

## Minutes

### Medical Oncology Work Group (MOWG)

<b>Date:</b>	Wednesday 29 March 2023
<b>Time:</b>	9.33 am to 12.30pm
<b>Location:</b>	Zoom
<b>Chair:</b>	Richard North, Clinical Leader Medical Oncology, Te Whatu Ora Hauora a Toi Bay of Plenty
<b>Attendees:</b>	Brendan Luey, Clinical Leader Medical Oncology, Te Whatu Ora Capital, Coast and Hutt Valley Gwen Pinches, Medical Oncologist, Te Whatu Ora Southern Jessica Maxwell, Clinical Leader Medical Oncology, Te Whatu Ora South Canterbury Anne-Marie Wilkins, Clinical Leader, Te Whatu Ora Te Toka Tumai Auckland Kirstin Wagteveld, Nurse Practitioner, Te Whatu Ora Southern Alvin Tan, Clinical Leader Medical Oncology, Te Whatu Ora Waikato Caroline Aberhart, Pharmacist Team Leader, Te Whatu Ora Nelson Marlborough Malcolm Anderson, Clinical Leader Medical Oncology, Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral Vincent Newton, Clinical Leader Medical Oncology, Te Whatu Ora Te Tai Tokerau Northland Tara Cheung; Clinical Nurse Specialist Te Whatu Ora Southern Matthew Strother, Clinical Leader Medical Oncology, Te Whatu Ora Waitaha Canterbury
<b>He Ara Tangata – Consumer Reference Group</b>	Thomas Ngaruhe Ngaroimata Reid
<b>Te Aho o Te Kahu attendees:</b>	Alex Dunn, Senior Project Manager, Data Monitoring and Reporting Team (ACT-NOW Update) Dawn Wilson, Chief Advisor Interim Manager Clinical Advisory Team Janfrey Doak, Interim Manager Southern Hub Luisa Acheson, Clinical Advisory Team Administrator Simon Pointer, National Pharmacist, Clinical Advisory Team John Manderson, Senior Project Manager, Data Monitoring and Reporting Team Janfrey Doak, Interim Manager Southern Hub
<b>Guests:</b>	Logan Heyes, Senior Therapeutic Group Manager, PHARMAC Jared Solloway, Therapeutic Group Manager, PHARMAC Chris Jackson, Medical Oncologist, Te Whatu Ora Southern and Clinical Lead ACT-NOW Johanna Padison, Medical Oncologist, Te Whatu Ora South Canterbury

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**Secretariat:** Melinda Greshoff (minutes)

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**Apologies:** David Gibbs, Liz Dennett, Humphrey Pullon, Ngaroimata Reid, Thomas Ngaruhe  
Navin Wewala, Medical Oncologist, Te Whatu Ora Te Pae Hauora o Ruahine o Tararua  
MidCentral  
Steve Delaney, Clinical Leader Medical Oncology, Te Whatu Ora Nelson Marlborough  
Louise Bremer, Clinical Director, Medical Oncology, Te Whatu Ora Southern (tentative)  
Elizabeth Dennett, Clinical Director (tentative)  
Kate Wakefield

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### Welcome & Karakia

The Chair welcomed everyone to the meeting.  
The Agenda was confirmed.

### Introductions to new members

Everyone introduced themselves.  
The Chair welcomed Gwen Pinches Medical Oncologist, Te Whatu Ora Southern who will be attending the meeting even though she is not a HoD and Tara Cheung, Clinical Nurse Specialist Te Whatu Ora Southern.

### Review and approval of the draft minutes from last meeting

As the recording of the previous meeting failed, the Minutes are missing information and are deemed to be as good as was possible under the circumstances.

### Conflicts of interest register

No conflicts of interest were disclosed.  
New members are asked to email their official titles to the Chair or Simon Pointer.  
Any changes should also be emailed to Richard North or Simon Pointer.

### List of Registered Medical Oncologists in NZ

A couple of changes were identified in the list:  
Attendees agreed to email changes through to Simon Pointer/Richard North.

### Action register

A complete review was deemed necessary but, due to time restraints, this was not completed.  
Item numbers 2020/14, 2021/07 and 2021/15 were addressed and closed (see action register for detail).  
Item numbers 2021/16 and 2021/17 are WIP.  
All other items are still to be reviewed.

### PHARMAC Update:

Logan Heyes and Jared Solloway joined the meeting at 10.00am. Jared introduced himself to the members.  
The Chair hopes that there will be better continuity in the relationship between Pharmac and MOWG.

### **Slide 1: New funding applications**

Pharmac is seeking feedback on new funding applications for treatments and how the list should be prioritised. These are funding applications that do not yet have recommended clinical advice. As Pharmac only looks at applications they receive, they are interested in what else should be reviewed and followed up.

Discussion points included:

- It is hard to prioritise a list without knowing what else is available.
- The group should be providing general principles rather than prioritising a list. Principles should be success rate and rarity of other treatments.
- MOWG is not a complete group of oncology practitioners and does not have the expertise to triage Pharmac's list. Special interest groups have the expertise but some groups are more successful in advocating for their members. Some rarer cancers also do not currently have a Special Interest Group.
- All of the treatment looks as though they have recent data.
- The discussion is missing the people with the money.

### **Slide 2. Supplier Issues**

Lomustine will be discontinued and Pharmac is looking at funding and other options to meet health needs.

- MOWG advised that Bevacizumab & Temozolomide are not the same and would have different indications
- Funding Temozolomide would be more beneficial. It is useful in a number of scenarios and is a cheap option. However, Pharmac needs to remove the need for applying for special authority.
- Preferably both Bevacizumab & Temozolomide should be funded and neither are expensive. MOWG is not aware of other options.
- MOWG suggests Pharmac make a quick decision (by June) and take Temozolomide off the special authority list.

### **Slide 3. Out of stock medicines**

There are supply issues around Lomustine, Calcium Folate, Doxorubicin, Vinorelbine IV, Capecitabine (500mg strength tablet only).

Discussion points:

- Vinorelbine IV can be reassessed. There is difficulty in gaining interest in this market. There would have to be a graded change from Vinorelbine IV to oral Vinorelbine treatment. Pharmac is aware of the need for IV in paediatrics. Most people will change to oral.
- Doxorubicin is a manufacturing issue.
- Covid has affected all pharmaceutical supplies and the main difficulties are the supply of medicines that are a bridge between hospital pharmacies and community pharmacies.
- The Pharmac one supplier policy has its pros and cons.
- There is very little notice given to practitioners about supply issues and brings into question Pharmac's notification process.

Patients seem to know about supply issues before advice is given to clinicians, so the clinician has to scramble around to change treatments.

Pharmac was questioned about the management of stock and whether there is a contact person.

It is Pharmac's responsibility to manage supply but there are situations where wholesalers and suppliers communicate inappropriately. There are supposed to be minimum holdings and timely notification process. Pharmac appreciates that notification is coming from other people other than Pharmac or Te Aho o Te Kahu.

Jared can be contacted directly about supplies.

- MOWG commented that the communications from Pharmac about supply issues come across as unhelpful as there is no plan or information regarding.

One member commented that there seems to be two communication streams i.e. pharmacies and prescribers and there may be a breakdown in communications between Pharmac and prescribers.

- It was pointed out that some alternatives are Section 29 drugs which have associated prescribing issues e.g. Section 29 drugs have additional medicolegal requirements, and can only be prescribed by Medical practitioners (not nurse practitioners or Pharmacist prescribers)
- The Therapeutic Products Bill will hopefully resolve the issues around Section 29. At this stage, the Bill will only come to be enacted in 2026 and is currently in select committee stage.  
The Therapeutic Products Bill is a wholesale change in policy and includes medical devices and natural products.  
The Bill should be discussed in further detail at another meeting.

Pharmac undertook to look at communications about supply issues and Section 29 drugs.

### ICI in NSCLC

Logan gave an overview of the new drug which comes in on 1 April.

Preparations are underway to implement this, and the intent was to manage the impact more quickly. There are two workstreams, Pharmac and Te Aho o Te Kahu who are supporting Te Whatu Ora in developing a business case.

A lot of work to be done to develop resources and consumer materials but there is a key issue around capacity.

Te Aho o Te Kahu are absolutely supportive about getting this implemented. MOWG has had input into national workshops to discuss the modelling. Te Aho o Te Kahu will distribute information to everyone asap.

The Chair asked each member about current practices and if they are planning to provide the drug from 1 April. Regions reported that patients are / will be changing from private to public hospitals because of the funding which has repercussions on capacity and pharmacies.

The Chair congratulated Pharmac, Te Aho o Te Kahu and on the engagement and preparation for this new drug. He expressed his profound disappointment about the lack of engagement from Te Whatu Ora and the delay in business case development.

Pharmac and Te Aho o Te Kahu will be having a meeting with Te Whatu Ora and regional heads to understand next steps with the business case.

### ACT-NOW

Alex Dunn, Chris Jackson, Tony Wilson, and Jo Paddison joined the meeting at 11.10am to discuss ACT-NOW.

#### **Regimen Library**

Alex gave an overview of the Regimen Library:

- The Regimen Library should be completed by June 2023.
- There are 4 major workstreams involved in implementation, supported by Te Aho o Te Kahu pharmacists.
- MOSAIQ need to upgrade their product to become standards (SNOMED CT + FHIR) compliant and facilitate seamless data exchange with the SRL and other IT platforms; it will be interesting when there is another vendor creating some competition.
- The long term success of national Regimen Library depends on it being kept up to date. It was agreed that workshops are the best way forward to reviewing the contents. However, to date, there are problems in scheduling meetings that have a quorum of members.

General discussion points:

- Some MOWG representatives were not aware of invitations to their team members to attend a workshop.
- A member asked about the definition of a quorum and if there is another way of contributing; this is a valuable issue but not urgent so tends to get pushed back.
- It was suggested that Alex send the invitation to HoDs and/or Clinical Lead and then the meeting could be formally scheduled.
- A “go-to” person could be identified for each cancer and region. A quorum could be defined as one or two people (perhaps only the Chair needs to attend) but there is a consultation process post-workshop to allow feedback.
- Arrangements could be made to link the review with a SIG.
- The meeting should be a static date every year with a built in time and be part of a clinician’s job description.

**ACT-NOW Analytics Plan**

JP demonstrated the ACT-NOW Analytics Plan and discussion points included:

- MOWG will have to work with Te Aho o Te Kahu to develop appropriate details around data access and visibility of analytics products.
- It is hoped that these analytics will facilitate the audit process.
- There is no individual clinician level data collected via ACT-NOW, only provider level.
- These analytics would be useful as a tool for individual clinicians to be able to compare with other clinicians across the country and develop benchmarks.
- Prof Jackson advised that there will have to be some work done around confidentiality; individual patient privacy is imperative.
- The Chair advised that lawyers will have to check that data is being protected properly. It was reported that Te Whatu Ora and Te Aho o Te Kahu are developing a comprehensive privacy impact assessment with significant health legal input.
- AD advised that standard processes for preserving patient privacy are being implemented (eg hiding dashboard selections with small patient numbers).
- AD commented that it needs to be assumed that public data will eventually be in the public domain and data will be subject to OIA requests.
- Maintaining data quality will require resourcing and will have to be part of someone’s role.
- A customised plan for data quality for each centre will be developed.
- It was advised that an intervention rate will be captured;
- There was a discussion about “non-treatments” and staging.
  - ◇ If a patient is not put into their oncology information system, their data will not show up.
  - ◇ Oral treatment is also poorly captured as prescribing often occurs outside of electronic systems.
  - ◇ Input of staging information by clinicians needs to improve.
  - ◇ Fleshing out any ambiguities around staging rules is being undertaken.
  - ◇ The CanShare structured pathology piece of work is a parallel workstream around considering staging, aiming to support a move away from reliance on clinicians to enter staging information.

**ACC and ACT-NOW:**

The Chair gave an update on developments between ACC and ACT-NOW.

There have been discussions between ACT-NOW and ACC about the Regimen Library. ACC will agree to fund anything under the Regimen Library, which will reduce inconsistencies. In general, this gives more certainty for patients about what will be funded.

A member asked if this will mean ACC will “only fund” what is in the library. The Chair replied that there are some fishhooks but is better to have a general understanding of what ACC will fund. This would create transparency and tidy up processes.

It would be helpful to understand ACC criteria for funding.

The “NPPA” process is not fit for purpose and ACC is the same.

The deal is that ACT-NOW workshops agree what is reasonable, the level of evidence is why the regimen is in the library.

A question was asked about the mechanism for clinicians to prescribe other drugs for the library. The clinician should contact the chairperson of the workstream to put a case forward to the group.

There is no threshold in ACT-NOW, the threshold for getting new things on is to have a meeting and get agreement that it should be included.

ACC creates huge unfairness in the day ward, and everyone is going to start applying for ACC.

MOWG needs to understand broad parameters of “entitlements”; the legislation around ACC is extremely vague.

The Chair will feed back that there is concern around the complicated process but appreciate there is some certainty over entitlements.

The group discussed whether ACC should be delivered privately or through the public sector. The Chair’s view is that as ACC is a private insurer, it should go through private sector. This will need to be clarified.

#### Roundtable discussion Incl. Recovery following cyclone Gabrielle

**Northland:** Northland has a new manager. They are short staffed in FTE and don’t have a registrar. The issues relate to SMOs rather than clinics. They have been asking Auckland for support, but they are also resource challenged. There are discussions around job sizes and what makes up FTE.

**Auckland:** A regional waitlist is being put together to get a bigger picture. Recruitment is dire for FTE. There is no reliever pool for registrars. Service constraints affect everyone so there is nowhere to put patients. Raurau Ngaehe (regional e-prescribing system) is being rolled out in Counties Manukau first. MOWG members keen to hear of progress and functionality of new system.

**Waikato:** Waikato is 2 registrars down and the waiting list has extended. There are lots of infrastructure constraints.

**Tairāwhiti / Mid-Central:** The cyclone was hugely disruptive and basically the service was kept going with telephone and heroic assistance by nurses doing extra days on the weekend. Staff are being flown around to see patients. A temporary clinic has been set up in Napier.

**Taranaki:** Recruitment is an issue.

**Wellington:** The situation is better than in October. A SMO has been recruited and Sharon transferred from Dunedin. The day ward nurses seem a bit more settled. The region has lost all leadership due to a range of issues (retirement/illness) and new leaders have no oncology knowledge.

**Christchurch:** 9 out of 12 FTE positions have been filled however, a submission to management identified a need for 18-20 FTE in 2018. There is hard constraint in rooms. There have been 3-4 months of reduced referrals due to decreased surgical capacity. The region is starting to report patients dying on the waitlist.

**Dunedin:** Most of the clinic spaces are nearly finished. They have lost a registrar. Radiation oncology services are currently under severe strain. There are discrepancies in cancer treatments.

**Tauranga:** Goodwill has burned up. Richard North is no longer HoD. Michelle Head has taken over as HOD.

## Cancer Services Planning

Simon Pointer of Te Aho o Te Kahu gave an update on planning work.

There is a draft report about feedback and recommendations to be submitted to internal steering group. MOWG will have a Cancer Services Plan to consider in a few weeks' time.

## Any other business

**DPD deficiency:** Medsafe has amended the wording and produced a prescriber update. MOWG will continue to manage as previously.

**Average wait for FSA:** The Chair asked for information on the average wait for FSA and the average seems to be 6-8 weeks.

**FTE:** Only 3 people sent the Chair information about FTE in their regions.

**Action:** *The Chair will send an email to members to elicit information about FTE in each region.*

**Succession Planning:** Richard North is no longer HoD in Tauranga. He is happy to carry on as Tauranga representative and Chair but would like to identify a successor. Any members interested in becoming Chair asked to please signal their interest. The MOWG members thanked Richard North for his work to date.

**Loss of Goodwill:** Some representatives were concerned about loss of goodwill among staff and the risk of burnout. As already reported, FTE are already short, and a couple of SMOs are stressed and want to cut their hours back. MOWG members agreed that it was better to grant colleagues reduced working hours than to risk burnout and potentially lose them altogether.

The Chair commented that the job of an oncologist has got a lot harder and more stressful over the years.

## Meeting Close:

The meeting closed at 12.50pm. Simon Pointer closed the meeting with a karakia.