into the development of such decision tools, and that NSAC and the NSU are well placed to provide such advice. **NSAC statement** NSAC's previous position, which does not support population level screening for prostate cancer in asymptomatic men, remains unchanged. **Actions** • NSAC Chair to write advising of NSAC's concerns around the messages the decision tool gives asymptomatic men and primary care, and that NSAC's position of not supporting population based prostate screening in asymptomatic men stands. • NSAC will reconsider prostate cancer screening at its March 2019 meeting, and will review in particular the recently published UK CAP randomised trial results.

8.	**Screening criteria** Jane O'Hallahan summarised views presented at a two day expert screening meeting she attended in the UK, including how screening criteria are applied. Key messages were: • the importance of information quality, informed choice, informed consent and patient autonomy • that the harms of screening need to be given equal consideration alongside the benefits • that when assessing a screening initiative the concept of an overall categorisation of high value, close call or low value may help decision makers. James Harris gave a presentation on the process PHARMC follows in making its decisions, particularly the assessment criteria it uses, that is, their "Factors for Consideration". These factors cover four dimensions (need; health benefits; cost and savings; and suitability) and three levels of impact (to the person; to the person's family, whanau and wider society; and to the broader health system). NSAC noted PHARMAC'S consideration of equity under the dimension of "need".
9.	**Open disclosure** NSAC provided feedback on the NSU's draft policy document on open disclosure. The committee noted that all screening programmes can cause harm. There is a need for the document to separate false negatives and false positives inherent to screening programmes (expected harms) from, for example, errors due to a wider system failure (unexpected harms).
10.	**Programme updates** *National Bowel Screening Programme (NBSP)* • The NBSP rollout is progressing as planned. • The Ministry has published on its website the document "National Bowel Screening Programme: Consideration of the potential equity impacts for Māori of the age range for screening". • The Ministerial Review for the Bowel Screening Programme has been completed with its release anticipated shortly. NSAC expressed interest in an in-depth discussion of equity related issues across the NSU programmes at a future meeting.
11.	**Terms of reference: annual review** Amendments to NSAC's role to include: • provision of strategic advice for screening activities in the wider health system • consideration of equity (in addition to its current inclusion under NSAC's principles).
12.	**Other business** Professor John McMillan has agreed to act as Chair during Dr Joanne Dixon's absence over the next 6-9 months. Next meeting: 28 November 2018. Meeting closed at 1530hrs.