



Minutes

Cancer Control Agency Advisory Council

Date: 14 February 2020

Time: 10:00am to 3:00pm

Location: Room 1N.3, 133 Molesworth St, Wellington

Chair: Ashley Bloomfield

Attendees: Christopher Jackson (leaving early at 11.45 am), Graeme Norton, Nina Scott, Richard Sullivan, Shelley Campbell, John Whaanga (arriving late/MOH), Ashley Bloomfield (MOH), Deborah Woodley (MOH), Diana Sarfati (CCA), Dawn Wilson (CCA), Jordan Jansen (CCA – Secretariat), Ailsa Claire (teleconference/leaving early)

Item	Notes
Welcome	The Director General (DG) welcomed the council and thanked them for their commitment to the kaupapa. David Tipene-Leach has resigned from the council, due to his extensive commitments elsewhere. He wished the Council and Cancer Agency well, and has offered his support on any specific issues that might arise. The Council thanked Dr Tipene-Leach for his valuable input to date, and wished him well in his endeavours.
Who are we and why are we here? <ul style="list-style-type: none">• Structure and functions of CCA	The Council introduced themselves and outlined their experience and the skills they brought to the Council. DS outlined the Cancer Control Agency's (CCA) principles, purpose and the current state of cancer in NZ through a presentation. Key lessons from the past were highlighted.

<ul style="list-style-type: none"> • General discussion <ul style="list-style-type: none"> a) role of council b) expectations c) issues process d) what success looks like? 	<ul style="list-style-type: none"> • The newly appointed Director of Equity, Michelle Mako was introduced. • It was noted that CCA is in an early stage of implementation, and currently has a small resource. For this reason, the Agency needs to be strategic in terms of which issues it addresses. Individual issues that are raised need to rapidly scoped and prioritised against other issues to ensure that staff are not overwhelmed. • Foundational documents are currently being drafted to inform those discussions in the future. <p>Key themes that emerged from Council members introductions were identified, highlighting that members were:</p> <ul style="list-style-type: none"> • Well connected • Equity focused • Committed • Enthusiastic but realistic • Brave • Change-focused • Fairness-focused • Resilient <p>Agreed to continue this discussion at next meeting, including clarifying the process for new issues that arise, and identifying optimal ways for the Council to work together, including considering asking specific Council members to focus on specific issues,</p>
<p>Prioritisation and priorities (12.05pm)</p> <ul style="list-style-type: none"> • Update on progress since last meeting • Priorities and prioritisation • Bowel cancer screening age extension for Māori 	<p>DW, Michelle Mako and Jason Gurney join meeting</p> <p>DS provided a presentation on prioritisation:</p> <ul style="list-style-type: none"> • The Council acknowledged the complexity of prioritising competing issues, and the fact that prioritisation itself can take substantial resources; • There is work underway currently to consider different approaches to prioritisation. • Work on equity first prioritisation and how the Council can operationalise an equity-first approach will be led by Michelle Mako. <p>This will be discussed at future Council meetings. JG provided presentation on cancer impact for Māori. Key statistics were shared:</p> <ul style="list-style-type: none"> • Māori are 10% more likely to get cancer. Most common cancers among Māori are Breast, Lung and Prostate. Māori have higher rates of many cancers, including lung, breast, stomach, liver and endometrial. The leading cause of cancer death and the greatest inequities are seen in lung cancer. • There are also persisting inequities in cancer survival.

- Drivers of inequities are found outside the health system (such as poverty). There are also systematic barriers facing Māori within the health system reflected in later diagnosis and, at times, poorer access to or quality of services.
- NS noted that her vision is that cancer diagnosis could be a positive thing for whānau, because it provides an opportunity address proximal drivers of poor health for whanau in these situations.

DS provided a presentation to the council with background on bowel screening age extension. Key points were:

- Historically bowel cancer was less common among Māori, but over time that gap has closed, so now there are similar age-specific incidence rates for Māori and non-Māori.
- The average age of diagnosis of bowel cancer for Māori is lower than that of non-Māori because the age structure of the Māori population is younger.
- There is no evidence that Māori develop bowel cancer younger than non-Māori, nor are Māori at a higher risk at a younger age.
- Overall, 43% of Māori bowel cancers are diagnosed between the ages of 60-74 (current NBSP age range), compared to 39% of non-Māori.
- Of all bowel cancers diagnosed between 50-74 yrs, 66% of those occur in 60-74 yr age group for Māori compared with 79% for European NZers.
- Bowel cancer screening participation rates remain lower for Māori and Pacific people compared with European New Zealanders.
- A study (McLeod et al) published in 2017, based on historic bowel cancer data found the following:
 1. CRC screening is cost-effective for both Māori and Non-Māori;
 2. The best balance for benefits and costs occurs at same age range for Māori and non-Māori (60-74 years);
 3. Māori as a population have “less capacity” to benefit from CRC screening because:
 - a. Māori have (or had) lower CRC incidence than non-Māori;
 - b. Māori have shorter life expectancy.
 4. Inequalities are exacerbated by:
 - Lower participation rates;
 - Lower bowel cancer survival.
- A range of options are possible to address the fact that Māori are less likely to benefit from the bowel cancer screening programme including ensuring equal participation in the screening programme, ensure equal and optimal survival from bowel cancer, investing in other pro-equity programmes (such as lung cancer screening), twinning pro-equity interventions to bowel screening.

	<p>Opportunities of increasing age range for Māori:</p> <ul style="list-style-type: none"> • Supports equity first in all programmes • Addresses major trust and confidence issue which may have implications for future engagement and success • Sets expectation for increased age range for BCSP <p>Challenges:</p> <ul style="list-style-type: none"> • Will have less equity promoting impact overall than many other interventions • Given Māori and Non-Māori have the same risk of CRC at 50-59 yrs, there may be controversy, which may impact on broader equity agenda • May negatively impact timing of national roll out of basic programme <p>The view of the Council was</p> <ul style="list-style-type: none"> • they generally supported the age-range extension for Māori; • they saw the age extension for Māori as an opportunity to demonstrate a clear focus on addressing inequity and a commitment to ensure all programmes are designed to achieve equitable outcomes, • capacity of colonoscopy national will also need consideration, • there was a perception at the meeting that this is a relatively ‘easy win’ and could be done quickly; • The Council acknowledged a staggered approach across DHBs might be most practical.
<p>Other business</p> <ul style="list-style-type: none"> • SACT project and alignment with D&D priorities (30 mins) • Early access schemes (15 mins) • Role of networks in CCA structure (20 mins) • HAMo’s engagement plan and progress (10 mins) • Schedule drug listing and de-listing process (5 mins) 	<p>1:30pm, Alex Dunn and Shayne Hunter join</p> <ul style="list-style-type: none"> • AD provided a brief update on SACT noting the following points: <ul style="list-style-type: none"> ○ The Agency is working with cancer centres to develop and implement national chemotherapy definitions to support consistent care and interoperability between IT systems. Colorectal & Lung complete. Breast, Prostate, Supportive care completed by June. ○ Currently developing requirements for a system that will leverage the detailed treatment data within DHB e-prescribing systems to drive equity, quality and efficiencies in chemotherapy delivery nationally. • A further update was provided on Oncology E-Prescribing, noting the following points: <ul style="list-style-type: none"> ○ Currently there is no oncology E-prescribing system in Northern and Midland regions ○ There are potential long-term cost savings, efficiencies and improvements in patient care achievable through Midland and Northern (and everyone else) working together in the e-prescribing space.

<ul style="list-style-type: none"> • Review DRAFT minutes • Any other business 	<ul style="list-style-type: none"> • We support national thinking and cooperation between regions in developing the national e-prescribing environment (particularly with Northern and Midland) . Noted that the council supports this work. <p>2:04pm AD and SH leave, John Roy and Maree Roberts join</p> <ul style="list-style-type: none"> • <i>Early access schemes</i> options paper is currently with the Minister. • The potential fund is a response to public calls to more quickly provide access to cancer medicines in the context of a rapidly changing environment. • Noted that it is important that any new process must not undermine PHARMAC's approval and negotiating process. • The paper outlined risks and opportunities of various options. • Noted by Council that an early access scheme may not address the concerns that have been raised (only two new medicines could be funded with the proposed funding, and existing effective medicines that are currently not funded, would remain unfunded) • Also noted that an early access scheme could have a negative impact on equity. <p>2:20pm MR and JR leave</p> <p>DS introduced cancer networks plan from the cancer action plan, and the draft hub model and its role in the CCA.</p> <p>2:24pm Jane Stringer joins, the following was discussed with points noted:</p> <ul style="list-style-type: none"> • Noted that a commitment was made in the Cancer Plan to create a national cancer network. This needs to be part of the implementation of the national Agency. Currently regional network contracts finish on 30 June. • Noted a regional presence is critical for a successful Cancer Agency, and we want to ensure continuity of regional services, and be mindful of losing regional expertise. At the same time, the structure needs to be sufficiently nimble to cope with future changes (including those that may come about as a result of the Health System Review). • The proposed regional hub teams will be employed by the Agency, and includes five consistent roles. Additional roles that are situated in the regions may also be employed in a national capacity within the Agency structure. • The Agency is currently looking at options for transitioning roles from Regional Cancer Networks to the Agency. • Noted that it was critical to support regional hubs to have strong Māori leadership, and a focus on equity. The equity roles within networks will have an explicit relationship with the Director of Equity at national level to ensure ongoing sustainable and coordinated approach. <p>2:49pm JS leaves</p> <p>NS briefed the council the on latest HAMo engagement.</p>
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Item	Action	Lead	Due Date
Welcome	Membership: <ul style="list-style-type: none"> • Consider David's replacement • Discuss Chair options (possible clinical/ Māori co-Chair) 	All	N/A
Who are we and why are we here?	Schedule another meeting before May and include this item on next agenda	Jordan	1 May
Prioritisation	Bowel screening age range extension: to summarise Council's advice, and provide this to Minister of Health.	Diana	18 Feb
Other business	Agendas of committee meetings to come to council with 3 key outcomes	Jordan	Each meeting
Other business	Priorities on next agenda with an equity first lens	Michelle Mako	Next meeting
