

# Minutes

## Clinical Assembly Meeting

**Date:** Thursday 21 October 2021

**Time:** 1pm to 4pm

**Location:** Via Zoom

**Chair:** Chris Jackson

**Attendees:** Alex Henderson, Chris Hemmings, Claire Hardie, Heidi Watson, Humphrey Pullon, Ian Bissett, James Entwisle, Justin Gulliver, Laura Clunie, Mary-Ann Hamilton, Scott Macfarlane, Tom Middlemiss

**Te Aho o Te Kahu attendees:** Diana Sarfati, Liz Dennett, Gabrielle Nicholson, Rose Simpson, Trish Smith, Elinor Millar, Helen Stobba, Jane Dancer

**Minutes:** Elaine Edwards

**Guests:** Alastair Higham-Lee and Kristin Good (End of Life Choice Act Update)

**Apologies:** John McMenamin, Meredith Jones, Richard North, Sue Waters, Jonathan Koea, Dawn Wilson, Ineke Meredith

### Item

#### **Review of draft minutes from July 2021 meeting, actions, and conflicts of interest register**

The minutes of the meeting held on 29 July 2021 were accepted as a true and correct record.

The action register was reviewed. All actions are complete.

The conflicts register was reviewed. Changes were recorded as follows:

- Chris Jackson is no longer Medical Director of the Cancer Society.
- Justin Gulliver notes he is now is Regional Lead for the Cancer Psychology and Social Work Support Service.
- Ian Bissett is no longer Chair of the NBCWG (he remains a member of the NBCWG).
- Scott Macfarlane to be removed from the register as this is his final meeting.
- Chris Hemmings list was updated in the Interest Register for the October agenda pack.

#### **Ministry of Health End of Life Choice Act Update**

The Ministry of Health End of Life Choice implementation team gave a presentation. The key information is available on the Ministry website. Key points were highlighted as follows:

- The Ministry has established a secretariat to provide support and guidance.
- Dr Kristin Good is the appointed Registrar for assisted dying.

- Two DHB pharmacies will be responsible for the distribution of equipment and medicines for the service throughout New Zealand.
- 120 people have put their names forward to be on the SCENZ list. The team are confident that the workforce is sufficient to deliver the service.
- The members are encouraged to view the Morag McDowell Webinar (recorded) and also the Medical Council documents.
- The document "*How to respond when someone raises the topic*" was noted as being an excellent resource.
- The Group queried if doctors could discuss eligibility but not confirm it? It was confirmed that only the attending medical professional (AMP) can confirm eligibility.
- Under 18 years of age are ineligible.
- Eighty percent of patients who access assisted dying in Oregon are Cancer patients.

### **QPI Process Review**

An overview of the Quality Performance Indicator (QPI) programme activities was provided. The proposed changes to the programme will build on work to date. The Cancer Care Data Explorer tool was demonstrated to the Group (available on the Te Aho o Te Kahu website). The presentation will be shared with the group after the meeting. The Group were encouraged to provide the team with feedback on the proposals.

Key points were discussed as follows:

- The bowel cancer QPI funnel plots were discussed. Reporting by year has been adopted as the best visual way to show change over time, but this cannot be done by DHB at this stage, instead it will be presented as national, aggregated numbers. This is because of low numbers in some DHBs.
- Clarity with regard to statistical analysis (eg: trend lines, confidence intervals, etc) was noted as being work in progress.
- It was noted that the QPIs do not take case mix/ co-morbidities into account.
- The group agreed that it will be important/ useful to calculate 5-6 universal indicators (core for all cancers).
- A strategic QPI advisory group has been formed to support the evolution of the QPI programme.
- Suggestions for groups/individuals to be consulted would be well received.
- How would this workflow into the new health system? Presentation of data by hospital was proposed.
- Suggested the need to future proof the programme and language; access to radiology and diagnostics was noted as a potential issue.
- Noted COVID-19 would be a significant impact; suggested there is an opportunity to clump data together e.g., route to diagnosis emergency department target.
- How will DHBs be encouraged to engage with improvement plans? suggested engagement by clinical leads, working group members and local champions is important.
- The percentage of cases presented at MDM was suggested as being useful to review – it was noted that this is often on the potential or aspirational list, but the data is currently not available.
- Measurement to be expanded (not necessarily in the QPI programme but from Te Aho o Te Kahu more generally) to include psychological and social support. The group was advised that patient reported measures (both outcomes and experience – PREMs and PROMs) are on the future work programme.
- Clinical networks and the ability to pivot from individual to network providers was suggested as being important in the future.
- Incorporation of private data into the QPIs is under discussion. Also, the Data Monitoring and Reporting team are working with the owners of different registries to bring appropriate ones in, in the future (eg: the breast cancer registry).
- Noted DHB patient ethnicity mix may well change in line with changes to DHB boundaries.
- The group noted the importance of reporting on data and agreed on the need to make progress and continue to measure our performance against international benchmarks.
- The group congratulated the team on their work to date.

Te Aho o Te Kahu noted Pancreatic and Breast Cancer QPI working groups are in the process of being reconvened.

### **COVID-19 Endemic Planning**

An overview of the Te Aho o Te Kahu COVID-19 response was provided.

Key points were outlined as follows:

- The shift towards COVID-19 becoming endemic requires a different approach.
- Cancer patients are in a challenging position – higher risk of infection and frequent contact with the health system.
- Te Aho o Te Kahu is connected with the Ministry of Health COVID response; health system response; immunisation policy team and DHB/local roles.
- Broader approach: equity first; continue prevention activity; continue to diagnose cancer; protect cancer patients in the community and healthcare settings; continue to deliver cancer care (protect capacity within the health system and ensure support services, transport and accommodation are available) and to continue monitoring (with real time information – cancellations, expanding wait lists, private hospital data).

Key points were discussed as follows:

- Noted concern about patients being sent back from centralised care in Auckland to less COVID exposed environments. Noted there would be sensitivities with patients being transferred and suggested there was the need for DHB guidance in this area.
- Noted the issue that when COVID is in communities' hospitals restrict access to support people. Noted there is a national visitor policy now in place. This places an extra burden on NGOs.
- Noted having large numbers of patients in hospital impacts on patient care/access to services ability to provide timely (particularly major surgery).
- Noted severely immune compromised individuals are now eligible for a third dose of the vaccine. Eligibility criteria is available via Health Pathways and is to be added to the Ministry of Health website. <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-health-advice/covid-19-vaccine-severely-immunocompromised-people#third>
- Suggested there is an opportunity for Te Aho o Te Kahu to drive cancer planning at the DHB level/across networks and to drive new models of care.
- Impacts on patients enrolled in clinical trials (who are unwilling to travel) was noted as needing to be considered.

### **Cancer Services Planning**

An overview of the cancer services planning project approach was provided. The presentation was provided in the meeting papers pack. Key points were outlined as follows:

- Key recommendations in the Recommendations Summary are themed under broad headings as follows:
  - The need for a transformative approach to cancer treatment and support.
  - National system leadership.
  - Clinical service distribution.
  - Workforce.
  - Coordination and supportive care services.
- Technical chapters for each workstream are being completed to finalise the full report (expected end of 2021).
- Transition planning is now underway, considering future implementation opportunities from this work (in consultation with the Health System Reforms Transition Unit).
- The Group reflected on the strategic foresight of the programme and thanked the team for pulling practical and implementable actions together into a cohesive action plan.

- The Group were encouraged to socialise and communicate the work of the Cancer Services Planning project across their networks (including those outside of the health sector).

The Group raised the following queries and suggestions:

- Clinical Service Distribution: The Group suggested a wording change to acknowledge potential for increased number of nationalised services, meaning some services could not be delivered close to home. Revised wording suggested: “Regardless of the system service model as much patient care as safely possible will be provided close to home”. The team were aware of this and noted this is covered in the full report.
- The Group queried some enablers i.e., proper accommodation and facilities for the delivery of cancer services, and the requirement for a stocktake of facilities/prioritisation of where investment needs to take place and how that influences workforce, recruitment, staff morale etc. The team noted this as under consideration in transition planning activities.
- The Group suggested applying the strong learnings from the COVID-19 vaccination rollout, specifically the importance of different strategies for different population groups in order to improve equity and access issues. Cancer Services Planning project to consider strategies for providing adequate compensation for those who need it most in accessing cancer treatment and care: “embed equalisation of effect on families (financially and emotionally)”.

### **Other Business**

The Group noted Ian Bissett is stepping down as Chair of the BCWG after 11 years. The Group thanked Ian for all his work and noted his replacement. The Group reflected on the extraordinary amount of quality work delivered by the NBCWG.

The Group noted this is Scott Macfarlane’s final meeting of the group. The Group congratulated Scott on his leadership, cooperation, teamwork and hard work in the field of child cancer. The announcement of the new clinical lead of the national child cancer network is imminent.

Updates from the Haematology Working Group, Medical Oncology Working Group and Radiation Oncology Work Groups were noted for information.

### **Next meeting**

The next meeting is scheduled to be held on Thursday 24 March 2022 from 1-4pm, face to face in Wellington.

### **Close**

The meeting closed at 4pm.