Minutes

National Bowel Cancer Working Group (NBCWG)

Date:	Wednesday 9 November 2022
Time:	9.00am to 1.00pm
Location:	Via Teams
Chair:	Ralph Van Dalen
Attendees:	David Vernon, Consultant General and Colorectal Surgeon, Lakes District Ian Bissett, Colorectal and General Surgeon, Auckland District Janet Hayward, General Practitioners College Representative John McMenamin, General Practitioner Representative Masato Yozu, Pathology Representative, Counties Manukau District Clarence Kerrison (On behalf of Nina Scott), Māori and Equity expert, Waikato District Siraj Rajaratnam, Regional Chair, General and Colorectal Surgeon, Waitematā District Teresa Chalmers-Watson, Gastroenterologist, Canterbury District For agenda item 5: James Falvey, Canterbury District For agenda item 7: Julie Arnold, Service Clinical Director, New Zealand Familial Gastrointestinal Cancer Service For agenda item 8: Alison Jackson, Anaesthetist, Waikato District **From Te Aho o Te Kahu, Cancer Control Agency**: Gabrielle Nicholson, Manager, Treatment Quality and Standardisation Elizabeth Dennett, Clinical Director Jan Smith, Manager, Te Manawa Taki Hub Terence Davidson, Advisor
Secretariat:	Imani Ram, Senior Advisor, National Bowel Screening Programme
Apologies:	Marianne Lill, Regional Chair and General Surgeon, Whanganui District Susan Parry, Clinical Lead, National Bowel Cancer Screening Programme, National Screening Unit Cathy Whiteside, Programme Manager, National Bowel Cancer Screening Programme, National Screening Unit Anne Cleland, Clinical Nurse Specialist, Midcentral District Iain Ward, Radiation Oncologist, Canterbury District Ben Lawrence, Medical Oncologist, Auckland District Bernard McEntee, Colorectal and General Surgeon, Hawkes Bay District Denise Robbins, Consumer Representative Justin Hegarty, Radiologist Representative, Pacific Radiology

Item

Minutes, actions, and review of the conflicts of interest register

Group agreed that previous minutes were an accurate record of the meeting.

Teresa queried whether the National Bowel Screening Programme is responsible for the publishing of the Family History Guidelines. Group agreed that this fell within the remit of the National Bowel Cancer Working Group. Imani advised that this document is currently with publishers and a final formatted document will be sent through to this group for review.

Teresa also queried whether the endoscopy workforce group was supportive of the FIT (Faecal Immunochemical Test) for Symptomatic initiative rolling out nationwide. Imani confirmed this and will send through the minutes from this meeting to Teresa.

Actions:

- 117 – is being progressed
- 126 – this work sits with Ben Lawrence to progress, an update will be provided at the next meeting
- 127 – Gabrielle will provide a general update on this but will defer a more detailed update to the next meeting
- 130 – Jan will provide an update on this
- 133 – as Denise will be stepping down from this group two consumer representatives are now required for this group, Imani and Gabrielle agreed to discuss this
- 134 – Teresa has agreed to remain on this group, CLOSED
- 135 - Teresa has agreed to lead this work with assistance from a student and will report back at a future meeting
- 136 – CLOSED
- 137 – work is ongoing, current priority is breast cancer and pancreatic projects
- 138 – no update provided – ACTION – Imani to request Ben Lawrence to provide an update on this action
- 139 – CLOSED.

Ralph asked members to send through any updates to the conflicts of interest register through to the secretariat.

Outgoing members
The group noted that this will be Masato Yozu's last meeting and thanked him for his contribution over the past 4 years. Masato noted that he would be available to provide input into this group when needed (particularly in molecular testing).

Anne Cleland (who is not present at this meeting) will also be stepping down from this group and has provided a possible replacement.

Denise Robbins will be stepping down from this group. Deise has been part of the group since inception and the group agreed that her contribution needs to be recognised at the next in person meeting, if possible.

National Bowel Screening Programme – update

The programme is progressing an evaluative implementation of the age range extension for Māori and Pacific (from 60 to 50) in Tairāwhiti and Waikato Districts. A mini readiness assessment (similar to what was used for the initial roll out of the programme) is scheduled for Waikato District next week. If the readiness assessment is successful, Waikato will commence age extension on 29 November 2022.

Work will commence with Tairāwhiti District to implement age extension in early 2023. Tairāwhiti will be utilising their community invitation strategy for this group. The Bowel Screening Register (BSR) component to support this strategy was deployed on 1 November 2022.

All 20 districts have now transitioned from the interim IT system (BSP+) to the BSR. Work is now commencing to decommission the BSP+ platform.

The National Bowel Screening Programme was the joint winner of the Service Excellence award at the Spirit of Service Awards. That award is given out each year by the public service commission for outstanding initiatives in the public sector. The award was shared with MSDs care in the community joint agency response to COVID-19.

The national bowel screening advertising campaign is still underway with advertisement on TV, radio and social media. The programme received feedback from our national coordination centre that calls and emails to request kits have increased since the campaign went live, particularly for Māori and Pacific.

Nina noted that the work thus far regarding age extension seems to be very siloed and is unsure why she has not been linked into the discussions on this project earlier. Nina noted that the process should be more robust. Group agreed on the importance of linking in key stake holders in as early possible.**ACTION** – Cathy to send a proposed process of engagement and governance for age extension to this group.

Update from regional chairs

Southern
No specific update currently. Teresa raised that there is not a specific bowel cancer group in the region (although one does exist specifically for bowel screening).

Te Manawa Taki
Regional group meets every two months and works well. Regional stocktake in process that assesses the whole pathway including endoscopy and surgical capacity. Implementation of MDM enhancements is in progress. Group is currently updating their services plan for next two years.

No further updates.

Update from Te Aho o Te Kahu

Te Aho o Te Kahu staff gave an update regarding the Cancer Service Planning (CSP) programme, which is a major piece of work for the Agency at the moment. contains 7 workstreams: stem cell transplant (SCT); radiation oncology; Systemic Anti-Cancer therapy (SACT), which includes haematology (except SCT); surgery; care coordination, optimal cancer care pathways (OCCP) and workforce.

Stem cell transplant work has been moving at pace due to the service in New Zealand being at a crisis point..

The radiation oncology and SACT workstreams are focused on providing advice to Te Whatu Ora re national approaches to services (e.g.: leadership and governance, models of care, improving inequities via approaches such as care closer to home, resolving workforce issues, and similar).

Work is underway assessing the requirements for surgical units. It is likely that some hospitals will require additional funding. It was noted that there are likely smaller hospitals who are completing major work without adequate resourcing/ skills and perhaps this ‘everyone does everything’ should be changed, and low volume, specialised surgeries should only be done in centres with the appropriate capability and capacity.
The workforce workstream is focused, on contributed to the national workforce taskforce (led by Te Whatu Ora) and making sure that addressing cancer workforce issues remains an immediate priority within that.

Te Aho o Te Kahu staff also updated the group on the work being done on the optimal cancer care pathways (OCCPs), the first draft bowel cancer version of which was presented at the last meeting. Feedback from this group has been incorporated into the document but an amended draft is not yet ready for further review. It was noted that the pathways are optimal rather than aspirational; unwarranted variation and inequities will be highlighted for resolution. The OCCPs are tools that will describe expected current practice and aim to drive service improvements. In addition, Te Aho o Te Kahu is planning to develop separate OCCPs for patients and whānau –“what to expect guide”.. Te Aho o Te Kahu aims to have draft OCCPs for 5 cancer streams (bowel, lung, prostate, breast and pancreas) by late 2023. The group agreed to review the next draft of the bowel cancer OCCP when it is ready.

Nina queried what the process of developing this document was and whether Māori were included. Jan confirmed that Te Aho o Te Kahu has been working with Hei Ahuru Mowai and He Ara Tangata including Clarence, Myra and Jo linked into this work.

Masato noted that the main criticism of the document presented at the last meeting was that the goal of it was not initially clear. Te Aho o Te Kahu advised that the draft has progressed significantly since that version was presented.

Te Aho o Te Kahu staff advised that the pancreatic cancer QPI monitoring report is currently being drafted and will be provided to districts for review early in the new year. Work on the pancreatic cancer QPIs has taken longer than anticipated due to the small cancer numbers.

Consultation on the draft breast cancer QPI descriptions was completed in September; extensive feedback has been received particularly from breast cancer patients. The descriptions will be updated in consultation with the national breast cancer QPI working group. Te Aho O Te Kahu is investigating whether the Breast Cancer Foundation’s data registry can be used for the calculation and a reporting of the breast cancer QPIs. If this is possible it will mean that the calculations can be done using more recent data and enable reporting on additional indicators.

Nina Scott raised concerns around the Breast Cancer Foundation data registry, as it does not accurately capture data on Māori. Gabrielle confirmed Te Aho O Te Kahu is aware of these shortcomings.

FIT for Symptomatic

Canterbury Trial – James Falvey

James outlined that the rationale for this initiative is the large number of individuals on the waiting list for a colonoscopy. The aim of the trial is to improve the detection of serious disease in those with colorectal cancer symptoms and target interventions to those with the most need. This would also reduce the time to diagnosis. The initiative has involved various stakeholders, including primary care, Māori and Pacific providers and laboratories.

James noted that in future it would be preferable if FIT testing could be done in primary care, with individuals reaching a certain threshold of symptoms being asked to complete a FIT kit. Those with a positive result would then be triaged for a colonoscopy accordingly (based on the result and the individuals' symptoms). If the FIT result is negative, then this individual will be managed in primary care.

A retrospective cohort study was completed in order to define the patient population in terms of symptoms. Rates of acceptance, sensitivity and specificity was consistent with other studies. Key symptoms identified were iron-deficiency anaemia, rectal bleeding and altered bowel habits (similar to what is observed in Waikato). A meta-analysis was also completed, and the identified sensitivity and specificity were similar to what was identified in the retrospective cohort study.

Accuracy and symptom data was combined in order to derive a FIT for Symptomatic pathway. Those with specific symptoms and a detectable FIT result would be referred to secondary care. Modelling suggested this pathway would reduce the number of colonoscopies required.

Currently patients referred for a colonoscopy are triaged. Administration staff contact the individual, explain the rationale behind the FIT kit and send one to the individual. A follow up pathway is present for those that do not return a kit. If a kit is returned with a result greater than 150 then the individual is referred for an urgent colonoscopy. Results between 10 and 149 are scheduled for the next available colonoscopy appointment. Those with results less than 10 are referred for a CT scan.

A total of 446 cases have been identified, 424 of those have been sent a kit with 369 samples being returned (a completion rate of 88% for all and a 100% completion rate for Māori and Pacific in recent months). 361 cases have progressed down the FIT for symptomatic pathway. Median age of patients was identified as 61 with 40% of individuals being Male. A total of 4.8% participants returned a high FIT result. 16 individuals were referred for urgent colonoscopies, 38 were referred for next available colonoscopies and 231 individuals were referred for a CT scan. Three cancers have been detected in this group with a median time to diagnosis of 21 days.

Conclusions from the trial thus far is that the FIT for symptomatic pathway can affect a shift in the referral and prioritisation of New Zealanders with colorectal symptoms, can facilitate rapid colorectal cancer diagnosis and reduce the demand for colonoscopies. Feedback from both primary care and patients thus far has been positive. Future actions will be to imbed this process so that it runs parallel to standard practice. Trial of a collection device would also be beneficial and would allow the broadening of the pathway to younger patients. James would also like to see the age range for this trial extended as well as continuation of the safety netting practises to improve the pathway.

Nina noted that Māori and Pacific are less likely to visit their general practitioner when exhibiting symptoms than other groups and noted that it would be beneficial to review the pathway to ensure we are maximising the potential for equity gain. Nina suggested that Māori and Pacific who don't return faecal samples could be prioritised for a colonoscopy. James noted that this trial has involved Māori and Pacific clinicians.

Ian queried how this trial has impacted the list of those waiting for a colonoscopy. James noted that it has impacted the waiting list but as he has been injured this has limited the number of colonoscopies that could be completed.

Waikato Trial – Ian Bissett

fit 4 symptoms
update Nov 2022.pp

The aim of the Waikato FIT for symptomatic trial was to inform a larger national rollout in regard to equity and processes. The protocol used is similar to that used in Canterbury – patients referred for a colonoscopy are phoned to discuss times for a colonoscopy as well as being informed about the trial. Individuals are sent a FIT kit that is completed and sent to the laboratory (this is the same laboratory used for the bowel screening programme however the packaging is distinctly different to ensure it is clear these kits are not part of the bowel screening programme). If a kit is not completed and returned after 14 days, the individual is phoned 3 times and a further kit is sent if required. If the FIT level is greater than 750ng then an urgent colonoscopy is performed in the next 2 weeks.

This process has been manual and a total of 294 kits have been sent (an average of 20 kits per week). The total number of valid fit result received was 223 (a completion rate of 80%). 12 kits were identified with high results with all receiving an urgent colonoscopy within 14 days. A total of eight cancers were found in this group. 18 individuals received a colonoscopy before a kit was returned. Response rate was found to be lower for Māori and Pacific (72% and 43% respectively).

Ian noted that this trial aims for a total of 1000 FIT kits to be completed. The trial has been strongly supported by Lu-ana Ngatai and Clarence Kerrison.

Masato queried whether Māori and Pacific should be prioritised directly to an urgent colonoscopy. Clarence agreed that this would be beneficial and noted that engagement with Māori was a multi-pronged approach.

James noted that a colonoscopy is a procedure with risks and should not be performed unless deemed necessary.

ACTION – Ian Bissett and James Falvey to provide an update on both FIT for symptomatic initiatives at the next meeting.

Regional Linkages

The group discussed enhancing national and regional linkages with this group.
Jan noted that the regional CEs in the Te Manawa Taki region at the very beginning agreed that there would be an end-to-end pathway approach for Bowel Cancer. A regional group was put in place for bowel that covered the whole pathway for both screening and symptomatic. The aim of the colorectal cancer working group is to achieve equity, imbed bowel screening, reduce colonoscopy wait times and achieve consistent and safe cancer services. As at 1 July the regional NBSP team changed. Te Manawa Taki retained the whole regional team for another year within HealthShare.

Jan noted that changes in the health system will ideally lead to regional ways of working for Hospital and Specialist Services, Localities and Networks. The Operating model will be available in 2023.
Group agreed to keep this as an agenda item for the following meeting. It was agreed members of the group could/ should raise the need for regional groups within their regions.

ACTION – Regional linkages to be discussed as an agenda item at the following meeting.

NZFGICS Sapere report – Julie Arnold

The NZ Familial Gastrointestinal Cancer Service (NZFGICS) has had an 18% decrease in referrals over the last 12 months but an increase in the complexity of the cases. NZFGICS currently manages 129 families and 289 individuals. These individuals are high risk and are being actively referred for colonoscopies and follow up assessment. Family history assessments account for the bulk of the clinical work and are currently fully staffed. NZFGICS Christchurch has now relocated from Christchurch hospital to alternative accommodation which will allow for the team to join the Auckland network and for records to be made electronic. The service has not received a funding increase since 2015. Julie notes that overheads and staffing use a significant amount of expenditure. Staffing turnover has affected the team significantly.

Julie notes that she is pleased the Sapere report has been completed but notes the significant delay. It outlines the benefit of the service and shows that the NZFGICS is saving the health system money. Julie notes that there is no mention of the long-term underinvestment in financials and only a short-term injection of finance and additional FTE has been recommended in the report. Julie notes that something more long term would be more beneficial. NZFGICS is receiving increasing numbers of bowel polyp referrals which increases the complexity of work. There is a lack of recommendations relating to treatment, pancreatic cancer, or gastric cancer. Julie noted that the description of the family history assessor role in the report is inaccurate and lacks an acknowledgement of the clinical expertise required in the role.

ACTION – Cathy Whiteside to provide an update on the timeline for the resolution of actions from the NZFGIS Sapere report.

Projects discussion

Colorectal cancer follow up – Ralph Van Dalen

Colon cancer
follow up NBCWG.d

Ralph thanked those that has sent feedback on proposed colorectal cancer follow up protocol. Process of clinical follow is well supported by feedback, but some timeframes given may need to be changed. Ralph noted that clinical review could be up to 6 weeks post-surgery. Liz suggested that follow up should be done on the basis of staging – Ralph noted this could be difficult to manage and insure is completed by general practitioners.

Protocol suggested that a colonoscopy is completed 3 years post-surgery and 5 yearly thereafter. Siraj noted concerns about moving away from a colonoscopy 1 year post surgery. European standards suggest a colonoscopy 1 year post surgery and every 3 years following. Ralph noted that New Zealand is already struggling with colonoscopy capacity and moving to 1 year would have a significant impact on this. The group agreed that feedback from primary care would be beneficial given their current capacity constraints. Janet raised that GPs don't routinely get access to test results performed at a hospital and that the protocol would need to be clear on who would follow up with patients regarding colonoscopy results (GPs would need additional financial support). David noted that patients who have not had a complete preoperative colonoscopy would require earlier follow up. Ralph noted that this could be organised by the clinician and that this process would likely look different depending on the centre.

Ian raised that survivorship needs to be considered and that 3 CT scans in the first 3 years may be too much. Ralph noted that many centres have colorectal nurses that could provide some follow up and ensure procedures are booked. Group noted that not all centres have this role and therefore this would not be consistent nationwide. Teresa noted that clinical nurse role could be a regional one for smaller hospitals and provide a platform for individuals to have a conversation with a nurse familiar with cancer. John agreed to bring this proposal to the primary care college for review.

ACTION – Ralph to provide an amended document to John and Janet for review.

Frailty assessment – Alison Jackson

Frailty in CRC
surgery.pptx

Aotearoa-Serious-Ill
ness-Conversation-(

The aim of this project is to reduce mortality in Waikato District (who prior to the project were not performing well on mortality QPIs) and make a difference o the way the colorectal service approaches more frail patients. This utilises the principles of realistic medicine. Alison noted that 10% of all patients are classed as high risk and are responsible for a total of 80% of call complications. Alison notes the importance of identifying high risk patients and tailoring the treatment to them. This can involve optimising the patient's condition before treatment as well as sharing realistic expectations with them and their whanau.

The colorectal service currently screens for frailty and comorbidity to identify patients that would benefit from a shared decision-making meeting with multiple clinicians and the patient. This meeting presents the individual with treatment options and guides the individual through conversations. Intervention began in 2020, with small numbers being referred to a shared decision-making clinic. Roughly half of these participants decided they did not want to pursue treatment.

The colorectal service now plans to incorporate more screening tools relating to cognition and nutrition into this process, but this has provided challenging thus far. The age criteria for this has also changed.

Ian stated that he is unaware of any other centre in New Zealand that is doing as much in this space as the Waikato District and noted that the fact that 50% of people who are high risk have opted not to have surgery shows that these conversations have been beneficial.

Next Meeting:

Group agreed to hold the next meeting on 11 May 2023, and this will be in person.

Close

There was no other business and the meeting closed at 12:30pm.