Minutes
National Bowel Cancer Working Group

Date:	Thursday 11 May 2023
Time:	9.30am to 4.00pm
Location:	Rydges Wellington Airport and via Zoom: https://mohnz.zoom.us/j/83250580384?pwd=UkorOVBLYkpReFB4ZUFnOFZIeUhQZz09
Chair:	Ralph Van Dalen
Attendees:	Ben Lawrence, Medical Oncologist, Auckland District (leaving at 2pm) Bernard Mcentee, Regional Chair, Hawkes Bay District Chris Hemmings, Anatomic Pathologist, Canterbury Health Laboratories, Te Whatu Ora Waitaha Canterbury, and Clinical Associate Professor of Pathology, Ahorangi pāhono o te ara, University of Otago and RCPA Vice President (NZ) Clarence Kerrison, Gastroenterologist / Māori and Equity expert, Waikato District (in Sydney, hopes to Zoom) David Vernon, Consultant General and Colorectal Surgeon, Lakes District Denise Robbins, Consumer Iain Ward, Radiation Oncologist, Canterbury District Ian Bissett, Colorectal and General Surgeon, Auckland District Janet Hayward, General Practitioners College Representative, Nelson Private Practise John McMenamin, General Practitioner Representative, Wicklow Avenue Medical Centre; Whanganui General Practice (joining via Zoom until lunch) Marianne Lill, Regional Chair, General Surgeon, Whanganui and Chair of the Endoscopy Guidance Group Nina Scott, Public Health Physician, Māori and Equity expert, Hei A Mowai Co-Chair, Waikato District (arriving at 12pm) Siraj Rajaratnam, Regional Chair, General and Colorectal Surgeon, Waitematā District Teresa Chalmers-Watson, Gastroenterologist, Canterbury District Justin Hegarty, Radiologist Representative, Pacific Radiology (via Zoom)
From Te Aho o Te Kahu, Cancer Control Agency:	Jan Smith, Manager, Te Manawa Taki Regional Hub Gabrielle Nicholson, Manager, Quality Improvement (QI) Terence Davidson, Advisor, QI Irin Lathif, Team Administrator, QI Abby O'Neill, Optimal Cancer Care Pathways (OCCPs), agenda item 12 Judy Warren, OCCPs, agenda item 12 John Manderson, Senior Project Manager, Data Monitoring and Reporting (DMR), agenda item 13
From the National Bowl Screening Programme:	Susan Parry, Clinical Lead, National Bowel Cancer Screening Programme (NBSP), National Screening Unit (via Zoom) Steve Wakeling, Principal Advisor, NBSP (attending on behalf of Cathy Whiteside)

Guests:	Michael Lau, Anatomical Pathologist, Southern Community Labs, Dunedin and clinical lead for Structured Pathology Data Standards Project, agenda item 14
Secretariat:	Terence Davidson, Advisor, QI Irin Lathif, Team Administrator, QI
Apologies:	Elizabeth Dennett, Clinical Lead, Te Aho o Te Kahu Cathy Whiteside, Programme Manager, National Bowel Cancer Screening Programme, National Screening Unit

Item

1. Welcome, introductions and review of minutes and actions

The meeting opened with karakia and whakawhanaungatanga. The chair welcomed new members and guests:

- Chris Hemmings, Pathologist, attending while the pathology rep position left vacant by Masato is filled
- Dr Alicia Blaikie, attending as an observer in her new role as GP lead NBSP Central

Minutes: Siraj stated that he was not the person who raised concerns about moving away from a colonoscopy 1 year post surgery in the minutes for the November 9 meeting. The group agreed the wording should be changed to "there were concerns". With this change it was agreed that the previous minutes are an accurate recording of the meeting.

Actions:

- 117 – To be discussed during the meeting
- 143 – Teresa stated that it is currently in its preliminary stages, they will be auditing the next 200 patients in the screening programme (currently at 70), and she will provide a summary at the next meeting
- 138 – To be discussed at next meeting
- 139 – Ian will discuss today, and he and James will update further in September
- 140 - Regional linkages will be discussed today, and will become standing agenda item so can come off 'Actions'
- 141 - Steve Wakeling to discuss on behalf of Cathy
- 142 – Ralph to provide updates today
- 143 – double up and can be removed
- 144 – double up and can be removed.

2. Agreeing to updated terms of reference - Gabrielle Nicholson

This is a minor update to the terms of reference (TOR) to reflect health and disability sector reforms; content has not been significantly changed. The changes involved removed references to DHBs and replacing them with districts and reflecting that the screening unit I snow within Te Whatu Ora not MOH. Also, on page 4, section 1.3 Te Pae Tata (interim health plan) has been added to the strategic alignment section.

Ralph noted that in section 4.5 (page 11) the number of meetings the working group is having per years should be changed from three to two. **Action:** Te Aho o Te Kahu to make this change.

The group discussed its membership and whether there are gaps in the skills/ specialties listed in the TOR. It was clarified that the group regularly brings in people for their expertise or to consult with them as and when needed, and that it was common for people to wear 'multiple hats' in the group, as the alternative would make the group too large to function.

The group was advised that Te Aho o Te Kahu is in the process of finding two consumer representatives to join the group. Susan noted that NBSP have Māori and Pacific networks that have quite a few consumers involved in them that have consumers. **Action:** Te Aho o Te Kahu to follow up with the national bowel screening programme team.

The possibility of reducing the size of the quorum was raised, to make achieving quorum easier; although this would include keeping the option of bringing in additional people as needed. It was agreed that this will be discussed by the group's executive when it next meets, and they will report back at the next meeting.

On page 13, the first paragraph needs a slight wording change so that the incomplete sentence "should be joint" is removed. **Action:** Te Aho o Te Kahu to make this change.

It was agreed that the conflicts of interest forms may need to be filled out again given the various changes in position amongst the group. **Action:** Te Aho o Te Kahu to follow up with members regarding this.

Update from regional chairs/ reps

Northern
Haven't met as a group this year; the first meeting is next month. Timely access to colonoscopy is an issue throughout the region. Hoping to get a regional surgical audit group going by the end of the year.

South Island
There is no specific bowel cancer group in the region (although one does exist for bowel screening). Screening is going well, with high participation across all ethnicities. Cancer surgery going ahead at normal rates, there are issues with accessing colonoscopy like in other areas, but referrals are being managed.

Te Manawa Taki
Regional bowel cancer group meets every two months and has good attendance.

The region has had to deal with the aftermath of the cyclone but the health system has largely recovered from that (although there are ongoing issues for many of the population).

Tairawhiti have started with age extension, which had previously been delayed. Lakes is getting a new endoscopy suite. There had been trouble getting endoscopists, but they are now up to the needed number. Waikato had been only running three rooms due to staffing shortages but are now up to four rooms. BOP and Taranaki are running well with no issues.

Last week the region hosted the first endoscopy forum in the form of an hour-long Teams event. Topics included tattooing, and learnings from colonoscopy quality improvement projects. People from each district were involved in the meeting, and there are plans to hold another towards the end of the year, with a focus on polypectomy techniques. The endoscopy forum is part of screening training, which brings in people as and when they need (surgeons, gastroenterologists, nurses etc) to encompass more of the bowel screening pathway.

Waikato is helping smaller hospitals who are struggling to provide training for nurse endoscopists.

MDMs are continuing with developments and working well in the whole region and are looking forward to structured pathology coming on board.

Lakes, BOP, and Waikato are outsourcing to Cambridge centre for overflow work to help keep on top of numbers.

Central
There is no specific bowel cancer group. Hawkes Bay is struggling and having to outsource. This has led to unacceptable waits for medical and radiation oncology, and delays for starting treatment. Surgical delivery is good. Will have more to update next meeting.

Action: The group requested that Te Aho o Te Kahu team members follow up with their regional colleagues regarding establishing/ supporting regional bowel cancer groups the same way that exists in Te Manawa Taki.

Marianne informed the group that as of March she is the chair of the endoscopy guidance group, which has reformed with a new TOR. The group has secretariat support for two meetings a year but no other resource/ FTE.

Marianne queried if everyone was aware of the potential impact of PSO 9 document from the Australian and New Zealand College of Anaesthetists on how to perform sedation. It recommends every patient scored ASA 3 or above needs another doctor or anaesthetist in the room. There are low levels of sedation-related harm in NZ, so the measure seems unnecessary, and it will impact staffing/ resourcing. The options to resolve this are to get the document changed to allow more flexibility (ie: the status quo), or a group could write an NZ specific version. Marianne will keep the NBCWG informed.

The group discussed the fact that there is currently no group responsible for maintaining an overview of bowel cancer guidelines, more generally. Whilst direct access criteria and surveillance have been owned by the NBCWG, other guidance documents and similar do not have an 'owner' that makes sure they're updated at regular intervals. The group agreed it would be best to park this issue for now until things with the health and disability sector reforms are clearer. **Action:** To be discussed in more detail at next meeting.

Marianne also advised that the College of Surgeons is offering mentoring/skills refresh for endoscopists. It will start with review of KPIs followed by mentoring and support, a practice visit, a review of KPIs after 6 months and graduation, or "rinse and repeat" depending on if standards were met. It's not compulsory just a service being offered. The service will be advertised in *Fax Mentis*.

3. Update from Te Aho o Te Kahu

- CSP Programme
- Molecular testing
- Hui Report

Molecular testing

Te Aho o Te Kahu is taking a three-tiered approach to molecular testing:

- Supporting strategy & policy development by Manatū Hauora.
- Supporting delivery and enabling Te Whatu Ora infrastructure.
- Supporting connections between different groups and organisations for specific matters related to molecular testing in cancer.

In practice, the key piece of work has been working alongside the Ministry as they develop a long-term Insights Briefing (LTIB) on precision health. It is the expectation of Te Aho o Te Kahu that this work will enable further development of strategy and policy to improve equitable access to modern molecular diagnostics.

Te Whatu Ora are still considering their approach to laboratory coordination and prioritised decision-making, and Te Aho o Te Kahu continue to seek opportunities to collaborate on this from a molecular testing perspective.

Members of the group queried who was being consulted as part of developing the LTIB; this is being led by Manatū Hauora, not Te Aho o Te Kahu, so it is the Ministry that needs to be followed up with regarding this, but members of Te Aho o Te Kahu would pass this on. **Action:** Te Aho o Te Kahu to feedback to MOH colleagues.

Hui report

To better understand the lived experiences of whānau Māori, Te Aho o Te Kahu partnered with mana whenua and local health organisations in 2021 to hold 13 community hui across the motu. Collectively, the Agency spoke with more than 2,500 whānau Māori. This included patients and whānau, as well as Māori working in cancer care and the wider health and social sectors. Since the hui series ended, Te Aho o Te Kahu has analysed the themes and insights identified by whānau; and created three reports in English and te reo Māori; all are now available on Te Aho o Te Kahu website.

John noted that they're using the hui reports in Whanganui to inform how primary care can better respond to whanau, and its insights have helped their primary care planning. He notes the reports are a great resource, and useful tool as a focus for korero in PHOs.

4. Canterbury project update - Iain Ward

Removed from agenda due to time constraints. **Action:** to be added to next meeting's agenda.

Update re Faecal Immunochemical Test (FIT) for symptomatic initiative

This pilot is being performed because there is concern about the capacity of the country to deliver timely colonoscopy to those who need it.

Over the past 10 months a FIT for symptomatic pilot has been running in Waikato. Patients on wait lists are sent a FIT test before colonoscopy to determine how many cancers can be identified, and how the test specificity for detecting bowel cancer with different cut-off levels.
On average there are a 14 patients per month returning FIT tests. 582 tests were sent out up until 27th April, 470 responded, and the response rate has been stable. Overall, 5% of respondents needed an urgent colonoscopy. Whilst 64.3% were below the threshold and likely didn't need colonoscopy. Women more likely to respond than men. Younger people, Pacific and Māori were less likely to respond.

If a completed FIT kit is not received within two weeks, the patient is called and reminded. This has been required for approximately a third of people. Of those who were called 150 returned a test and 30 did not. There was some variance amongst ethnicity but calling overall provided a positive response rate. The pilot has recently been extended to the North Shore and the aim is to get 1000 returned kits between the 2 sites.

It was noted that the ultimate aim is to introduce the test to the primary care setting with appropriate safety netting and protocols. This will result in major changes in referral guidelines. However, at present, the project is focussing on being able to analyse and inform efforts to improve equity of access and assess the ability of the high FIT threshold to identify the large majority of those with cancer for urgent colonoscopy.

Action: James to present Canterbury data at next meeting.

Waitemata FIT negative study

The Waitematā pilot looked at patients who developed cancer who had a negative FIT test with a threshold of 15 micrograms per gram of faeces (75 nanograms HB / ml of buffer). The cohort included 50-74 year olds from 2012-2017. The aims were to evaluate the diagnostic performance of FIT for detection of colorectal cancer, identify factors associated with FIT-IC diagnosis, and describe long term outcomes for participants with CRC and BSP. The pilot programme went to the NZ cancer registry and BSP register and identified patients who had cancer and extracted data from their electronic clinical records from Waitematā. This group included all primary colorectal adenocarcinomas. A diagnosis of interval cancer was defined as someone who had a cancer diagnosed withing 24 months of a negative fit test.

In that group there were 520 who had cancers, 111 of these meet the criteria of a missed cancer, 409 were screened. That gave a 78.7 sensitivity, and a negative predictive value of 99.9%. Meaning a negative FIT test had a 99.9% chance of not having cancer.

The pilot found the number of interval cancers increases as the FIT test threshold goes up. The pilot threshold was 15 micrograms per gram of faeces. At 15 micrograms 21.3% of cancers were missed. But had the threshold been the lowest it could have been 15% of cancers would still have missed, at the expense of doing many magnitudes more colonoscopies.

The interval cancers were more likely to be proximal than distal, more likely to be late stage and more likely to be high grade. The FIT diagnostic performance in BSP was comparable to other cohorts, but there would likely be more interval cancers in later age groups. A recently published metanalysis study showed a sensitivity of 72%, compared to our 78.7%.

There's very clear messaging to those who take FIT tests that if you have symptoms after a negative test to be alert and seek medical advice. Ian will keep the group advised on next steps with this project.

5. Bowel screening update - Susan Parry (via Zoom)

The NBSP programme are currently planning age range extension for Māori and Pacific peoples down to 50 years old. An evaluative implementation was started in Waikato towards the end of last year in association with the Māori and Pacific networks who have representatives from each of the 20 districts. The group is not chaired by NBSP and acts as an advisory body to the pilot. They were strong in their advocacy for age range extension. It has become clear all the equity initiatives that the NBSP have put in place have not resulted in the desired participation levels for Māori and Pacific peoples, and that pre-reach activities are needed. It is now possible to invite people as part of a campaign run by Puhimoana Ariki Collective that is linked with focussed community pre reach events - formal evaluation of these initiatives is underway. Hopefully there will be a national rollout of age range extension for Māori and Pacific within the year. Successful initiatives will then be extended to current age group of 60-74 years old.

The NBSP are still working to identify areas of inequity and are working with the Māori and Pacific networks to address the concerns about cancer being identified at a younger age.

A cabinet paper and implementation business case are going to cabinet, after multiple layers of review including financial, about what has been learned from the age extension pilot and what NBSP plan/will need to spend for rest of the country. It is hoped that this will go to Cabinet for review in July or August. Once more is known about funding NBSP will be able to finalise the business case.

The success of the national advertising campaign to increase awareness for Māori and Pacific peoples has been very well received but the NBSP will have to wait and see whether it translates to increased participation.

The NBSP will complete an audit of outlier adverse surgical events for bowel screening detected pathology in order to learn lessons to avoid further deaths. The NBSP has a named surgical lead in each district, and they have been advised of the proposed process by email. NBSP don't want to duplicate other processes but do want to know od deaths within 30 days of treatment for bowel screening detected pathology as this is distressing for all concerned.

Colonoscopy Waiting times are a concern. Waiting times for longer than maximum in non-urgent and surveillance are significant. NBSP are trying to find out how it can work with specialist services to manage these delays.

Susan presented in Chicago last Friday about post colonoscopy colorectal cancer analysis in NZ, which is being performed in line with recommendation from the World Endoscopy Organisation CRC screening Committee. Colonoscopy KPIs show that NZ do meet the international KPIs for highly performing colonoscopy.

The NBSP is focusing on the rescreen rate which is sitting at 74%; this is a bit low.

Action: Teresa to update on polyp cancer initiative at next meeting.

6. Bowel screening update – Waikato age range extension

The objectives of the Waikato age range extension evaluative implementation are to work with the NBSP to:

- ensure the resources and website are useful and appropriate for participants and health professionals
- raise awareness of the age range extension for Māori and Pacific peoples

- work collaboratively to identify local initiatives to support participation of eligible people in the with the NBSP screening pathway
- test different approaches to engaging with, and supporting, age extension participation
- inform the wider implementation of age extension across the country.

What they've done in Waikato to achieve these objectives is to work with community providers, pre-order test kits and make them easily available at kit drop off sites, create online tools, and use texting for pre-reach, outreach, and pre-assessment. Pre-assessment was after work hours (6-8pm) allowing more people to attend, and weekend and after-hours colonoscopy lists will have Māori staff rostered on, as much as possible.

Community coordinators from Nga Miro Medical Clinic covered certain areas of Waikato to ensure that there was good coverage, and to allow relationships to be built. One of target campaigns was at the Turangawaewae League Club. Nga Miro created a list of participants, and an education event was held at the club, with test kits distributed to everyone at the end of the session. Tests are sent out automatically every two years. Two observations from this session are that it is of more value when the provider already has a relationship/contacts with the participants, and there will always be people who engage but don't return the kits.

The other approach being looked at is teaming up with the breast care centre and doing a targeted approach for people having breast screening; it's important to try various ways to approach this age group to create awareness and encourage participation.

7. Bowel screening update – Primary Care Campaign - John McMenamin

The bowel screening primary care campaign now has leads in each region. **Action:** John to add names of Primary Care Regional Leads to minutes.

The Primary Care Campaign meets with the College of General Practitioners every three months to give updates on bowel screening, and to put information in their newsletter to get info out to GPs.

The Primary Care Campaign is asking/gathering information regarding two questions:

1) Can GP nurse conversations boost engagement in Māori and Pacific populations with bowel screening?
2) Is the electronic kit requesting tool increasing the number of kits being requested?

There is good data from Whanganui that 1) is effective, and the Primary Care Campaign is trying to develop a national evidence base that this is an effective tactic.

Puhimoana Ariki Collective worked with focus groups who strongly endorsed the role of GPs and primary care as respected voices they were willing to listen to. They developed several key messages based on that work, which have formed the basis of a campaign aimed at encouraging GPs to have active conversations with patients over the month of May.

Participants were given two options for involvement: 1) passive (posters in reception etc); or 2) encouraging conversations in clinical settings using a flip chart that guides the conversation and giving out FIT kits. Each region will be evaluated on how they approached it and what the outcomes were in order to learn successful ways of engaging with the primary care sector across the board and find out the differences between each area/ each approach.

It was hoped to involve 200 practices; 360 practices responded. Most (2/3) practices registered through their districts or PHOs, which shows the value of active leadership within districts.

The programme is confident they're reaching target populations based on reports from practices on patient make up and will monitor for a boost in FIT kit requests, and an increase in returned kits. There will be a survey of clinicians on how they felt about the project (asking if flip were charts helpful etc.). The results of the survey will be used to decide if this was helpful and could become an annual event.

The primary care screening guide has been updated, which gives GPs and nurses an understanding on what the programme is about, and to inform the increasing amount of new people coming into primary care.

The programme has also developed a practice audit that allows GPs to do an audit, giving some peer review around how they as a practice are managing their bowel screening and letting them see their own data.

There was a recent Goodfellow seminar where Ian and Adele Welton spoke, which was well received (feedback approval ratings in the high 90s). The primary care bowel screening programme had a stand at the seminar, which proved very successful, with many people stopping to ask questions. This showed the need for resources and FAQs. GPs all want kits in their rooms to hand out, so the programme is looking at a pilot around that.

8. Potential to standardise the CRC Follow Up Process

A draft new colorectal cancer (CRC) follow up protocol was presented to the group. The aim of this work is to standardise CRC follow ups and give clinicians support for streamlined surveillance based on current literature/ best practice.

The most significant change is removing the need for clinical follow up to be managed by surgeons and their teams. Removing this responsibility will free up significant time for clinicians to see new patients. Other changes include changes to timing for investigations (CEA blood test and CT).

The proposed changes are:
1 Clinic Review:
Review in clinic following surgery at 2 to 6 weeks from discharge. This would allow discussion of histology, resolving any issues, and education of patients on their surveillance plan. Current BPAC Guideline is 6 monthly for first 2 years, then annually for 3 more years. If patients develop symptoms in the following years, they are followed up by GP's.

Proposed change to current guidelines: No routine surgical clinic follow-up, instead follow up is done via GP only if symptoms develop. This has been discussed with GP representatives of NBCWG and individual GPs, who support this process.

2 Investigations – CEA blood test:
CEA blood test every 6 months for 5 years, with GP to arrange and monitor results. If raised, then repeat in 2 months. If still raised, then refer to local surgical clinic who will arrange further investigations. Otherwise continue 6 monthly CEA. Current BPAC Guidelines are 6 monthly for first 2 years then annually for 3 years.

Proposed change to current guidelines: Simplify the timing to be every 6 months and, as above, make the monitoring and follow up the GP's responsibility.

3 Investigations – CT
CRC patients would get CT scans at 18 and 36 months or 12, 24, 36 months. These will be arranged by surgeons at patient discharge.

The group noted that CT scanning is a scarce resource, though there is benefit in doing it over never doing it, the benefits of doing it frequently are less useful. It was also noted that the least useful is the CT scan just after adjuvant treatment and that it's very centre-dependent on whether they do or don't do it at the moment.

Proposed change to current guidelines: CRC patients to get CT scans at 18 and 36 months.

4 Post-operative colonoscopy

Proposed change to current guidelines: It is proposed that the first post-operative colonoscopy should be at 1 year and if no pathology is found then the next would be at 3 years, then 5 years until age 75.

Given the quality of colonoscopy in NZ there is scope for it to become 3 years from start if there is a study that provides data to reflect this.

Action: Te Aho o Te Kahu to follow up re getting the BPAC guidance updated to reflect the above proposed changes.

The group noted that they thought there should be specific guidelines around variance. Current upper variance in the districts varies from 3 to 5. Also, it was clarified that it doesn't have to be the GP who follows up; it could be a GP practice nurse

The group noted the need to keep track of patients who move between different areas, so they don't get missed to follow up.

9. Update on the timeline for the resolution of actions from the NZFGIS Sapere report

Feedback from the report has been collated, the main themes/ areas of concern in the feedback are:

- Key areas requiring immediate action, including service capacity, IT infrastructure and accommodation
- points needing to be clarified
- broader system issues
- the report didn't go into some areas in enough depth.

The next steps are to progress actions in those key areas requiring immediate action. The BSP national team are working with the service around the budget which would increase capacity and will seek funding through the Te Whatu Ora sign off process. There is a new operations manager which will provide the service with additional staffing capacity to address concerns in report and provide changes needed to IT infrastructure. The service is working with a local real-estate team for an appropriate space to be housed in, and the search is ongoing.

Optimal Cancer Care Pathways (OCCP) update from Te Aho o Te Kahu

Te Aho o Te Kahu presented an updated draft bowel cancer OCCP for feedback, noting that the key audience is Te Whatu Ora district, regional and national service providers, funders and planners; the OCCPs are not clinical guidelines. The majority of the document is master content and is relevant to most tumour streams. Bue text indicates inclusions that are specific to bowel cancer and its these that the project team would like feedback on.

The draft Bowel OCCP now includes whānau voice by way of recommendations from the recently released hui report. Changes to the Australian OCP principles include a focus on being equity led, changing from patient to whānau centred care, changing to knowledge driven rather than clinical trials, changing from prevention to wellness, and changing end of life to palliative care and end of life.

The hope is that by defining optimal care, the OCCPs will help Te Whatu Ora drive improvement and reduce geographical variance and inequities. The Agency have begun engagement with Te Whatu Ora on the need to design the implementation of the OCCPs.

Feedback from the group was received during presentation of the bowel OCCP.

Further feedback from individual team members can be provided to the OCCP project team. OCCP document included with meeting papers.

Structured Pathology Project update from Te Aho o Te Kahu - John Manderson, Michal Lau

Te Aho o Te Kahu is working with pathologists/path services to help them transition to a more interoperative digital health environment. This will be enabled by the development and adoption of data standards that will enable sharing of standardised pathology information over the coming years. The agency is developing standards and working with lab providers to support implementation. There is an online interactive tool allowing clinicians to review the draft standards as they are developed. **Action:** Working group members to send feedback to John Manderson if they are keen to be involved in this work.
10. Regional Linkages – All This was covered earlier in the agenda, during the regional update agenda item, but the group discussed Te Whatu Ora work to set up of the regional and clinical networks. The establishment of the clinical networks is happening at pace, with 30 planned for the next 12 months, of which one is radiation oncology. However, in the meantime and until more is known about what groups will be established when, groups managed by Te Aho o Te Kahu continue.
11. Any other business - Ralph Van Dalen The group agreed that the next meeting will be online via Zoom, on October Wednesday 25th from 9-12.
12. **Meeting closed with karakia**

TE AHO O TE KAHU CANCER CONTROL AGENCY

Actions:

No.	Actions open from previous meeting	Date Raised	Lead	Status
117	Potential to standardise the CRC Follow Up Process: Ralph to present an update to the next meeting including focus on GP involvement, difference between 1 and 3 yr. colonoscopy follow up data and the holistic model.	Dec 2020	Ralph van Dalen and BSP	Is being progressed
135	Susan Parry and Ralph Van Dalen to discuss polyp cancer data and present findings back to this group.	July 2022	Susan Parry and Ralph van Dalen	Teresa has agreed to lead this work with assistance from a student and will report back at a future meeting
138	Ben Lawrence to prepare a statement on watch and wait and sent to group members for review	July 2022	Ben Lawrence	Imani to request Ben Lawrence to provide an update on this action
139	Ian Bissett and James Falvey to provide an update on both FIT for symptomatic initiatives at the next meeting.	Nov 2022	Ian Bissett and James Falvey	Ian and James to provide update
140	Regional linkages to be discussed as an agenda item at the following meeting.	Nov 2022	TBC	To be discussed next meeting
141	Cathy Whiteside to provide an update on the timeline for the resolution of actions from the NZFGIS Sapere report	Nov 2022	Cathy Whiteside	Cath to provide update
142	Ralph to provide an amended document (Colon Cancer Follow Up) to John and Janet for review.	Nov 2022	Ralph van Dalen	Complete and on agenda for May 2023 meeting
143	Polyp cancer data findings update at first meeting 2023	Nov 2022	Teresa Chalmers-Watson Ralph Van Dalen Susan Parry	May 2023 update – carried over to next meeting in 2023
144	Rectal Cancer Treatment Options at appropriate meeting in 2023	Nov 2022	Ben Lawrence	May 2023 update – carried over to next meeting in 2023

145	Te Aho o Te Kahu to make changes to TOR	May 2023	Gabrielle Nicholson	
146	Te Aho o Te Kahu to follow up with the national bowel screening programme team regarding finding two consumers through their Māori and Pacific networks.	May 2023	Ralph Van Dalen Susan Parry Cathy Whiteside	
147	Te Aho o Te Kahu to follow up with members regarding re-filling out conflict of interest forms.	May 2023	Gabrielle Nicholson	
148	Te Aho o Te Kahu to consider whether or not hub managers could support regional bowel cancer groups, as per the approach in Te Manawa Taki	May 2023	Gabrielle Nicholson and Jan Smith	
149	Cathy and Susan to discuss appropriate joint ownership and/or which working groups should oversee guidelines and bring the issue for discussion at the next meeting.	May 2023	Susan Parry Cathy Whiteside	
150	Gabrielle to pass on feedback on molecular testing to team at Te Aho o Te Kahu who is responsible for the project	May 2023	Gabrielle Nicholson	
151	Canterbury project update from Iain Ward moved to October meeting	May 2023	Iain Ward	
152	James to presesnt Canterbury FIT data at the October meeting	May 2023	James Falvey	
153	Teresa to update on polyp cancer initiative at October meeting.	May 2023	Teresa Chalmers-Watson	
154	John to add names of Primary Care Regional Leads to Te Aho o Te Kahu for inclusion in the minutes	May 2023	John McMenamin	
155	Te Aho o Te Kahu to follow up re: getting the BPAC guidance updated to reflect the changes proposed in the meeting.	May 2023	Gabrielle Nicholson	