Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

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29 July 2019

9(2)(a)
[redacted]

[redacted]

[redacted]

RE Official Information Act request CDHB 10127

I refer to your email dated 19 June 2019 requesting the following information under the Official Information Act from Canterbury DHB regarding priority spending and cancer treatment.

We don't really have priority areas for spending, that would suggest a higher level of discretion and discretionary funding is very limited. Where we do have choices, the three strategic objectives which underpin our strategic direction and influence our funding decisions, along with our decision making framework are:

- The development of services that support people to stay well and enable them to take greater responsibly for their own health
- The development of primary/community-based services that support people in the community and provide a point of ongoing continuity, which for most people will be general practice
- The freeing-up of hospital-based specialist resources to be more response to episodic events, provide timely access to more complex care and specialist advice to primary care.

The Minister of Health's Letter of Expectations does signal priorities and expectations for DHBs on an annual basis. The annual national priorities are signalled in our Annual Plan, under the regional alignment section, with the Minister's Letter being included as an appendix to each Annual Plan. The expectations for the coming year (2019/20) signal a strong focus on equity in health and wellness.

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes, supported by a strong and equitable public health and disability system
- Better population health outcomes, supported by primary health care
- Strong fiscal management.

The DHB's Annual Plan outlines how we will deliver on the Minister's expectations in each coming year.

1. **What is the DHB's top 10 priorities for spending in the 2019/20 financial year?**

We cannot provide the detail of our 2019/2020 financial year as this has not yet been finalised and approved by the Ministers.

2. **What were the DHB's top 10 priorities for spending in each of the past 5 financial years?**

You will find the information included in our Annual Plans going back to 2008/2009 on our website. https://www.cdhb.health.nz/about-us/document-library/?_sft_document_type=annual-plan

5. **Please also provide any spending priorities or targets the DHB has to hand for the years beyond 2019/20, if those exist.**

Priorities beyond 2019/20 are yet to be determined.

3. **What has been the proportion of patients accepted for urgent diagnostic colonoscopy who received the procedure within 14 days (2 weeks) for each of the last 5 years? And what is the target for 2019/20?**

Our target for 2019/2020 for Urgent Colonoscopy: 90% of people accepted for an urgent colonoscopy receive their procedure in 14 days (two weeks) or less.

Please refer to Table one (below) for the proportion of patients accepted for urgent diagnostic colonoscopy who received the procedure with 14 days and those seen over the 14 days mark.

Table one:

Financial year	Seen within 14 days	Seen over 14 days	Grand Total	% Seen within 14 days
2014/2015	252	30	282	89.4%
2015/2016	294	21	315	93.3%
2016/2017	342	19	361	94.7%
2017/2018	361	40	401	90.0%
2018 – 2019*	377	72	449	84.0%
Grand Total	**1626**	**182**	**1808**	**90.0%**

*As at 31/5/2019

4. **What has been the proportion of patients who received their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks, for each of the last 5 years; and what is the target for 2019/20?**

The figures provided for the Canterbury DHB relate to the 62 days target. Eligible patients triaged as having a high suspicion of cancer (HSCAN) and a need to be seen urgently should wait no more than 62 days from when their referral (usually via their GP) is received by the hospital to their first treatment.

Until July 2017 the compliance target was **85%** for eligible patients on the 62 day pathway. In July it rose to **90%**. At the same time another change was introduced. Up until July '17 all patients who failed to meet the 62 day target were included in the compliance calculations: there were no exceptions. In July '17 the MoH informed DHBs that patients who did not meet the target through patient choice or clinical considerations leading to a delay in treatment would be excluded from the totals. Therefore only patients who fail to meet the 62 days target because of capacity constraints, poor processes or any other reasons that are not patient choice or good clinical reasons are now included in the compliance calculation and the information overleaf in **Table two and Fig(1)** reflects this change.

Table two

Year	% compliance	Target %
2015	75.2	85.0
2016	79.7	85.0
Jan-Jun 2017	87.4	85.0
Jul-Dec 2017	94.8	90.0
2018	94.9	90.0
Jan-May 2019	97.0	90.0

Fig 1

6. **Any current most-recent statement of DHB priorities regarding cancer management or treatment, or concerns with that, that the Ministry has been briefed on or received any report about, oral or written, from your DHB in the 2018/2019 or 2019/20 years to date**

FCT (Faster Cancer Treatment) is one of the Canterbury DHB's 5+1 priorities. The following paragraphs are from the 'new Patients' summary document' on what FCT is all about.

Each month all DHBs are required to provide the MoH with FCT data down to patient level showing their compliance against FCT targets and measures. Our FCT performance is a top 5+1 priority for the CDHB. However the focus of FCT is not about meeting an arbitrary MoH target: the FCT team have always believed that if we get the processes right, not only will that benefit patients but it will also be reflected in our FCT performance.

The core of the Canterbury DHB approach to FCT is that by putting the patient at the centre of what we do and arranging services accordingly then compliance with the FCT targets will follow. Therefore each patient who did not meet the target is checked via HCS and other data sources to determine why. If it was through patient choice or clinical considerations then normally no further analysis is undertaken because these delays are either respecting the patient's right to choose or in the patient's interest.

Please find attached as **Appendix 1** (attached) information pertaining to the Business Case for Bowel Screening Programme roll out and emails/letters between David Meates and MoH re Radiation Oncology Wait Times.

Please note: Key documents held by the Ministry of Health relating to the implementation of the National Bowel Screening Programme are available on the link below throughout the life of the programme.

https://www.health.govt.nz/our-work/preventative-health-wellness/screening/national-bowel-screening-programme/key-documents-national-bowel-screening-programme

We have redacted information under the following sections of the Official Information Act:
Section 9(2)(a) i.e. *"…to protect the privacy of natural persons, including those deceased."*
Section 9(2)(j) i.e. *"…to enable a Minister, department or organisation holding information to carry out commercial activities or negotiations."*
We have also redacted information we consider to be "out of scope" of your request.
Note: We are withholding Section 4 of the Business Case for Bowel Screening Programme (Financial Case) under section 9(2)(j) i.e. *"…to enable a Minister, department or organisation holding information to carry out commercial activities or negotiations."*

I trust that this satisfies your interest in this matter.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek a review of our decision from the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Kathleen Smitheram

Subject: FW: Canterbury DHB Business Case for Bowel Screening Programme - OIA 10127
Attachments: 21749.pdf; 21749-CDHB NBSP Business Case Info Required for 19-20 Implementation.pdf

From: David Meates <David.Meates@cdhb.health.nz>
Subject: Canterbury DHB Business Case for Bowel Screening Programme
Date: 3 March 2019 at 9:52:07 PM GMT-5
To: s9(2)(a) [redacted] @moh.govt.nz'" s9(2)(a) [redacted] @moh.govt.nz>
Cc: Ralph La salle <Ralph.Lasalle@cdhb.health.nz>, Carolyn Gullery <Carolyn.Gullery@cdhb.health.nz>

Please find attached letter and Business Case for Bowel Screening Programme roll out

David Meates, MNZM
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Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CHIEF EXECUTIVE'S OFFICE

Tel: s9(2)(a)
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4 March 2019

s9(2)(a)
National Bowel Screening Programme
National Screening Unit
Ministry of Health
mailto:s9(2)(a)@moh.govt.nz

Dear s9(2)(a)

Canterbury DHB Business Case for Bowel Screening Programme

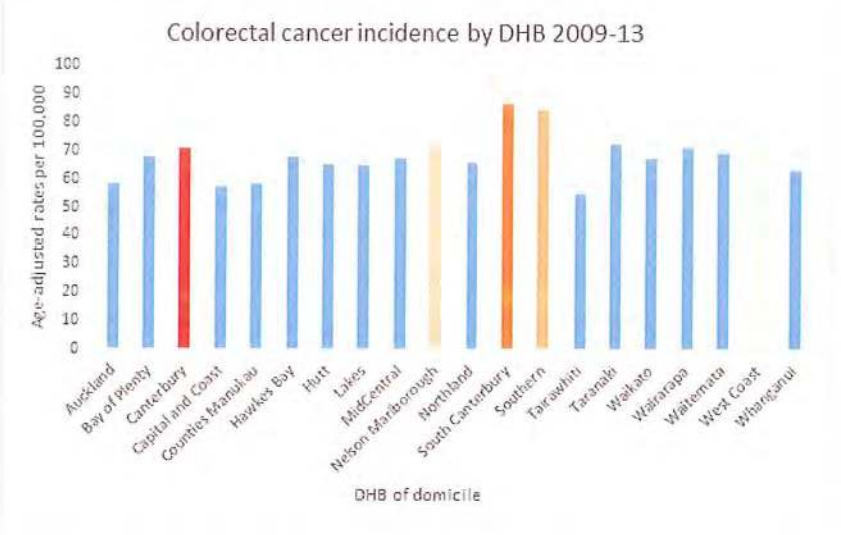
Accompanying this letter please find Canterbury DHB's Business Case for the Bowel Screening Programme roll out.

The Bowel Screening Programme is endorsed by local clinicians, our local population and is the right thing to do. Our Board has been particularly interested in our commencing the programme at the earliest opportunity. Postponing the roll out again would cause a great deal of disappointment.

However in the current circumstances the Programme does present significant challenges which we have identified in the business case along with how we will respond to them. Unfortunately the physical capacity challenges faced by the DHB will not resolve in the short term so we will need to meet them in a different way.

We want to bring a few examples of the challenges Canterbury faces so they are clear and upper most in your mind as you use the information in this business case to assemble your brief to the Minister, Treasury and others within the Ministry.

Incidence of Bowel Cancer on the South Island
(determined by colorectal cancer registrations from 2009-2013 – age adjusted)



While the Business Case is specific to Canterbury, the incidence of bowel cancer across the whole South Island (SI) is higher than any other region. Canterbury (70.8) has a higher than national rate (65.7) and a particularly high rate in Maori (71) noting that Canterbury has the sixth largest Maori population. The rest of the SI is higher than Canterbury generally but not in Maori. However, the higher rate in the rest of the SI is material for us as it increases the load on our system as a tertiary oncology provider. Southern (84.4) has a large problem in this space now and South Canterbury (86.5) will notice it when they do their business case which will have a direct impact on Canterbury's capacity.

In Southern and Nelson Marlborough DHB, this is manifesting itself in the types of scope cases which are being found. High polyp loading, specific programme requirements and other clinical indications are resulting in only being able to do 3-4 scopes in a normal session where up to 8 might previously have been done. We have modelled this into our business case as we will expect the same thing to occur in Canterbury at least in the first years. We will strive to achieve the programme's target of 5 per session in later years but this is still lower than our current productivity.

This data also shows that Canterbury and the SI will likely have higher rates of uptake than other portions of the country. We point out as an example that Canterbury has a very high rate of uptake for Breast Screening for both Maori and non-Maori. Both as a DHB and a part of the SI region, we do not see this has been worked into any of the national modelling. We have noted this places the risk with the DHB in terms of the modelling and allocation of funding particularly in the first years. If Canterbury does better than the plan as Southern is doing right now during their first years, Canterbury has to accommodate all the costs with that higher screening rate which will be at the expense of other programmes.

Physical Capacity
The lack of physical capacity in Canterbury DHB is forcing the outsourcing and outplacing of scopes at an identifiable extra cost to the DHB. The majority of the extra cost (39%) will be

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felt in the first year[1] of the Programme and is not one which will be recouped in any subsequent period. The five-year additional costs s9(2)(j) have been clearly outlined in the Business case. Please note, should Canterbury DHB see the same uptake as Southern in screening rates, the shortfall rises to s9(2)(j)

This is compounded by the point above. Canterbury DHB has to outplace 175% of the current number of screening scopes to be able to meet the BSP specifications due to our limited physical capacity. This comes at the same time we are experiencing over a 20% increase in referrals due in part to the awareness caused by the Programme roll out in other areas and to our aging population with a higher prevalence.

Physical capacity is also not currently within Canterbury control. While planning work has recently started with the MOH, no decisions on campus masterplans have been made, agreed or funded. Any new capacity is still many years away after significant construction and earthquake repairs. There remain possibilities that the gastro suite may have to be moved more than once before any final location is determined.

In summary, we endorse the Business Case as submitted and are aware that our clinical teams are keen to implement. We recognise that some elements included in this business case will be uncomfortable but encourage you to continue to have open conversations about how these issues can be addressed. It would be wrong to dismiss the financial implications of Canterbury's physical capacity constraint as just being something that the DHB has to manage. We seek clear acknowledgment that the MoH recognises that the implementation of this programme will increase the deficit particularly in the first year due to the unique circumstances Canterbury finds itself in post the earthquakes combined with the scale of activity that Canterbury will need to undertake.

We will be sharing this business case with our Board at its next meeting and will pass on any further comments from them.

Yours sincerely

David Meates, MNZM
Chief Executive

[1] First year is considered as May 2020 through June 2021 – the initial rollout of two months of May and June in 2020 are unlikely to have much volume – while modelled this way, realistically the volume will be handled in 2020/21

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National Bowel Screening Programme

Canterbury DHB Information

This document:

- Is a summary of the anticipated approach to the implementation of NBSP in the DHB.
- Is to inform the Ministry of Health 2019/20 NBSP business case, to be presented to joint Ministers of Health and Finance.

Guidance to complete the template

Please note that this is a template document. Some sections have been pre-populated to assist in the completion of the document. If you have any queries regarding the completion of this document please contact the NBSP team at the Ministry of Health.

Table of Contents

Document Information

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Document Review

Role	Name	Review Status
Executive Director Planning, Funding and Decision Support	Carolyn Gullery	Review by 28 February 2019
Charge Nurse Manager - Endoscopy Unit	Gendy Bradford	Review by 28 February 2019
Service Development Manager Secondary Care - Planning & Funding	Gill Fowler	Review by 28 February 2019
Clinical Director - General Surgery	Greg Robertson	Review by 28 February 2019
Service Manager - Anatomical Pathology	Greg Devane	Review by 28 February 2019
Team Leader - Planning and Funding	Ralph La Salle	Review by 28 February 2019
Operations Manager –WCDHB	*Vacan*t	Review by 28 February 2019
Clinical Director - Gastroenterology	James Falvey	Review by 28 February 2019
South Island Alliance Programme Office	Janice Donaldson	Review by 28 February 2019
Service Manager - Oncology	Jane Trolove	Review by 28 February 2019
Service Manager - General Surgery	Kathy Davenport	Review by 28 February 2019
Programme Director - SSSLA	Keith Wright	Review by 28 February 2019
Service Manager - Gastroenterology	Rob Hallinan	Review by 28 February 2019
General Practitioner Liaison - Gastroenterology	Sue Levin	Review by 28 February 2019

Document Sign-off

Role	Name	Sign-off Date
Accountable Person		
David Meates	Chief Executive Officer	by 28 February 2019

1 Background: NBSP

1.1 Need for Investment

Bowel Cancer in New Zealand

New Zealand has one of the highest rates of bowel cancer in the developed world. When compared with other Organisation for Economic Co-Operation and Development (OECD) countries, in 2011 (the latest year for which official figures are available for this comparison), New Zealand had the fifth highest rate of colorectal cancer mortality. In New Zealand, bowel cancer is the second most commonly registered cancer and is the second most common cause of cancer death[1].

New Zealanders with bowel cancer are more likely to be diagnosed with advanced stages than people in Australia, the United States and the United Kingdom. This translates directly to death rates, which are 35 percent higher in New Zealand than Australia for women and 24 percent higher for men[2]. Bowel cancer is one of the few cancers for which Māori show lower registration and death rates than non-Māori. However, whilst bowel cancer occurs less frequently in Māori compared to non-Māori, once diagnosed, Māori are more likely to die of bowel cancer than non- Māori.

Benefits of a National Bowel Screening Programme

New Zealand is one of the few OECD countries not to have a national bowel screening programme in place. Bowel screening is an investment with health, social and economic benefits with a programme Net Present Value (NPV) estimated at $1.034 billion. Bowel screening aims to reduce the mortality rate from bowel cancer, by diagnosing and treating bowel cancer at an early curable stage, as well as identifying and removing pre-cancerous advanced adenomas from the bowel before they become cancerous, which can, over time, lead to a reduction in bowel cancer incidence.

Screening detects cancers at an earlier, more treatable stage. 65-70 percent of cancers identified in the Bowel Screening Pilot in Waitemata DHB were Stage I or II (the earliest stages) compared with approximately 40 percent of all bowel cancers diagnosed in New Zealand through symptomatic services. Where cancer is diagnosed at an earlier stage, this is associated with lower treatment costs compared to the cost of treating more advanced cancer. One in ten of all cancers found during the Bowel Screening Pilot were identified at such an early stage that they required no further surgery, chemotherapy or radiotherapy post colonoscopy.

It is important to note however, that screening has the potential to benefit but also the potential to do harm. Participants in a screening programme should be assured that the screening programme can deliver the potential benefits and minimise the harms, and that the implementation of a screening programme will consider both the harms and the benefits.

The evaluation of the Bowel Screening Pilot has concluded that bowel screening will save lives, with data from international studies indicating that a screening programme may reduce mortality in the population offered screening from bowel cancer by at least 16-22 percent, and potentially up to 30 percent, after 8-10 years. The evaluation also concluded that a national bowel screening programme will result in significant cost-savings from reduced treatment of bowel cancer, which outweigh the cost of screening.

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[1] Source: http://www.health.govt.nz/publication/cancer-new-registrations-and-deaths-2013

[2] The PIPER Project Final report 7 August 2015, Health Research Council reference: 11/764

The main benefits of a national bowel screening programme will be:

- **Improved health outcomes** (reduced mortality and morbidity associated with early detection and, potentially, reduced bowel cancer incidence rates).
- **More cost-effective health care** (lower cost of screening versus the cost of treatment, increased early detection resulting in lower (or no further) treatment costs and increase in quality life-years gained).
- **Improved service delivery** (increase in people receiving consistent and high-quality services, reduction in symptomatic first presentation at Emergency Departments, and improved data capture and reporting). It is a common consequence of screening programmes that the required quality standards associated with population screening have a direct follow on to improvements in symptomatic services.
- **Significant social and economic benefits**, including Quality Adjusted Life Years (QALYs) saved (estimated at $1,184 million for New Zealand over the 20-year modelled period). The cost evaluation analysis undertaken for the Programme business case indicates that there is also a contribution to society, estimated at $671 million over the 20-year modelled period.

Equity

As experienced internationally, screening programmes often increase ethnic inequalities in health. The findings of the December 2015 paper from the University of Otago[3] suggest that although a national bowel screening programme would offer health gains for both Māori and non-Māori, it will almost certainly increase inequalities between the two.

Māori have lower incidence of colorectal cancer, higher background mortality and are likely to have lower screening coverage compared to non-Māori. This would almost certainly result in an increased disparity in cancer outcomes. To be clear, a national bowel screening programme would improve total population health and result in health gains for both Māori and non-Māori. However, non-Māori gains are likely to be larger. The net effect is that the disparity between Māori and non-Māori cancer health outcomes would increase. Māori are often diagnosed with bowel cancer at a more advanced stage than non-Māori, and treatment options are more frequently complicated by a greater co-morbidity burden. Māori, therefore, have more potential to benefit from the prevention, earlier detection, more simple treatment options and better survival outcomes for early stage disease, that result from a screening programme.

The Programme would seek to address and minimise inequalities. Ensuring that activities are undertaken to promote and maximise Māori and Pasifica participation will be critical in mitigating inequalities in outcomes. The Programme will build on the work of the pilot to increase participation for Māori and Pasifica. Actions to ensure equitable participation in bowel screening will include:

- targeted actions to increase participation in bowel screening for Māori, Pacific and high deprivation populations groups (active follow up on invitations, targeted health promotion, engagement with community groups such as marae and churches);
- each DHB will have an equity plan to implement locally appropriate actions to increase equity;
- national monitoring of participation and outcomes by ethnicity through the bowel screening IT solution to inform and drive actions to improve equity;
- primary care involvement in promoting participation and managing positive results;
- a public health campaign about the signs and symptoms of bowel cancer, targeted at Māori and Pasifica;
- national governance with a strong focus on equity.

Regional strategies to address inequalities are described in Section 3.4.

[3] University of Otago, Colorectal cancer screening: Variation in health gain and cost-effectiveness by ethnic group, and optimal age-range to screen, paper under review as at December 2015

Programme Strategic Alignment and Stakeholder Support

Investment in a national bowel screening programme supports a number of key Government initiatives, including the New Zealand Health Strategy, the Faster Cancer Treatment Programme, the New Zealand Cancer Plan 2015-2018, the New Zealand Cancer Information Strategy and the Ministry of Health Statement of Intent 2015-2019.

Since 2013/14, the Government has invested over $19 million in additional colonoscopy capacity to reduce the number of people waiting for a procedure. This is a critical factor in enabling a rollout of a bowel screening programme, as colonoscopies are required for people with symptoms and for those with a history or greater risk of bowel cancer and will be required for people identified through screening.

There is strong sector support for a national bowel screening programme. In June 2016, the Ministry received signed confirmation from all DHB CEOs that they agree in principle, with the support of their Board Chair, that delivery of the bowel screening services according to the national bowel screening pathway and standards is achievable for their DHB, subject to receiving funding to cover the cost of the Programme. In April 2016, Health Workforce New Zealand confirmed that on the basis of the workforce planning and modelling undertaken, it supports the implementation of a national bowel screening programme.

1.2 Programme Description

Screening Pathway

The bowel screening pathway is made up of five stages:

- **Identification:** Identifying eligible population, populating and maintaining the participant information on the NBSP Register.
- **Invitation:** inviting people to participate in a screening episode.
- **Fit kit:** Receiving and testing screening kits and distributing results. Receiving and testing screening kits and distributing results**.**
- **Colonoscopy:** Informing participants with positive results and referring for investigation. Assessing, scheduling, and delivering investigative services. Identification and recording of adverse events post investigation.
- **Treatment:** Identification and recording of treatment information.

The Bowel Screening Pathway is depicted in Figure 1.

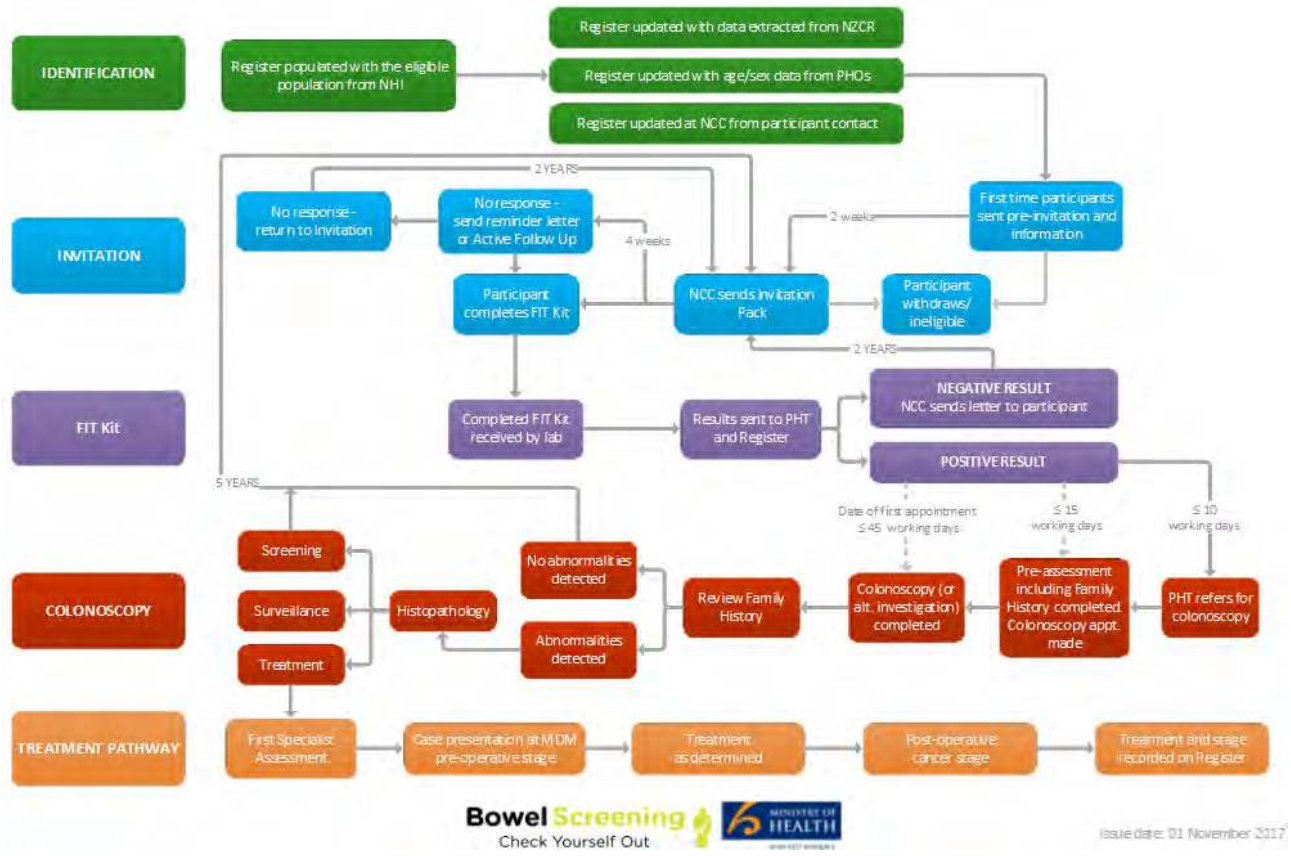


Figure 1: Bowel Screening Pathway, 1 November 2017

Service Model

The key elements of the national bowel screening programme are described below.

- **National Coordination Centre (NCC):** The NCC reports to the Programme at the Ministry of Health. The NCC is responsible for activities involving the entire Programme population. This includes: managing the Register; pre-invitation letters, distribution of screening invitations to participants; notification of negative results to participants; notification of positive results to General Practice; and notification to participants of exit from the Programme. The NCC is also responsible for ensuring quality, through monitoring and following up on participation and monitoring performance (including resolving or escalating exceptions). The NCC has a lead responsibility for promoting equitable participation nationally.
- **National FIT Laboratory:** One laboratory will provide the FIT kits for the NCC to send out and will process the returned FIT kits.
- **Bowel Screening Regional Centres (BSRC):** Four BSRCs have been established, one for each region. The BSRC key roles are to: support the DHBs in the region in their planning and establishment of bowel screening, particularly in the areas of quality and clinical expertise, and assist the Ministry in ensuring consistency in roll out of the NBSP; provide clinical leadership to the region to ensure consistent, safe and high quality screening, diagnostic and histopathology services at each DHB; ensure that there is a regional equity plan which has been developed in collaboration and consultation with the DHBs and key stakeholders in the region; and provide overview of the performance of DHBs in the region against the Interim Quality Standards and identify and support opportunities for quality improvement.
- **District Health Boards:** DHBs are responsible for colonoscopy delivery, including appropriate results notification and referral to treatment/further investigation as appropriate. DHBs are also responsible for colonoscopy histology, monitoring local quality and equity, local coordination of awareness raising activities and for funding GP services as required (e.g. management of positive results) via the PHOs. Surgical and other cancer treatment, follow-up and ongoing colonoscopy surveillance for high risk polyps will be arranged by the participant's DHB.

- **Screening test:** The primary test for bowel screening will be the Faecal Immunochemical Test (FIT)[4], as used in the bowel screening pilot. If strong evidence emerges to indicate that a more cost-effective and achievable alternative test is available, the programme will re-evaluate the preferred approach and, if required, will amend the programme accordingly.
- **Age range:** The programme eligible age range in 60-74. This is aligned with the age range in other countries with a national bowel screening programme. The age range parameters will be evaluated after the Programme has been fully implemented[5]. The Programme will have an eligible population of over 700,000 men and women nationally, who will be invited for free screening for bowel cancer, over a two-year period (a screening round).
- **Screening pathway:** The screening pathway is based on international best practice and will largely mirror the Bowel Screening Pilot pathway. Eligible participants will be invited to participate every two years. The FIT test kit will accompany each invitation and will require participants to take a small faecal sample at home and return it to the testing laboratory by post.
- **Primary care engagement:** GPs will be responsible for encouraging uptake in participants who have received an invitation but not responded, and for the management of screening results. GPs will be informed of positive and negative results and will inform participants of positive screening results. The GP is then responsible for referring participants with positive screening results to the DHB for further investigation.

Enablers and Implementation

- **Ensuring safety:** The majority of the participants in any screening programme are healthy individuals and exposing the population to the potential of major harm is always a major consideration. Considerable infrastructure and resource will be put in place to ensure that the quality of a national bowel screening programme is monitored and kept as high as possible. Safety of participants is of paramount importance. Psychological as well as physical harm will be minimised, whilst targeting those most at risk.
- **Addressing inequalities:** The proposed National Bowel Screening Programme includes actions to ensure equitable participation in bowel screening, including targeted actions for specific population groups and national monitoring of participation.
- **Workforce:** Health Workforce New Zealand (HWNZ) has undertaken extensive workforce modelling and projections of the gastroenterology, general surgery and pathology workforce and determined that New Zealand will have the workforce capacity to implement the NBSP. HWNZ will work with DHBs and the relevant professional bodies to ensure the gastroenterology workforce continues to increase to meet demand for colonoscopies.
- **Information Technology to support NBSP:** The Programme will be underpinned by a high-quality information system. It will provide a population register for people screened, enable the issuing of invitations for initial screening, recalling of individuals for repeat screening, follow those with identified abnormalities, correlate with morbidity and mortality results, monitor and evaluate the programme and

[4] FIT and iFOBT (immunochemical faecal occult blood test) both describe exactly the same bowel screening test; the two names can be used interchangeably. Previous Ministry of Health documentation referred to iFOBT, however FIT is now being used to align with international documentation.

[5] As detailed in the Programme Business Case, the age range was selected following careful consideration of international findings, results of available cost-effectiveness analyses, the age-profile of colorectal cancer incidence and the colonoscopy resources available to the country. It aligns with the approach used in other OECD countries, as the age range of 60-74 targets those with high bowel cancer incidence and balances this against the number of quality life years that could be saved, with the colonoscopy resources currently available. As additional data becomes available once the NBSP is fully implemented, further evidence-based consideration can be given to the age range. If and when national colonoscopy capacity increases, subject to appropriate evidence, it may be possible to widen the eligible age range and screen a larger proportion of the population.

its impact and will have the capacity to support audit. The National Screening Solution (NSS) which will support the NBSP will be rolled out in 2019.

- **Quality management:** Rigorous quality standards have been developed for the pilot and will form the basis of national standards. In addition, it is expected that the NZ Global Rating Scale tool (a quality monitoring tool) will form the basis of monitoring endoscopy unit standards for the programme and, with information from the electronic reporting system, will allow monitoring of quality standards for the performance of colonoscopy.

1.3 Commissioning and Procurement

The National Bowel Screening Programme is responsible for:

- Procuring the National Coordination Centre;
- Commissioning the laboratory for national FIT testing (including provision of test kits, analysers, lab services);
- Commissioning four Bowel Screening Regional Centres;
- Commissioning the design and integration of the National Bowel Screening IT solution;
- Commissioning National Quality Improvement Programme services.

1.4 Planned Rollout

The National Bowel Screening Programme will commence in 2016 and conclude in 2021 with the go-live in the final DHBs and handover to 'business as usual'.

2 DHB Overview and Investment Context

2.1 Canterbury DHB Overview

Eligible population

Canterbury DHB has an eligible population (60-74 years) of 84,120 projected for the 2018/2019 financial year.[6] Over the following three years (2018-2021) the population is expected to grow by 3.2% - 4.0% per annum.[7]

Māori and Pacific priority populations represent 4.7% and 1.2% respectively, of the total eligible population in Canterbury. The eligible proportion of Māori and Pacific population is expected to grow by 6.2% per year over the next three years.

Canterbury has a relatively high proportion of people in the least deprived section of the population compared to the national average, whilst the most deprived section is under represented.[8]

Canterbury DHB provides health services to the Chatham Island population (of 600 people) and this group is not expected to have a significant impact on the bowel screening programme due to the overall low population but may represent a significant impact financially as travel costs for this population are significant.

Bowel Screening Target Population Projections
December 2018 Series

Ethnicity	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Other	73,670	75,710	77,610	79,120	80,140	81,110	81,990	82,870	83,860	84,840	85,820
Asian	5,560	6,110	6,620	7,110	7,570	8,010	8,380	8,750	9,110	9,430	9,800
Maori	3,920	4,170	4,390	4,660	4,900	5,160	5,400	5,640	5,860	6,110	6,380
Pacific	970	1,030	1,100	1,170	1,220	1,280	1,340	1,420	1,440	1,510	1,560
Total	**84,120**	**87,020**	**89,720**	**92,060**	**93,830**	**95,560**	**97,110**	**98,680**	**100,270**	**101,890**	**103,560**

Age 59	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Other	6,025	6,200	6,440	6,330	6,170	6,055	5,960	6,020	6,070	6,185
Asian	555	585	625	680	680	665	685	710	735	780
Maori	410	430	470	485	485	495	500	515	535	575
Pacific	110	120	115	115	120	135	135	120	125	120
Total	**7,100**	**7,335**	**7,650**	**7,610**	**7,455**	**7,350**	**7,280**	**7,365**	**7,465**	**7,660**

Figure 2 - Population Projections

Māori and Pacific Island peoples are considered to be priority populations for the Programme. In addition, a population with special requirements is the Chatham Island residents. The population on the Chatham's in

[6] As provided by Simon Berry (Senior Information Analyst, Planning and Funding Canterbury DHB) 09 Jan 2019

[7] As provided by Simon Berry (Senior Information Analyst, Planning and Funding Canterbury DHB) 09 January 2019

[8] http://www.health.govt.nz/new-zealand-health-system/my-dhb/canterbury-dhb/population-canterbury-dhb accessed 03 October 2017

the 60-74 age group is 95. The predominant ethnicity of the population is Maori and there has been strong feedback to date on the inequity of the age range eligibility for this population. Practical requirements for the Chatham's residents is the coordination of mailing the screening sample with flights to and from the island so that the sample is tested within seven days of sample collection. Concern has been expressed that opportunities for screening (e.g. on visits to GP, health expos) may be missed because the tracking system requires that an individualised kit is mailed to the person's home.

2.2 Bowel Cancer

Existing colonoscopy and treatment services

Service delivery: Canterbury DHB provides a full tertiary gastroenterology and colorectal service as well as providing inter-district-flow (IDF) services to the West Coast, South Canterbury, Nelson-Marlborough and Southern DHBs (for some secondary and tertiary services). Canterbury DHB provides symptomatic, urgent and Familial Gastrointestinal Bowel Cancer Registry (FGBCR) services as well as treatment for suspected and confirmed bowel cancer.

Services are provided from the: Gastroenterology Unit on Level 2 of the Clinical Support Block, the Intensive Care Unit, radiology or the operating theatres at Christchurch Hospital. Gastroenterologists undertake 75% of the endoscopy procedures for Canterbury DHB with 25% provided by General or Colorectal surgeons. There are no nurse Endoscopists working in Canterbury at the time of writing (February 2019).

A small number of procedures are undertaken on the Mobile Health surgical unit (when located at Waikari and Rangiora), approximately 25-30 procedures a year. Endoscopy services are also provided from Ashburton Hospital (approximately 600 procedures per year) and at out-sourced/outplaced facilities in Christchurch.

The full range of tertiary-level support services such as oncology, radiology, pathology and bowel cancer surgery are available in Canterbury. Multi-Disciplinary Meetings (MDMs) for oncology patients are undertaken. MDMs are led by the oncology service (with a general surgeon as group chair) and patients with a cancer diagnosis are supported by a Cancer Nurse Coordinator.

Diagnostic services are provided for symptomatic patients in line with the national prioritisation guidelines. Surveillance colonoscopy services are provided to the standards required by the New Zealand Guidelines Group and the New Zealand Familial Gastro-Intestinal Cancer Service (NZFGICS). CTC (Computed Tomography Colonography) is available on-site and national access guidelines determine acceptance of referrals to this service. Approximately 500 ERCP (Endoscopic retrograde cholangio-pancreatography) procedures are undertaken by the endoscopy service in the Radiology Unit each year.

Canterbury DHB undertook 8,809 endoscopy procedures in the 2017/2018 financial year within its facilities and outsourced 1,210 procedures.

Waiting times: Canterbury DHB maintained the diagnostic wait time indicators for urgent colonoscopies for the past two years (the 2015/2016 to the 2016/2017 financial years). Currently CDHB is experiencing approximately a 25% increase in referrals for colonoscopy for a number of reasons including patient expectations, increased awareness from other DHB NBSP rollout, increased media. This increase is in advance of any planning we had done to bring on staff for NBSP rollout. For November 2018, CDHB had the following results:

Wait Time Performance for November 2018:

- 55.1% of urgent colonoscopies were performed in 14 days or less.
- 20.1% of non-urgent colonoscopies were performed in 42 days or less.
- 41.1% of surveillance colonoscopies were performed in 84 days or less.

What are we doing to move our targets to green?

Additional capacity within Christchurch Hospital has been created through

- extra Saturday lists – performed most months (when indicated due to high demand) as well as other initiatives (to optimise the utilisation of the endoscopy suite).
- outsourcing contracts: currently one contract for 850 procedures to clear the surveillance waitlist and a second contract for a volume of 360 procedures.
- in January 2019 up to 14 outplaced sessions per week has been put in place
- one fixed term locum for 12 months started in September 2018 and another one started in January 2019
- one permanent SMO started in January 2019

CDHB also rolled out SIPICs on 05 October 2018. SIPICS is a new patient administration system which ultimately will replace up to five legacy systems. While the rollout was successful, several data quality issues have emerged and are being corrected. This will impact our result positively – however in the interim, results that are being published may not be as accurate as they could be.

CDHB has started an Endoscopy Projects Steering Group in December 2018. The group is focussed on several major workstreams including

- Response to increased demand, recovery planning and monitoring to achieve targets
- Development of Senior Nursing Leadership
- Setting and monitoring staff recruitment for NBS rollout
- Supporting the facilities plan for any movement of facilities, decanting or changes required due to new standards or NBSP
- Updates of ProVation systems
- Work with our Bowel Screening Project Manager towards successful rollout as well as achievement of recovery plan prior to BCP go live.

CDHB manages its cancer load well achieving Faster Cancer Times (FCT) consistently (see below) and manages participation in MDMs to a high standard.

Faster Cancer Treatment

62-day indicator achievement (Health Target)

DHB		Adjusted number of records submitted: Patients within the 62-day FCT health target cohort (excluding patients breaching with a delay code of clinical consideration or patient reason), by month of first treatment							Number of records within 62 days							Achievement 6-month quarter	Achievement 3-month quarter
		Jan	Feb	Mar	Apr	May	Jun	Total	Jan	Feb	Mar	Apr	May	Jun	Total	Quarter 4 2017/18 Jan 2018 - Jun 2018 *tracking*	Apr-Jun 2018 *tracking*
Canterbury		36	46	60	54	43	47	288	31	45	58	50	39	45	268	93.1%	93.1%

62-day indicator delay codes and total volumes

DHB	Met 62 day target met	Patient reason	Clinical consider-ation	Capacity	Unknown / invalid delay code	Total (tracking)	Expected total # of records (six months)
Canterbury	268	6	39	17	1	331	368

31-day indicator (policy priority)

DHB	Expected monthly cancer registrations	Number of records submitted: Patients within the 31-day FCT health target cohort, by month of first treatment							Number of records within 31 days							Achievement
		Jan	Feb	Mar	Apr	May	Jun	Total	Jan	Feb	Mar	Apr	May	Jun	Total	Quarter 4 2017/18 Jan 2018 - Jun 2018 *tracking*
Canterbury	246	126	120	154	122	124	116	762	106	101	142	103	112	106	670	87.9%

Investment Alignment with Local and Regional Strategies

The implementation of the NBSP is aligned with national policies and strategies, including the New Zealand Health Strategy 2016, Fast Cancer Treatment Programme, New Zealand Cancer Plan 2015-2018, New Zealand Cancer Information Strategy and the Statement of Intent 2015-19.

Table 1: Alignment of NBSP with key DHB and Regional Strategies

Strategy	Summary of Alignment
	The Canterbury DHB Annual Plan 2018/2019 outlines the vision for an integrated health system that keeps people healthy and well in their own homes & communities. • Long term CDHB outcomes that align with the NBSP include 'a reduction in the rate of avoidable mortality' and the medium term impact of 'people's conditions are diagnosed earlier' with the output of 'early detection and management services'. • Specific NBSP related initiatives are included in 'shorter waits for cancer treatment' and the development of specialist nurses to perform colonoscopies (as part of expanding workforce capabilities). • A clear focus of the Plan is on reducing inequalities and the decrease in amenable mortalities.
	The system Level Measures Improvement Plan 2018-19 has been developed collectively with the Canterbury Clinical Network Alliance partners. **Specifically relevant section of the System Level Measures Improvement Plan** • Continue to decrease the amenable mortality rate
Te Waipounamu South Island Health Services Plan 2018-2021	The South Island Health Services Plan provides a framework for the next four years and outlines the region's priorities for 2016-19. This plan has been developed by the five South Island DHBs in conjunction with the South Island Alliance's Service Level Alliances (and Workstreams). This plan is aligned with the NBSP on many levels and areas of direct support include: **Specifically relevant sections of the cancer section of South Island Health Services Plan** • Support DHBs to deliver the extended Faster Cancer Treatment (FCT) of 'At least 90% of patients receive their first treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks'. • Continue to support the maintenance or improvement of the 31 day Indicator: Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days. • Undertake a focused review to understand the 'Route to Service Access/Diagnosis' for all SI cancer patients, with a focus on first presentation through the emergency department. • Supporting DHBs and Alliance teams work collaboratively in preparation for the introduction of a national bowel screening programme (including supporting DHBs to meet the Colonoscopy Waiting Times indicators). • Implement and rollout the regionally agreed Multi-Disciplinary Team (MDT) recommendations and service improvement initiatives started in 2015-16. • Promote and implement the integration of FCT within the functionality and remit of MDTs. • Review & evaluate the heterogeneity of practice within radiation oncology, and optimal use of radiotherapy across the South Island (subject to available resources).

Strategy	Summary of Alignment
	• Improved understanding and collection of ethnicity data cross the whole health spectrum. • Support the rollout of the Maori Cancer Pathways Project across the South Island. • Develop a plan to support and implement the NZ Cancer health Information Strategy across the SI. • Produce and further develop a Quarterly Cancer Dashboard to understand progress against cancer standards and targets, and to identify areas for service improvement. Other relevant Information Services Service Level Alliance initiatives include: e-referrals; Health Connect South clinical workstation; SI Patient Information Care system; HealthOne; e-prescribing; e-medications; SI Telehealth Strategy in development.

2.3 Main Benefits and Dis-benefits

Approach.

Table 2: Local Benefits of Implementing NBSP

Benefit	Summary
Improved nursing leadership structure and roles.	• A senior nursing re-structure is underway to provide an updated service delivery model for endoscopy services - necessitated by the increased demand for gastrointestinal endoscopy procedures. This demand will be further compounded following the implementation of the NBSP. • The re-structure will adjust the current model of care to facilitate leadership across two or three separate sites as there is currently only one senior nursing position (CNM) with no nurse educators or clinical nurse specialists in the Endoscopy specialty. • A new specialty nursing role will be created to undertake the pre-appointment screening as a requirement of the NBSP.
Increased focus on endoscopy services and quality standards.	• The CDHB Gastroenterology service is working to current industry guidelines and standards for Bowel Screening (as specified by the Endoscopy Governance Group for New Zealand 'EGGNZ'). However, the service is aware that there is scope to improve documentation provided to staff to ensure consistency of service provision. • The need to monitor data indicators that would demonstrate adherence to currently accepted good practice is time consuming (but attempts are being explored by Mid-Central DHB to see what is possible to extract through ProVation). Implementing the NBSP will provide an increased focus on the improvements required to the services' quality management system.
System-wide attention to developing a sustainable endoscopy service.	• Focusing senior DHB leadership on the challenges currently facing the CDHB endoscopy service, such as the need to relocate the unit for earthquake repairs and expand capacity to meet demand. • The recruitment of additional nursing and SMO staff to meet increased demand from the NBSP. • Focusing on inter-district flow (IDF) patient journeys to support a smooth and efficient pathway for patients.
Dis-Benefit	**Summary**
NBSP funding will not cover all costs incurred in the phase 1 and 2 periods of the programme).	• Currently NBSP is providing $290,000 to handle the business case development and the project work required to take the program from now through roll out • Canterbury DHB in previous submittals has noted this would take over $500,000 and the project plan developed with the current deliverables shows we need $579,000 • Canterbury DHB also expended considerable funds in late 2017 preparing for submittal of the business case at that time – the business case was not required as NBSP changed the date of CDHB roll out due to the timing of the National

	Screening Solution. NCSP has agreed to work with CDHB to reduce to recast the agreement to provide later dates for some items to minimise cost; however CDHB will still be required to subsidise this portion of the work
NBSP funding will not cover all costs incurred in the delivery of the programme	• Funding for screening scopes is not at a rate which allows CDHB to meet its costs – NBSP proposed screening scope rate is s9(2)(j) of true cost • Funding for surveillance scopes is not at National Pricing – CDHB costs are slightly higher than national pricing – the DHB will be subsidising the NBSP programme s9(2)(j) for each surveillance scope done or s9(2)(j) of the total cost • The time required to complete the NBSP patient colonoscopies reduces the number of colonoscopies able to be completed per session - from approximately eight per session to five. • NSU notes that as DHBs have gone live they start initially started with 4 screening scopes per list. Some have moved up to 5. There still is a question of whether or not this can be achieved in the short term on the South Island but we understand NSU expects the DHB to work to get to 5 where possible • NBSP is proposing a s9(2)(j) payment to GPs for positive test result consultation – this is constant over the course of the programme – GPs will expect this payment to increase year on year – CDHB will have to subsidise the programme for any increases in costs above the s9(2)(j)
NBSP funding will not cover any costs incurred in the resultant cancer load increase to CDHB for its own population and or any South Island-referred populations to be done in Canterbury (such as surgery to address diagnosed bowel cancer).	• The need to undertake additional bowel cancer surgery will result in reallocation of existing resources – and this will negatively impact on delivery of other elective surgical volumes. • Most of these surgeries will also require chemotherapy and/or radiotherapy – all of which is provided by CDHB as a tertiary provider. These areas are currently under pressure. • Many of these surgical procedures will require resultant staged procedures (such as stoma closure) which will again result in reallocation of existing resources and will negatively impact on the delivery of other elective surgical volumes • Given the lateness of delivery of the new ASB building, theatres and procedure rooms by the MOH, CDHB will have to utilise outsourced or outplaced arrangements to handle this work for its own population as well as tertiary load
NBSP colonoscopies will commence during a time of generalised increase in demand for endoscopy services, with insufficient capacity to meet current demand – NBSP insistence on current scope target achievement prior to NBSP roll out places undue stress on staff working in the area as well as unplanned cost on the DHBs.	• The same resource required to meet current demand is also required to meet NBSP demand. • Increased awareness of the Bowel Cancer from the roll out of the BSP in other areas as well as increased media coverage of those not part of the target population for NBSP is providing an increased demand for colonoscopy service. • Despite planning for the increase in demand for colonoscopies from the NBSP, the cost of increasing colonoscopy volumes will impact on the service as it absorbs the increase in scope volumes ahead of BSP roll out. • Likely reduction in focus on gastroscopy service in the short term which will result in an increased gastroscopy wait list. • Canterbury DHB has the largest endoscopy training programme in NZ and this will be impacted (temporarily) by the increase in demand by re-directing FTE to the NBSP. • The increased volume of work within a fixed footprint (with no capacity for facility expansion) will require the CDHB to move to a two-site model within Christchurch city (three sites if Ashburton is included). This increases the complexity of managing the service and will result in reduced productivity (compared with a single site approach). • The added volumes require a workforce build and therefore will not be achieved at marginal cost, the cost of carrying them out exceeds the funding being offered by the MoH, diverting expenditure from other functions.
NBSP funding will not cover the cost of increased, expensive travel for eligible population of the Chatham Islands	• The predominant population on the Chatham's fits the equity model but treating more patients from the Chatham's means the DHB rather than the NBSP incurs more unfunded cost of travel.

2.4 Key Risks

Table 3: Key Risks

Key Risks	Likelihood	Impact	Summary and Risk Management Strategies
There is no clarity of timing for CDHB on when facilities decisions will be made which is making the planning of managing services over multiple sites difficult	5	5	• The timing of the move of the Endoscopy Unit (for earthquake repairs) is not yet known, it is dependent on decisions made by the Facilities Committee which depends in turn on decisions made by the MoH's HRPG (Hospital Redevelopment Partnership Group) regarding future capital developments. Clarification will be provided as soon as these constraints are known. Planning for the move will commence when the destination and configuration of the interim facilities is known.
Government funding allocation is not sufficient for CDHB to start the BSP	5	5	• CDHB originally outlined its cost in the Bowel Screening assessment in June 2013 for MOH budget bid. • That assessment itemised that CDHB would need approximately s9(2)(j) [redacted] s9(2)(j) [redacted] for project costs – currently we have identified a need for s9(2)(j) [redacted] plus we have expended approximately s9(2)(j) [redacted] in previous years before the go-live was changed. • That assessment itemised that first year costs would be about s9(2)(j) [redacted] for CDHB – current calculations indicate our first year costs are s9(2)(j) [redacted] with funding provided by BSP of s9(2)(j) [redacted] • Any decision not to proceed would see 338 people over 5 years not being diagnosed with cancer in a timely manner and /or causing increased high cost treatment options to be utilised by delayed diagnosis
If there is a delay in recruiting Gastroenterologists or training Nurse Endoscopists then this will impact on the ability of the service to expand capacity	4	5	• Workforce planning has commenced and in some workforce groups, suitable applicants have been identified. The additional FTE required to deliver on the NBSP scoping volumes is being identified.

2.5 Key Constraints and Dependencies

The proposal is subject to constraints (limitations imposed on the investment proposal from the outset, e.g. timing, resources) and dependencies (external influences e.g. actions or developments outside the control of the team implementing bowel screening upon which success of NBSP is dependent).

Table 4: Key Constraints and Dependencies

Constraints	Notes
Interventional colonoscopy, radiology, pathology, surgical and oncology capacity (and cost) for bowel cancer procedures (especially in the first two years).	• Canterbury DHB interventional colonoscopy, general surgery, pathology, radiology and oncology services capacity is limited to absorb the short-term increase in bowel surgery/cancer treatment as a result of the NBSP as evidenced by the local increase in demand due to increased bowel cancer awareness. • As Canterbury is a regional tertiary centre, this temporary 'hump' in demand will be more acutely felt as it will be providing surgery/oncology treatment for patients identified through other districts' bowel screening programmes. The current plan is to increase staff resources to meet the growing base demand and outsource procedures to meet the temporary 'hump'. • Additional surgical procedures, pathology and oncology treatment will need to be funded from within the existing budget which means a reallocation of current surgical time and resources.
Workforce	• Additional staff (RNs, endoscopists, nurse endoscopists, administration support, pathologists and lab technicians) will need to be recruited to support the patient volumes generated by the NBSP. • The current plan is to recruit staff to the increased baseline demand rather than the 'hump' created in the early years of the programme. The hump will be resourced through outsourcing/outplacing. • As well as outsourcing to meet the hump, outsourcing will be likely required to cope with any recruitment gap - on these bases the capacity of outsource providers becomes a constraint, alongside Canterbury DHB's staff capacity.
Dependencies	**Notes**
Alternative facilities are available to provide uninterrupted Endoscopy services.	• Facility earthquake repairs necessitating the need to move are required to be covered by alternative facilities to provide uninterrupted endoscopy services. • The timing of the move of the Endoscopy Unit is not yet known, it is dependent on decisions made by the Facilities Committee which depends in turn on decisions made about future capital developments (as outlined in section 2.3 above).
Rollout of the NBSP program is dependent on the NSS solution being in place	• This is outside of CDHB control and is being managed by the NSU • If the NSS is delayed, it will affect the go-live date for CDHB
IT platform is workable and data extractable	• The endoscopy reporting tool should be user friendly at the point of data input and extraction. • Individual DHBs do not have power to influence development of the ProVation software. • The data should be extractable from ProVation such that the data can be housed, compiled and interrogated without dependence on ProVation or any other single software package.

2.6 Stakeholder Engagement

Key Stakeholders

Table 5: Canterbury DHB Key (Local) Stakeholders

Stakeholder	Impact	Influence
SI Alliance Leadership Team (link to the NBSP National Coordination Centre) and includes Southern Region NBSP Centre	*Low* (for the SI Alliance as is does not need to change business activities as a result of the NBSP). *High* for the Southern Region NBSP Centre as they have been formed to lead and coordinate the southern DHBs in the implementation of the programme.	*High* in support of the greater South Island regional approach.
CDHB Board, CEO and Executive Management Team (EMT)	*Low*	*High* in terms of allocating resources to support the programme.
CDHB Information Services Group (ISG)	*High* as the CDHB ISG will need to support: • ProVation (or another IT solution as required by the screening programme). • The platform on which ProVation is provided – and this support may need to be South Island wide. • Staff working at three sites who will require IT assistance and possibly an interface with another patient management system.	*High* as the IT solution (yet to be determined) is integral to managing the screening programme. (Note that ProVation is the endoscopy IT platform for all of the South Island and the lower North Island DHBs).
CDHB Decision Support (DS)	*Medium* as DS will be required to provide information/analyst support for a new programme that is not currently resourced.	*Medium* as DS have expertise in data analysis and will be able to assist in providing information on the impact of the programme.
Southern Cancer Network (SCN), including Te Herenga Hauora (Māori Leadership Group), Consumer Group	*Low*	*High* as the SCN will be able to actively support the programme both in terms of network activity and personnel.
Canterbury PHOs	*Medium* as the PHOs member practices will be responsible for supporting the screening programme and referring patients with positive FOB test results. *Medium* as medical practices on the border of CDHB will be responsible for supporting the screening programme for patients who live in bordering DHBs that have gone live	*High* as the PHO member can have a significant influence on patient uptake of the screening programme. *High* as this increases the workload of medical practices in the CDHB area
CDHB Endoscopists, General & Colorectal Surgeons	*High* as the SMOs performing the additional endoscopy volumes they will need to adjust work practices to support an increase in capacity for the CDHB.	*High* as scoping SMOs are critical to the success of the NBSP in Canterbury.
Māori Key Stakeholders • CDHB General Manager Māori • Manawhenua Ki Waitaha.	*Low*	*High* to ensure the bowel screening programme is delivered in a

Stakeholder	Impact	Influence
• Māori and Pacifica Provider Collective (Maui Collective). • Te Kahui o Papaki ka Tai (CCN Māori reference group). • Chatham Islands representatives		culturally acceptable manner and supports equitable outcomes.
CDHB Gastroenterology Nursing team	*High* as the RNs will need to adjust work practices to support an increase in capacity for the CDHB.	*High* the RNs are critical to the efficient running of the endoscopy service and the success of the NBSP in Canterbury.
CDHB Pathology and Laboratory services	*High* as pathology services will experience an increase in demand for services and will need to adjust FTE and work practices accordingly.	*High* as timely pathology results are central to the delivery of the NBSP.
CDHB Pathology Laboratory Information Services (LIS)	*High* as LIS staff will be required to resource and support the electronic interface pipeline for results, ensure it is functional and includes all the required fields of the NBSP for electronic messaging of pathology results onto the new bowel screening national register.	*High as LIS* staff provide the key interface between laboratory patients, NBSP and the CDHB and therefore have high influence on the success of the programme.
CDHB Gastroenterology Administration	*High* as the admin team will be required to answer more queries relating to the NBSP and facilitate the additional 1200 appointments per annum.	*High as* Admin staff provide the key interface between patients, NBSP and the CDHB and therefore have high influence on the success of the programme.
Eligible participants	*Medium* as patients are likely to experience anxiety associated with the screening process and especially for patients that are required to undergo a colonoscopy.	*Low*
General public	*Low*	*Low*
CDHB Staff	*Low*	*Low*
General Surgery	*High* as General Surgery will experience increased demand for bowel surgery, which is likely to include inter-district flow patients needing complex surgery.	*Medium* as patients requiring surgery for bowel cancer require this to be undertaken within the FCT timeframes and this demand will be in addition to the current general surgery surgical demands.
Oncology	*High* as oncology will experience increased demand for their services which are likely to extend to inter-district flow demands beyond the Cancers diagnosed for Canterbury-domiciled patients.	*Medium* as patients requiring oncology services will need these provided within FCT timeframes. .
Radiology	*High* as radiology services are likely to experience increased demand for services (Colonography), as	*Medium* as patients requiring a CT Colonography will need to receive timely and quality imaging and

Stakeholder	Impact	Influence
	approximately 20% of patients referred for colonoscopy receive CT Colonography instead – the highest CT Colonography rate in NZ.	reporting from Radiology to support timely diagnosis.

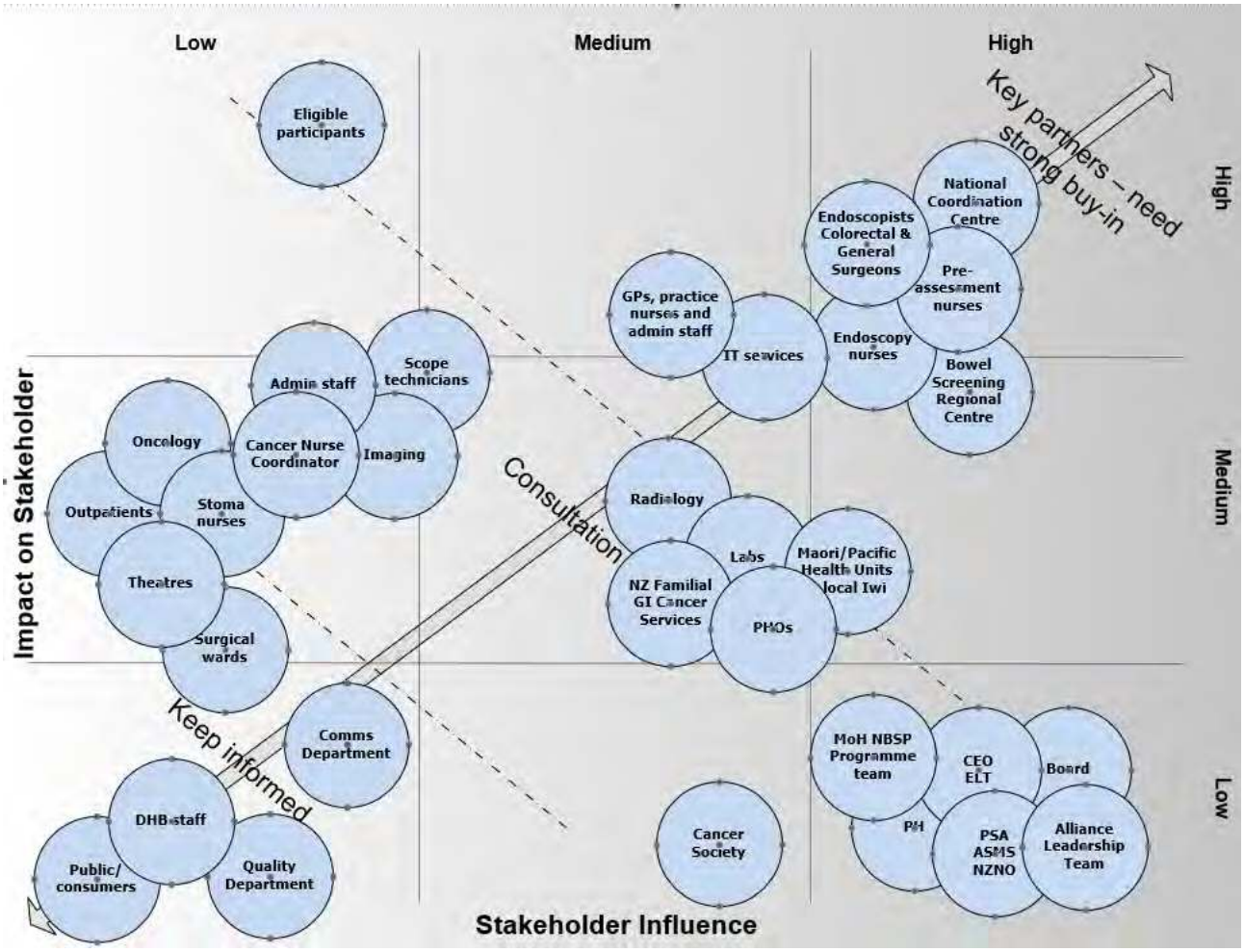


Figure 3: Key Stakeholders

Stakeholder Communication and Engagement Approach

In preparing this business case and undertaking initial planning for the implementation, meetings and workshops have been held with key stakeholders

Table 6: Key Stakeholder Communication and Engagement Activities to Date

To be updated during the Phase II process.

Event	Purpose	Period/Date
Exploratory discussions and early planning for implementation.	Exploratory discussions have been held with the: • Gastroenterology Leadership Team (Clinical Director, Charge Nurse Manager and Service Manager) • Surgical Service Level Alliance (SLA) Director • Director of Nursing • Surgical Clinical Director • Planning and Funding (Secondary Care) representatives • Endoscopy Users Group • Department of Surgery at the University of Otago. The 'Bowel Screening and Facility Requirements document will be submitted for endorsement to the CDHB Realign Alliance Leadership Team (RALT) in early 2019. RALT has three members who are from the Executive Leadership Team. The Director of Nursing has presented the 'Bowel Screening and Facility Requirements' document at EMT.	January 2017 – October 2017
Improving South Island Colonoscopy Waiting Times and Bowel Screening Rollout – Clinical Leads Group Meeting	Monthly meeting to link all South Island DHBs with the implementation of the NBSP and Southern DHB Regional Centre coordinated by SIAPO (South Island Alliance Programme Office). The meetings focus include the Southern Cancer Network, as well as with primary care as the Gastroenterology General Practice Liaison 'GP Liaison' is part of this group.	Meets monthly
Communication with General Practice in Canterbury	• A letter has been sent by the CDHB Endoscopy User Group explaining how the NBSP will work and the requirement of GPs to refer patients with a positive test result for colonoscopy and the changes to the National Referral Guidelines (for bowel concerns). • A meeting of Canterbury GPs, Maori and Pacific health leaders, primary and Canterbury Initiative was held in September as a first step to discuss equity issues.	August 2017 September 2018
Consultation with Maori	• Te Waipounamu Māori Leadership for Cancer have provided guidance on the implementation of this programme to ensure equity for Māori and will continue to be involved as the Programme is planned and implemented. • Ngaire Button (Portfolio Manager Māori and Pacific – Planning & Funding) has provided feedback on early planning for the programme and will lead consultation with Maori (and assist in the development of the communications plan as part of Phase 2 of the NBSP programme). • Other groups/key stakeholders that will be consulted as planning for implementation progresses include: Mana Whenua ki Waitaha Māori and Pacifica Provider Collective (Maui Collective). Te Kahui o Papaki ka Tai (The CCN Māori reference group). Chatham Island representatives.	Ongoing
Consultation with Gastroenterology nursing team	The Gastroenterology Charge Nurse Manager has undertaken consultation with the nursing team on a regular basis. This includes RNs, HCAs, ENs and administration staff.	Ongoing

Event	Purpose	Period/Date
Consultation with CDHB Endoscopists/SMOs	• The NBSP is viewed as a major benefit to the New Zealand population and as a group, Endoscopists view this as an important service. • The New Zealand Society of Gastroenterologists (NZSG) Annual Society Meeting sessions have been dedicated to the NBSP since at least 2006. • Local discussions within the Departments of Gastroenterology and Surgery have been ongoing over the period of NBSP development and have been informed by knowledge of international data and data from the NBSP pilot. • This data has been presented both nationally and locally. • CDHB is a satellite unit of the New Zealand Familial Gastrointestinal Cancer Registry, which provides national screening and surveillance oversight to patients with familial polyposis syndromes. • CDHB has a representative on the National Bowel Cancer Working Group. • In summary, CDHB Endoscopists have long supported the development of the NBSP, are well informed as to the potential benefits and risks of the programme, and are enthusiastic about their involvement in it.	Ongoing
Consultation with Pathology (and Laboratory services)	• Canterbury Health Laboratories (CHL) were involved in the roadshow meetings organised by MoH and attended the initial NBSP planning meetings organised by P&F. • The Project Manager for Phase 1 has consulted with CHL (Pathology Service Manager) to ensure NBSP implications are well understood.	Ongoing
Consultation with Surgical Services	• Local discussions within the Department of Surgery have been ongoing over the period of NBSP development and have been informed by knowledge of international data and data from the NBSP pilot. • Consultation with surgical services has also occurred through the Endoscopy Users Group (which has surgical representation).	Ongoing
Consultation with Oncology	Consultation with Oncology has occurred through initial feedback request from MoH which was coordinated by the Planning and Funding Service Development Manager for Secondary Care.	April 2017
Consultation with Radiology	Radiology were involved in the roadshow meetings organised by the MoH and attended the initial NBSP planning meetings organised by P&F.	April 2017

Stakeholder Support

There is strong support from Canterbury DHB clinicians and other stakeholders as identified in Table 6 and evidenced by expressions of support and good attendances at meetings. However, all acknowledge the challenges in meeting the requirements of the programme particularly in relation to facilities and workforce resources.

A letter of support from the Chief Executive outlining Canterbury DHB's support for the programme will be included in the final Information document by 28 February 2019.

3 Local Implementation of NBSP

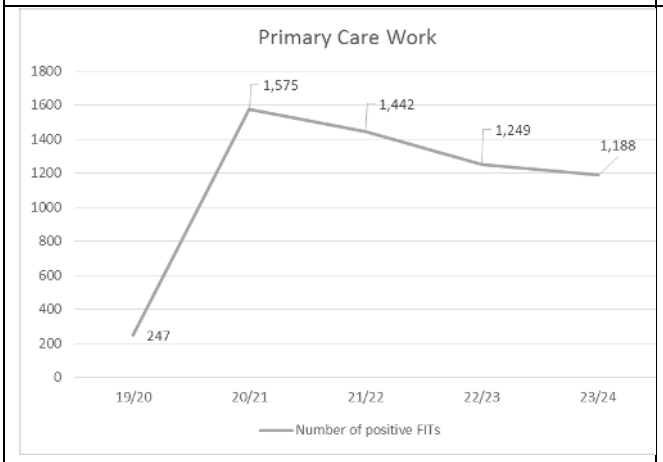
3.1 Projected Demand

The projected demand for the Canterbury DHB roll out provided by the Ministry of Health in December 2018 is detailed below:

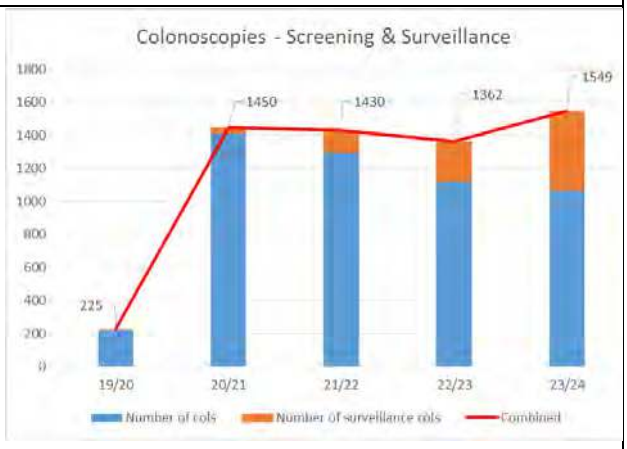
Figure 4 - MOH Projected Demand

Start Date	May-20				
Canterbury DHB	19/20	20/21	21/22	22/23	23'24
Eligible Population age range	60-74	60-74	60-74	60-74	60-74
Eligible Population	99,073	105,232	100,347	109,772	104,396
Number of invites per annum	8,256	52,616	50,174	54,886	52,198
Number of positive FITs	247	1,575	1,442	1,249	1,188
Number of cols	221	1,411	1,292	1,119	1,064
Number of cancers	17	107	93	62	59
Number of surveillance cols	4	39	138	243	485
Number of Months	2	12	12	12	12
Total Cols (positive FIT + surveillance)	225	1,450	1,429	1,363	1,549
Histology %	70%	70%	70%	70%	70%
CTC %	4%	4%	4%	4%	4%
Colonoscopy Price (incl histology and CTC as required)	s9(2)(j)				
Surveillance Colonoscopy Contribution					

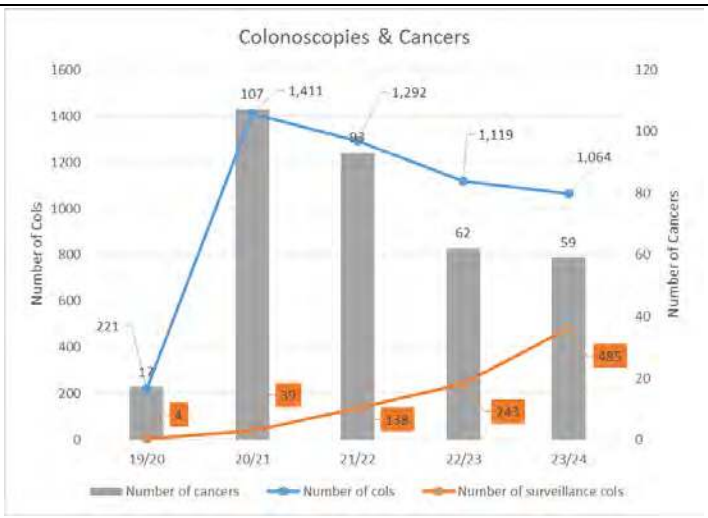
Primary Care Work Load



Endoscopy Work Load



Surgery Work Load



3.2 Options Evaluation Criteria

- **Strategic fit and business needs:** How well the option meets the NBSP objectives, related business needs and service requirements, and integrates with other strategies, programmes and projects.
- **Potential Value for Money:** How well the option optimises value for money (i.e. to deliver the optimal mix of potential benefits, costs and risks).
- **Supplier capacity and capability within timeframe:** How well the option matches the ability of potential suppliers to deliver the required services, and likelihood of a sustainable arrangement that optimises value for money.
- **Potential affordability:** Likelihood that the option can be afforded within likely available funding, taking into account other funding constraints.
- **Potential achievability:** Likelihood that the option would be successfully delivered, given the organisation's ability to respond to the changes required, and the level of available skills required for successful delivery.

3.3 Service Delivery Options

- **Demand Management – how symptomatic demand will be managed alongside screening demand**

Alongside the implementation of the NBSP, the DHB will continue to manage symptomatic demand. Greater publicity around bowel screening has increased early symptomatic self-referrals. The modelling for the Programme predicts a 20 percent increase in demand for symptomatic colonoscopies (as seen in the Bowel Screening Pilot and internationally).

Over time, symptomatic demand should reduce as more people will be identified through the screening programme. However, in the early years, the additional demand arising from the screening programme will need to be balanced with ensuring appropriate and timely access to diagnostics and treatment for symptomatic people. The impact of a national screening programme on the colonoscopy and histopathology workforces also needs to be managed, to retain equity between symptomatic and screening services.

The Ministry is responsible for ensuring that bowel screening quality standards and screening and symptomatic monitoring indicators are met. This includes ensuring that the needs of both screening participants and symptomatic patients are balanced.

The following Table 8 outlines the options to address increased demand for symptomatic and screening colonoscopy services in Canterbury, with consideration for the Options Evaluation Criteria. This table outlines four options considered with option two representing the most feasible and cost effective option (at least in the short to medium-term). Table 8 also includes consideration for facility and staffing requirements as outlined in the following sections.

Competing demands for screening and symptomatic colonoscopies (as well as other symptomatic endoscopy work) will be managed through additional capacity created by outplacing non-NBSP work to an external facility (supported by clearly articulated and consistently applied triage and prioritisation criteria). These criteria are shared with primary care referrers and secondary/tertiary care colleagues through HealthPathways. The external (to the Christchurch Hospital campus) facility could undertake lower-acuity procedures that can be safely managed away from the tertiary hospital setting. This is likely to include routine screening patients and not NBSP patients as the colonoscopies resulting from the screening programme are likely to be more complex.

Canterbury provides considerable assistance to the West Coast DHB for the provision of endoscopy and gastroenterology services and the West Coast is likely to rely heavily on Canterbury for the implementation

of their NBSP. This need for support will be compounded by the expected retirement of two of the current West Coast based Endoscopists in 2018.

Patient wait times for Endoscopy are currently managed by the service and overseen by the Service Manager, Clinical Director and Charge Nurse Manager. The additional facility and staffing capacity outlined in the preferred option (in Table 7) will ensure that procedures are undertaken in a timely manner for both symptomatic and screening patients. Option 2 (outplacing contract) will assist with meeting the initial increase in patient demand for colonoscopy as a result of the NBSP and will also provide on-going sustainable capacity in the medium-term. Longer term options, such as an increase in the number of procedure rooms and the footprint of the Endoscopy unit at Christchurch Hospital (option one), or the building of a dedicated second unit, can then be considered as part of the future facilities development to address increasing demand.

Table 7: Demand Management

Option	Strategic fit and business needs	Potential value for money	Supplier capacity and capability within timeframe	Potential affordability	Potential achievability
1. Increase the footprint of the current unit to include two additional procedure rooms and support areas (e.g. recovery, patient waiting room).	Ideal option to maintain efficiency and efficacy of service.	Would allow the CDHB to have control over costs as no outsourcing or outplacing contracts would be required. However capital investment is required in larger facility.	Builds Canterbury DHB Gastroenterology capacity and capability with a contingency for increased future demand. Could incorporate facilities to undertake ERCP work in the Gastroenterology unit (rather than staff having to leave to work in Radiology as occurs currently). This would reduce the number of locations in Christchurch hospital that the Gastro team work (from four to three, i.e. ICU, operating theatres and the Endoscopy Unit).	Would require capital investment and re-organisation of current hospital redevelopment plans (which has not allocated a larger footprint to Gastroenterology).	Unlikely to be achieved in the short term.
2. Single service provided from two (CHCH city) sites utilising an outplaced facility contract. (Three sites in total for the CDHB if Ashburton is included) **Preferred option**	A feasible working arrangement in which the department believe safety and productivity can be maintained over two sites, whilst also building capability.	Potentially good value for money as no capital outlay required and lease payment for the facility only (as CDHB staff would be provided to undertake the endoscopy procedures). This however means the marginal cost for these procedures is higher as CDHB has to pay for private vendor's fixed and overheads. Additional staff would be required to support two	There is current underutilised endoscopy capacity in Christchurch. Outplaced arrangement would build workforce capability as opposed to outsourced contractual arrangements. Currently the use of outplacing as a solution is scalable and will be a medium term solution but is dependent on the delivery of the new Hagley Facility to repatriate dental services from the local endoscopy provider to Hagley.	Two procedure rooms would need to be leased from a private facility, which are fully utilised by the CDHB. Likely to also require outsourcing in the short-term to address the NBSP 'hump' in demand and before the CDHB can recruit additional staff.	Could commence as soon as staff are available and contractual arrangements agreed between parties. Outplaced patients would be the lower-acuity patients and not likely to be part of the NBSP.

Option	Strategic fit and business needs	Potential value for money	Supplier capacity and capability within timeframe	Potential affordability	Potential achievability
		additional procedure rooms.			
3. Single service provided from one site with increasing volumes of outsourced endoscopies (current model).	Allows for business as usual to continue but does not grow capacity or capability for the CDHB.	Fee for service model. No capital outlay required.	Outsourcing does not build capability or capacity of the CDHB workforce to address future needs. May result in loss of skilled CDHB staff to private as the demand for private services increase.	Pricing may be difficult to control as dependence on outsourcing increases.	Current model.
4. Single service provided from one site with expanded hours of operation.	Good fit for NBSP and provision of an efficient gastroenterology service. Most services would be able to be provided from one site.	Would require considerable after hours work likely at higher rates due to frequent evening and weekend work.	Insufficient staff and facility capacity for this to be feasible in current working arrangements. Could only be achieved with expanded hours of operation and revised staff contracts (to amend current working conditions). Without additional endoscopy facility, space constraints would be limiting in the medium-term. High degree of collegiality and clinical back up would be maintained.	Costs would increase, as service would be running later in the evening and more on weekends.	Unlikely to be achieved as current workforce at capacity. May be an option if space is going to come available on CHCH campus in the near future, and current working conditions/contracts can be revised.

Facility Requirements – where the additional activity arising from the implementation of the NBSP will be undertaken

Endoscopy

The current model of care and CDHB Endoscopy facility at Christchurch Hospital are insufficient to meet existing demand for endoscopy services. Strategies in place to increase the 'in house' capacity are (reference back to Section 2.2):

- outsourcing 360 procedures p.a. to private providers in Christchurch
- additional 850 outsourced to clear the previous surveillance wait list
- outplacing 84 sessions (that will cover colonoscopies and gastroscopies)

The demands created by the additional colonoscopies required to be undertaken for the NBSP are going to place additional pressure on a service already operating at capacity.

As outlined in Table 7 the service has been able to identify four options to address this increase in demand and the facility considerations are also evaluated in this table. In addition to planning for increased demand from the NBSP, the unit is required to move for Earthquake repairs (to be undertaken to the building (after the Acute Services Building is open). The timing of the move of the Endoscopy Unit is not yet known, and it is dependent on decisions made by the Facilities Committee which depends in turn on decisions made by the MoH's HRPG (Hospital Redevelopment Partnership Group) regarding future capital developments. Clarification will be provided as soon as these constraints are known, but this is an additional pressure which

will impact on Canterbury's delivery of the NBSP. Planning for the move will commence when the destination and configuration of the interim facilities is known.

Surgery

The additional surgery volume imposed by NBSP will be covered by our general surgery department. The department has incorporated its staffing requirements for NBSP into the growth plan for the new facility and is on target to have staff on board once the new facility opens in late 2019. The additional surgery load will have to be accommodated within any new elective uplift funding received for 2019 and future years.

Radiology

The additional volume on radiology for both any CTC and surgery has been planned for in the new facility staff growth. New equipment is in place now in Burwood and plans for new equipment in the CHCH campus are advanced. Currently we have expanded our reporting capability by utilising offshore vendors. Recruitment for internal staff continues.

Laboratory

The additional volume on laboratory for both any endoscopy and surgery has been planned for in the new facility staff growth. Staff recruitment is underway.

Medical Oncology

In previous submissions, CDHB has estimated a 14-25% increase in medical oncology impact as a result of NBSP with the largest group in Stage 1 cancers. While we do not see an issue with work force at this point, the pharmaceutical cost impact of this increase to the DHB is not known.

Radiation Oncology

In previous submissions, CDHB has estimated an increase of about 2% in overall RT demand from both CDHB as well as regional load. CDHB will be in the process of renewing three LINAC machines starting in 2020 and plans further LINAC capacity to come on line within 5 years. In the interim, we will use both local capacity at St Georges Cancer Centre and Southern DHB to meet the demand.

Workforce Requirements – how the workforce will be configured to enable the NBSP to be implemented and successfully maintained

Health Workforce New Zealand modelling and projections of the gastroenterology, general surgery and pathology workforce has determined that New Zealand, overall, will have the workforce capacity to implement the NBSP.

Table 7 outlined four options for the delivery of additional NBSP and this considers the impact on the endoscopy workforce. Canterbury DHB is aware that the current endoscopy facility and staffing are at the point of being insufficient for demand. Regular and periodic outsourcing is required in order to manage demand within reasonable wait times. The addition of the NBSP colonoscopy volumes increases demand to an extent that considerably more facility and staff capacity is required. Recruitment strategies for additional staff are underway and will be deliberately focused to encourage ethnicity and gender diversity.

Despite the immediate requirement to access additional facility space from an external provider, the service would like to continue to build staff capability through outplacing arrangements. This will ensure a sustainable workforce and distribution of the burden of acute rosters, as well as direct control over the quality of service delivery. The outplaced facility (resourced by Canterbury DHB-employed staff) would undertake lower acuity patient work, which is not likely to include NBSP patients. Whilst outplacing is the

preferred method to address increases in demand, the DHB is aware that it will continue to need to outsource procedures to cover any recruitment delays/shortfall and as an interim measure until the outplacing facility and staff are ready to deliver services.

3.4 Implementation

IT Capability

CDHB has the IT capability to ensure successful rollout of the NBSP. CDHB will allocate resource as necessary to ensure this occurs as well as to integrate the new NSS solution.

Engagement with the National Coordination Centre

Canterbury DHB will engage with the NCC through the NBSP Project Manager. Programme reporting, in the initial stages of programme implementation, will be undertaken by the Project Manager with transfer to appropriate staff in either Gastroenterology or Decision Support in due course, as the programme reverts to business as usual and the IT solution is identified and understood.

Engagement with Bowel Screening Regional Centre

Canterbury DHB has already commenced engagement with the Southern Bowel Screening Regional Centre, South Island DHBs and is meeting via Teleconference every two months, coordinated by the SIAPO Electives Programme Manager. Minutes are recorded of these meetings and distributed electronically by the SIAPO Electives Programme Manager.

Engagement with Primary Health Organisations (PHOs) and Primary Care

Nationally, the NBSP implementation requires close engagement with PHOs and Primary Care. DHBs will be responsible for funding GP services as required (e.g. management of positive results) via the PHOs.

The Canterbury DHB General Practice Liaison for Gastroenterology has been included in the project team and is leading communication to Primary Care in relation to the NBSP.

All GPs in Canterbury DHB are members of one of three PHOs. Canterbury DHB and the three Canterbury PHOs are alliance partners in the Canterbury Clinical Network, which provides leadership for the Canterbury health system. Local arrangements for engagement with PHOs and Primary Care include:

- Meetings with PHO management and representatives.
- Clinical and referral information in Canterbury is communicated via the HealthPathways and HealthInfo websites. Information on the NBSP will be made available on HealthPathways (for clinicians) and HealthInfo (for patients). Two colorectal pathways are in the process of being updated to ensure that referrals for symptomatic patients are aligned with national guidelines. Following completion of these revised referral guidelines, subscriber updates will be provided direct to GPs via. Email.
- Meetings with General Practitioners – individual and group training occurs via Continuing Medical Education (CME) programmes, Practice Visits by the Canterbury Initiative teams, PHO education sessions and direct mail from the Department of Gastroenterology at Christchurch Hospital. The PHO educators are aware that the NBSP is commencing in 2019 and are planning education relating to the programme in 2019.
- Feedback from General Practice has indicated concern that the level of funding for consultations relating to the NBSP many not be sufficient to adequately support this additional activity.

Engagement with the Laboratory

Engagement has commenced with the Canterbury Health Laboratories (CHL) Anatomical Pathology Service Manager, to ensure planning is underway for NBSP-related endoscopy (biopsy) and colorectal surgery pathology. The implications of this increase in workload are being planned by CHL and the estimated increase in Pathologist and Medical Laboratory Scientist FTE has been calculated at 0.2 and 0.6 FTE respectively. The implications of West Coast DHB commencing the NBSP following Canterbury is not expected to have a significant impact on CHL as the volume of work is low.

Quality

Canterbury DHB will ensure the NBSP is implemented in accordance with the NBSP National Quality Standards (which the service is already working to) and by working closely with the Southern Regional NBSP Centre and the EGGNZ (Endoscopy Governance Group for New Zealand). Endoscopies undertaken as part of the NBSP will be subject to the same clinical review process as the rest of the Endoscopy service.

Canterbury is part of the National Endoscopy Quality Improvement Programme (NEQIP) and participates in the Global Rating Scale census to measure quality improvement.

Driving Equity

Canterbury DHB will address inequities through analysis of NBSP uptake by ethnicity, domicile and any specific high needs populations identified during the course of planning for implementation or steering group recommendations. The high needs populations considered likely include eligible Maori, including Chatham Island residents, and Pacific populations and areas of high deprivation.

Management of Conflict of Interest

Canterbury DHB will manage any conflicts of interests as they arise. As at the time of planning for Phase 1 (October 2018) the only potential conflicts of interests identified are that some SMOs currently employed by Canterbury DHB are also working in private endoscopy units (as both specialists and shareholders) and may have a vested interest in their facility undertaking the outsourced work. The tendering process will be managed by Planning and Funding to ensure Government Rules of Sourcing are followed.

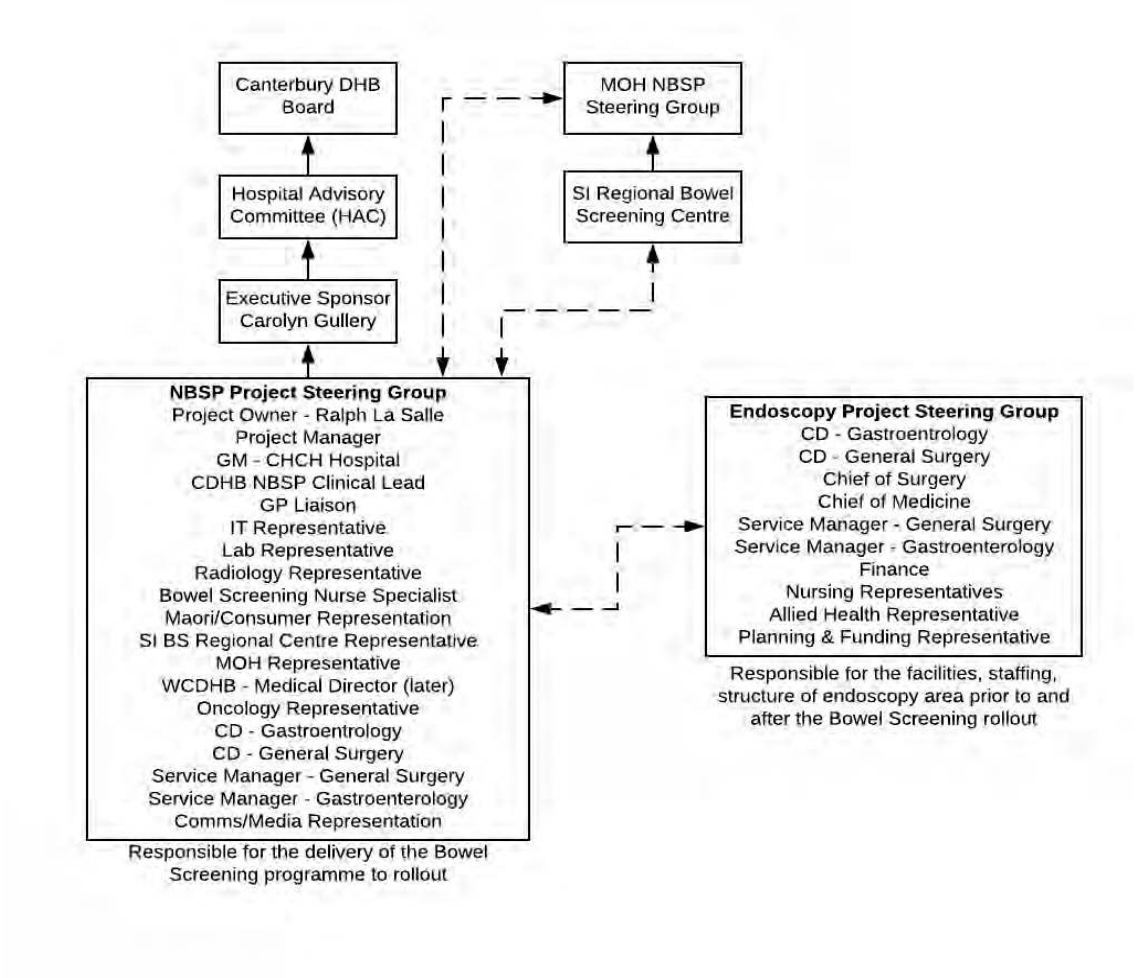
5 Management Approach

5.1 Governance

The governance arrangements for the implementation of the NBSP in Canterbury DHB are outlined in Figure 3 below. Overall accountability for the programme sits with the NBSP Project Steering Group who report to the Canterbury DHB Board through the Executive Sponsor and the Hospital Advisory Committee (HAC). HAC is made up of representatives from the Board.

West Coast DHB will be included in the governance structure when planning commences for implementation of the NBSP on the West Coast (with the inclusion of a nominated WCDHB Medical Director).

Figure 11 - Governance & Project Structure



5.2 Project Management

Approach

The project management approach for the implementation of the NBSP in Canterbury is focussed on gastroenterology, oncology and surgical team consultation, structured planning, effective governance and project management facilitation. The Project Manager will work closely with the Endoscopy Project Steering Group, the NBSP Project Steering Group and other key stakeholders to ensure that a thorough planning

process is undertaken prior to implementation. Evidence of this consultation and approach is outlined in Table 6. The project will be overseen by the Project Owner (Team Leader Secondary Care - Planning and Funding).

The Endoscopy Project Implementation at Canterbury DHB will sits as part of a wider project management structure (as it has its own governance group), however it is being rolled out at the same time as the move to the new Acute Services Building at the Christchurch Hospital campus and the implementation of PICS (new Patient Information Care System) and will maintain close contact with those programmes of work.

Project Structure and Staffing

The implementation of the NBSP in Canterbury will be coordinated by the Project Manager. The Project Manager will work closely with the NBSP Project Steering Group, the Endoscopy Leadership Team (Clinical Director, Service Manager and Clinical Nurse Manager) and surgical/oncology teams as well as other services (such as Radiology and Pathology), the IT representative, the Bowel Screening RN/s as well as the Canterbury Clinical Network Primary Care Liaison team. The Project Manager is accountable to the Project Owner. The Project Manager role has not yet commenced. Depending on project resourcing, this role may be undertaken by an external project manager or a delegated Planning and Funding portfolio/programme manager. The key roles and responsibilities are outlined in Table 6.

The NBSP Project Steering Group structure is itemised in Figure 3 above.

Table 6: Key Roles and Responsibilities

Role	Responsibilities
Project Owner	The role of the Project Owner is to champion and provide support to the project manager, to ensure ongoing alignment between the project and organisational priorities. The Project Owner is responsible for: • Overseeing the project implementation to ensure that it will enable the realisation of the desired benefits and that it remains within the approved scope, timescale and budget. • Holding and authorising allocation of the Project budget. • Leading communications with internal and external stakeholders and ensuring that internal and external governance groups and the Ministry NBSP Team are kept appropriately informed on progress, risks and issues. • Resolution of issues beyond the scope of the Project Manager.
Clinical Lead	The DHB NBSP clinical lead will provide clinical advice to inform the local planning and implementation of the Programme. The clinical lead is responsible for: • Ensuring alignment of the local implementation with the wider Programme clinical requirements. • Identifying and ensuring mitigation of potential clinical risks. • Engagement with clinical colleagues to ensure that implementation is well planned and executed from a clinical perspective.
Project Manager	The Project Manager reports to the Project Owner. The purpose of this role is to lead the implementation of the Project within the DHB. Key responsibilities include: • Detailed project planning for the implementation of the project on time, to budget and scope. • Liaison with the Ministry NBSP team. • Coordinating and overseeing all project resources undertaking planning and implementation, including change management, IT alignment and detailed requirements for the outplacing tender. • Maintaining a risk and issues register, for internal management of the implementation project and for escalation to the MoH NBSP team as appropriate.

Role	Responsibilities
NBSP IT Representative (from ISG)	The IT representative is responsible for: • Leading the implementation of the IT solution chosen by the NBSP to manage clinical information. • Supporting the use of ProVation in Gastroenterology. • Liaising with the MoH Data team as required. • Facilitating the storage/link with pathology results in ProVation. Training Gastroenterology staff in the use of software as required.
NBSP Speciality Registered Nurse	The NBSP 'Specialty' Nurse is responsible for: • Working closely with the Project Manager and Charge Nurse Manager to prepare the Unit for the implementation of the NBSP. • Setting up systems for 24/7 phone support for NBSP patients. • Setting up systems for patient booking and pre-colonoscopy education as well as actively supporting patients who require colonoscopy. • Linking with the NBSP National and Southern Region offices. Leading the programme at the completion of the project phase
Consumer Representation	• Specific representation from Maori and Pacific is proposed to identify and support equity discussions and decisions • Other consumer representation will be added as necessary
Other representation	• Other representation is enumerated and will provide specific support in their particular area of interest

Project Monitoring and Reporting

To be developed.

5.3 Key Milestones

The Gantt chart attached shows the milestones as specified in the NBSP Phase 1 and 2 contract. These milestones will be detailed once the project management function is in place. Current approximate dates are shown in Table 7.

Table 7: Key Milestones

Key Milestones	Approx. Date
Output 4: Project Management and Governance Framework in place	October 2019
Output 5: Primary Care arrangements in place	February 2020
Output 6: Diagnostic Services in place	February 2020
Output 7: Histopathology Services in place	February 2020
Output 9: IT Integration Workplan confirmed	February 2020
Output 9: Readiness Assessment(s) completed satisfactorily	February 2020
Go-live	May 2020
Outputs 4-10: Final Report for Phase 2	June 2020

5.4 Change Management

Change management (related to the implementation of the NBSP), will be led jointly by the Gastroenterology leadership team (Clinical Director, Service Manager and Clinical Nurse Manager) and the surgical/oncology

team with support from the Project Manager and the NBSP RN. The Project Manager and existing Planning and Funding Portfolio Managers will link the MoH Relationship Managers as required.

5.5 Communication and Engagement

Communication with key stakeholders has been and will continue to be managed by the Gastroenterology Service, the Project Manager/Working Group, Planning and Funding Portfolio Managers and other channels, such as the Canterbury Clinical Network Primary Care Liaison Team, the Canterbury Initiative and the use of HealthPathways and HealthInfo websites.

5.6 Benefits Management

Programme benefits will be measured through regular analytical channels such as Decision Support, Planning and Funding Analysis, ProVation reporting tools and Signals from Noise (SfN) data analysis. The Project Manager, the Gastroenterology leadership team or Planning and Funding representatives, will access these analytical channels. Data collection, evaluation and reporting will include ethnicity to support reporting against equity targets.

5.7 Risk Management

The Canterbury DHB Risk Management framework will be applied to the implementation of the NBSP both at a project and service level. A copy of the Project Risk register will be added when completed. A risk register is also maintained for Gastroenterology and it is likely that both registers will cover risks relating to the bowel screening programme implementation.

The Project Manager will maintain the project risk register and the Service Manager will continue to maintain the Gastroenterology risk register.

5.8 Monitoring and Evaluation

Monitoring: The planning and rollout will be supported and monitored by the Ministry team, to ensure that all required elements are in place prior to go-live. The project will be subject to Treasury Major Projects Monitoring and Gateway review as part of the overall Programme monitoring and assurance.

The Steering Group will monitor the Implementation of the NBSP in Canterbury.

Readiness for Service review: A Readiness for Service review will be scheduled prior to go-live, to ensure that the DHB is well placed for a successful implementation. If required, further actions required for readiness would be determined and an action plan implemented.

Project evaluation: Post Go-Live evaluation will take place within a month of the go-live. The evaluation will review the implementation process, to identify any learning points which could be incorporated into planning for subsequent DHB implementations

Appendix 1: NBSP Benefits and Dis-benefits

The National Bowel Screening Programme is expected to deliver four key benefit outcomes:

- Improved health outcomes;
- More cost-effective healthcare;
- Improved service delivery (including improved IT infrastructure supporting service delivery); and
- Better social and economic outcomes.

The known adverse impacts (dis-benefits) of investing in the NBSP were identified in the Programme business case. Whilst it is not possible to eliminate the dis-benefits, every effort will be made by the Programme to minimise the impact.

The benefits and dis-benefits fall into three overall categories: those which can and will be measured (screened and total population); those which may be subject to future evaluation, but which will not be routinely monitored; and unquantified benefits which, whilst important will be neither monitored nor evaluated.

The benefit and dis-benefit measures are classified as either being measurable for the screened population or for the total population. The classification is summarised in Table 8.

Table 8: Benefits Classification

Classification	Description	Frequency of monitoring/ responsibility	Frequency of monitoring/ responsibility
Screened Population	Measures will be applied to the screening population only. Benefits realisation/dis-benefit mitigation can begin as soon as the screening programme is introduced into the first DHB. The screened population benefits will provide early indicators of the Programme's success.	Monthly by the Principal Advisor.	Every four months by the Programme Manager for Bowel Screening Implementation, to coincide with the reporting for Treasury.
Total Population	Measures will be applied to the whole population of New Zealand. Measuring to assess the benefits realisation/ dis-benefit mitigation will begin as soon as the first DHB goes live, in order to assess whether the trends demonstrated are in line with expectations. Over time, a national picture will be produced. The population per DHB results will provide early indicators of the effectiveness of the Programme and an initial proxy as to what the National level may look like.	Annually or according to current practices, by the Principal Advisor until handover to BAU.	Annually by the Programme Manager for Bowel Screening Implementation until handover to BAU
Future Evaluation	Benefits realisation results for the screened population and total population provide early indicators of the Programme's success. A full evaluation may be carried out by a third party on the benefits in this classification.	A minimum of 10 years post the roll out to each DHB.	One off, post monitoring.

The benefits and dis-benefits for the NBSP were outlined in the Programme Business Case. As a result of further investigation into data availability, some revisions have been made to the benefits and measures identified. The updated benefits and measures are summarised below.

Programme Benefits and Dis-benefits – Measured/Future Evaluation

The measures and areas of potential future evaluation for the NBSP benefits are summarised in Table 9.

Table 9: NBSP Benefits

Benefit Outcome	Screened Population	Total Population	Future Evaluation
Improved health outcomes Cost effective healthcare	• Appropriate rate of detected cancers • Increase in the proportion of screening-detected bowel cancers detected at TNM Stage I. • Appropriate rate of screening-detected advanced adenomas.	• Reduction in bowel cancer mortality. • Reduction in bowel cancer incidence. • Increase in 5-year relative survival rate for bowel cancer. • Benchmarking improvement with international comparisons (smaller variance from OECD average).	• Quality of Life Years (QALYs) saved (estimated at $1,194 million nationally over the 20-year modelled period). • Contribution to society (estimated at $671 million nationally over the 20-year modelled period). • Decrease In total bowel cancer treatment costs.
Improved service delivery			• Quality improvement to DHB endoscopy unit services.
Dis-benefit	**Screened Population**	**Total Population**	**Future Evaluation**
Health outcomes	• Psychological harm arising from participation in the Programme	• Widening of equity gap for mortality and survival rates	
	• Adverse physical health outcomes from the screening process e.g. bleeding or tearing of the bowel or complications from sedation.		

Programme Benefits and Dis-Benefits – Not Measured

Other benefits arising from the NBSP have been identified which cannot easily be quantified but which nevertheless support the case for investment.

- **Improved relationship/engagement with primary care:** Having primary care as an active partner in the bowel screening programme facilitates improved integration and relationships across the health system, which has the potential to have flow on effects for other health issues. It would support the maintenance of a person's main health relationship with primary care, given the broad knowledge and information primary care has about their enrolled population.
- **Raised awareness of bowel cancer:** Results from the Waitemata DHB to date indicate that over the initial two years of the pilot, bowel screening raised awareness of the symptoms of bowel cancer, resulting in an approximately 20 percent increase in referrals for diagnostic colonoscopy, i.e. for investigation of bowel symptoms. The 'bystander effect' of raising population awareness of bowel cancer and symptoms, and disease prevention, is a significant benefit. 'Health literacy' would be improved as people understand more about their health needs and options.
- **Increased identification of individuals and families with genetic bowel cancer syndromes:** Highlighting and assessing the significance of family history of bowel cancer as part of the bowel screening pathway has the potential to identify families with a genetic predisposition to developing bowel cancer. In the Netherlands, approximately 16 percent of participants presenting for colonoscopy as part of the bowel screening programme had a family history of bowel cancer and approximately 6 percent were referred

for genetic assessment. Offering these families regular colonoscopy has the potential to substantially further increase the bowel cancer incidence and mortality benefit from bowel screening. The current Familial Gastrointestinal Service has provided an estimated cost benefit of $11 million annually in saved hospital costs.

- **Wider health benefit:** In addition to the direct health benefit to the individual, there is a wider health benefit to the system and other cancer patients as a result of detecting and treating, earlier stage bowel cancers. Where no further surgery, chemotherapy or radiotherapy is required post colonoscopy, this frees up constrained resource for other cancer patients and assists the achievement of the faster cancer waiting times for all patients. Earlier diagnosis and reduced mortality would also reduce pressure on hospice and palliative care services.
- **Utilisation of high quality data:** Through the introduction of a bespoke information solution the programme will collect relevant, high quality data that does not currently exist. This data will be made accessible through a variety of mechanisms to a wide group of stakeholders including the wider health sector. This will ensure the programme can:
    - provide high quality clinical information relevant to the cancer pathway;
    - provide high quality service delivery information relevant to the cancer pathway;
    - provide high quality information to cancer patients; and
    - provide data which can be used for evaluation, monitoring, and research purposes.

  The provision of complete and accurate data is a requirement of the IT solution and is therefore not measured separately. Whilst the value of the data generated could potentially be assessed (by measuring the relevance of the data to (service delivery), clinicians, patients, and DHBs), it is not considered practical to do so.
- **Reduction of bowel cancers identified through Emergency Department (ED) admissions:** The NBSP should decrease the proportion of colorectal cancers that are first diagnosed following presentation at ED, which will reduce pressure on EDs and reduce diagnostic and treatment costs. The 2008/2009 PIPER study was able to identify that 34 percent of colon cancers and 14 percent of rectal cancers were first identified following presentation at ED. There are no plans to repeat a similar PIPER study, therefore these values cannot be used as a baseline. It is expected that at a point 10 years following the commencement of NBSP, the proportion of all bowel cancers first diagnosed following presentation at ED will be lower than the 2008/2009 rates, for the total population and for Māori.

The dis-benefits arising from NBSP which cannot easily be quantified are also taken into consideration as part of assessing the overall value of the investment.

- **Delays in diagnosing bowel cancer for some populations:** The proposed phased rollout of the Programme would result in people in some areas being offered screening later that those in other areas. Some cancers will have diagnosis delayed as a result of the rollout approach.
- **Programme parameters will result in some cancers not being identified:** The constrained age-range for the programme will result in people outside this range not being screened, resulting in some cancers not being identified. The threshold for positivity on the FIT test will result in some cancers not being identified, which would have been detected with a lower threshold for positivity.
- **Opportunity cost:** The cost of implementing the National Bowel Screening Programme would preclude investment in other priority areas. This would be at both a national level and a local level, as DHBs may need to prioritise capex and/or opex to implement the programme in their area.
- **Increased pressures on resources:** Endoscopy and histology capacity is constrained. As the rollout progresses, the pressure on staff in these areas would increase until increased investment can improve workforce capacity.

Appendix 2: Key Risks and Issues

Key Risks	Likeli hood	Impact	Summary and Risk Management Strategies
If significant volume of work is outsourced then publicly-committed SMOs may reduce their commitment to the programme	3	4	• Tendering for outplacing of services to be managed independently of Endoscopists by Planning and Funding (P&F) • P&F works to the Government Procurement/Tendering processes and standards. • Monitoring of quality standards will be a requirement of the tendering process and will address perceived inequities. Outplacing model using CDHB staff and resources in a leased facility will help to build CDHB capability in the long-term.
There is no clarity of timing for CDHB on when facilities decisions will be made which is making the planning of managing services over multiple sites difficult	5	5	• The timing of the move of the Endoscopy Unit (for earthquake repairs) is not yet known, it is dependent on decisions made by the Facilities Committee which depends in turn on decisions made by the MoH's HRPG (Hospital Redevelopment Partnership Group) regarding future capital developments. Clarification will be provided as soon as these constraints are known. Planning for the move will commence when the destination and configuration of the interim facilities is known.
If the limitations of the current version of ProVation does not support meaningful data extraction then that will impact on the quality of clinical review/audit or NBSP reporting	3	3	• We will work towards increasing the number of ProVation Super Users available in Canterbury, currently 3, and work with Information Services Group (ISG) to increase their expertise in this software. • The IT reporting system required by the MoH is not yet defined. • Work is required to improve the platform that hosts ProVation in the South Island.
If there is a delay in recruiting Gastroenterologists or training Nurse Endoscopists then this will impact on the ability of the service to expand capacity	4	5	• Workforce planning has commenced and in some workforce groups, suitable applicants have been identified. The additional FTE required to deliver on the NBSP scoping volumes is being identified.
If symptomatic patients rely on negative FITs from the screening programme to ally their concern this may result in delayed diagnosis	2	4	• NBSP advertising should be designed to highlight this risk
If South Island DHBs require Canterbury to support their NBSP through the provision of interventional endoscopy and complex surgery this will impact on CDHB demand	3	5	• CDHB is expecting an increase in referrals for complex polyp resections and complex bowel cancers requiring chemotherapy, radiotherapy and/or surgery. It is likely some patients will require repeat surgical procedures e.g. through closure of stomas. • CDHB is currently operating at a level of 8 surgical theatres short. CDHB manages this deficit by outplacing and outsourcing theatre capacity at private facilities. Pushing

Key Risks	Likeli hood	Impact	Summary and Risk Management Strategies
			more of the complex cases from other DHBs to CDHB may have the effect of limiting the normal elective surgery CDHB can provide for our population.
NBSP colonoscopy (quality) requirements will mean that small centres may not have the staff, experience or sufficient volumes to perform the screening procedures.	3	5	• The specified quality requirements of the NBSP will mean that small centres primarily with general surgeon support may not be able to provide these screening colonoscopies and will require support from CDHB. • The time required to complete the NBSP patient colonoscopies reduces the number of colonoscopies able to be completed per session - from approximately eight per session to five – negatively impacting smaller centres who may not have sufficient theatre capacity. • The experience requirement may also mean that smaller centres may not be able to provide the scoping work locally – meaning patients will have to travel and larger centres will have to do even more for other populations.
The ProVation Medical Endoscopy Procedural Reporting Information System (installed in 2012) is not working as intended resulting in the risk of patient harm due to the loss of patient health information to guide clinical decisions. This is also a waste of staff time due to the need for rework, procedures are taking longer and the need for on-going problem solving to keep the system working. The risk is elevated for the operating theatre endoscopy patients due to the mobile (travel Stack) not being reliable when used in the on line mode. There is also a risk that the information that will be provided to capture for the Bowel Cancer Screening programme will not be available resulting in a need to design work around processes.	2	4	• CDHB also provides the platform for ProVation for use in DHB Endoscopy suites in the lower North Island • Rather than upgrade the systems to a more recent version of ProVation to try to eliminate the current problems the decision has been made to wait until the release of version 410 • Version 410 will be able to meet the new requirements for extractable audit data for the NCSP
Government funding allocation is not sufficient for CDHB to start the BSP	5	5	• CDHB originally outlined its cost in the Bowel Screening assessment in June 2013 for MOH budget bid. • That assessment itemised that CDHB would need approximately s9(2)(j) [redacted] in previous years before the go-live was changed. • That assessment itemised that first year costs would be about s9(2)(j) [redacted] for CDHB – current calculations indicate our

Key Risks	Likeli hood	Impact	Summary and Risk Management Strategies
			first year costs are s9(2)(j) with funding provided by BSP of s9(2)(j) • Any decision not to proceed would see 338 people over 5 years not being diagnosed with cancer in a timely manner and /or causing increased high cost treatment options to be utilised by delayed diagnosis
Endoscopy Increased waiting time for outpatients referred for endoscopy due to the increasing demand for service outweighing our planned growth for this services This may result in delayed diagnosis leading to increased morbidity or avoidable death	4	2	• Additional surgical staff with endoscopy skills have been appointed plus additional nursing staff. An additional Endoscopist has been employed until the end of 2017 with recruitment ongoing for a permanent role The Organisational development unit are working with the department to improve workflow in the reprocessing area

Table of Figures

Appendix 3: Project Plan

Project Plan to be developed when project manager in place.

Kathleen Smitheram

From: s9(2)(a) @moh.govt.nz
Sent: Tuesday, 7 May 2019 5:57 p.m.
To: s9(2)(a) @moh.govt.nz
Cc: s9(2)(a) @moh.govt.nz; s9(2)(a) @moh.govt.nz; s9(2)(a) @moh.govt.nz; s9(2)(a) @moh.govt.nz; s9(2)(a) @moh.govt.nz; s9(2)(a) @MOH.govt.nz
Subject: Radiation Oncology wait times
Attachments: H201901865 Signed Response.pdf

Dear DHB CEOs

As part of a very recent Official Information Act (OIA) request we have undertaken an analysis of radiation service data with particular emphasis on the wait time for radiation treatment. We have used the Priority Categorisation for Radiation Treatment Radiation Prioritisation Guidelines to assess best practice for priority patients across all categories. The information is attached for your information.

We note that the analysis shows significant variation between recent quarters in wait times for patients requiring radiation treatment in particular those who are categorised as 'priority B' patients (people who are treated with curative intent within 2 weeks of diagnosis).

We are aware that the patient numbers in this category are small however no patient with cancer should experience unnecessary delays in their treatment.

I ask that you use the information provided to investigate if people with cancer within your DHB are receiving radiation therapy within the recommended timeframe. If this is not occurring please put in place a plan to improve access to treatment that meets the standards and manage any clinical risk associated with delays in treatment. We will make contact individually to confirm timeframes and expectations for this plan.

I have also asked that radiation wait times is included on the agenda and discussed with the members at the next ROWG meeting later in May. In addition this issue will be raised by the DHB Performance and Support team in your regular Monitoring and Intervention Framework (MIF) or other meetings.

I look forward to improvement in this area.

regards

s9(2)(a)

s9(2)(a)

Population Health and Prevention
Ministry of Health

s9(2)(a)

http://www.health.govt.nz
mailto s9(2)(a) @moh.govt.nz

immediately and delete this message.
****

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
s9(2)(a)

7 May 2019

s9(2)(a)
APEX

By email: s9(2)(a)@apex.org.nz
Ref: H201901865

Dear s9(2)(a)

Response to your request for official information

Thank you for your request for information under the Official Information Act 1982 (the Act), transferred from the Office of Hon Dr David Clark to the Ministry of Health (the Ministry) on 26 March 2019, for:

> *"For each DHB in the quarters ended 31 March 2018, 30 June 2018, 30 September 2018 and 31 December 2018: • What percentage of patients categorised as Priority A received treatment within 24 hours; and what percentage received treatment within 48 hours? • What percentage of patients categorised as Priority B received treatment within two weeks; and what percentage received treatment within four weeks?*
> *• What percentage of patients categorised as Priority C – curative received treatment within four weeks; and what percentage received treatment within eight weeks?*
> *• What percentage of patients categorised as Priority C – palliative received treatment within two weeks; and what percentage received treatment within four weeks?*
> *• What percentage of patients categorised as Priority D received treatment within four weeks; what percentage received treatment within eight weeks; and what percentage received treatment within twelve weeks?"*

Information held by the Ministry pertaining to your request is itemised in Appendix One. Please note the Ministry has not presented results in the tables when there are fewer than ten (10) people in the denominator.

Radiation oncology prioritisation guidelines classify category D patients as follows: 'Priority D - Planned delay on radiation treatment as per treatment protocol'. As such, the Priority D figures provided below are largely insignificant as these patients have been intentionally delayed as part of their treatment protocol. Some of these patients, for example, undergo several months of chemotherapy or drug treatment prior to receiving radiation, therefore, it is part of their treatment plan to wait longer than 8 or 12 weeks to receive radiation.

I trust that this information fulfils your request. Please note that this response, with your personal details removed, may be published on the Ministry of Health website.

Yours sincerely

s9(2)(a)

Population Health and Prevention

Appendix One

What percentage of patients categorised as Priority A received treatment within 24 hours; and what percentage received treatment within 48 hours?

Table 1. Priority A – within 24 hours

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	-	-	92%	100%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Table 2. Priority A – within 48 hours

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	-	-	92%	100%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

What percentage of patients categorised as Priority B received treatment within two weeks; and what percentage received treatment within four weeks?

Table 3. Priority B – within 2 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	8%	7%	11%	7%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Table 4. Priority B – within 4 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	85%	86%	89%	83%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

What percentage of patients categorised as Priority C – curative received treatment within four weeks; and what percentage received treatment within eight weeks?

Table 5. Priority C (Curative) – within 4 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	68%	77%	83%	61%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Table 6. Priority C (Curative) – within 8 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	90%	91%	91%	90%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

What percentage of patients categorised as Priority C – palliative received treatment within two weeks; and what percentage received treatment within four weeks?

Table 7. Priority C (Palliative) – within 2 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	71%	70%	79%	79%
s9(2)(a)				
West Coast	-	77%	92%	69%
s9(2)(a)				

Table 8. Priority C (Palliative) – within 4 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	96%	94%	98%	96%
s9(2)(a)				
West Coast	-	92%	100%	92%
s9(2)(a)				

What percentage of patients categorised as Priority D received treatment within four weeks; what percentage received treatment within eight weeks; and what percentage received treatment within twelve weeks?

Table 9. Priority D – within 4 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	19%	20%	30%	17%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Table 10. Priority D – within 8 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	43%	47%	40%	33%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Table 11. Priority D – within 12 weeks

Row Labels	2018 Q1	2018 Q2	2018 Q3	2018 Q4
s9(2)(a)				
Canterbury	59%	63%	60%	58%
s9(2)(a)				
West Coast	-	-	-	-
s9(2)(a)				

Kathleen Smitheram

From: s9(2)(a) @moh.govt.nz on behalf of s9(2)(a) @moh.govt.nz
Sent: Wednesday, 15 May 2019 10:29 a.m.
To: s9(2)(a) @moh.govt.nz
Cc: @moh.govt.nz; s9(2)(a) @moh.govt.nz
Subject: Radiation Waiting Times
Attachments: Recovery plan template v1.docx

Dear DHB CEOs

This is to follow up on the email sent to you on 7 May 2019 about the Radiation Waiting times for those patients classified as Priority 'B' patients and to provide you with some timeframes on what we expect to see from each DHB.

In my email you were all asked to use the information provided to investigate and verify the data against the agreed criteria and guidelines (sent previously) and put a plan in place to ensure cancer patients are seen within recommended timeframes for radiation treatment. Please don't hesitate to request any information required from us from the Radiation Oncology Collection that may assist your DHB with a plan. I note that some DHBs have already requested this.

We expect to see a summary of:

- The current situation including reasons that have impacted on waiting times for radiation treatment generally.

- A plan on how you intend to ensure radiation treatment is provided within the agreed national guidelines which will include managing the immediate clinical risks, short term and longer term goals i.e. a specific improvement plan and the time frames for recovery.

The Regional Network Managers may have been in contact with you already as they have been asked to support your DHB with this work, they are additional resource. We are happy for them to coordinate the responses as there are benefits to working regionally where it is appropriate.

Please note that your plan is due with us 24 May 2016. I have attached for you a template for your plan. We will also require monthly updates against the actions you will outline in your plan. This information can be sent to s9(2)(a) s9(2)(a) Cancer Services s9(2)(a) @moh.govt.nz. Please provide her with contact details for the key person in your DHB who is leading this work so that contact can be made as required.

We will be providing the Minister of Health updates on progress against your plans so it is important that you provide us with the required information and assurances that cancer patients receive the required care.

Kind Regards

s9(2)(a)

Population Health and Prevention

s9(2)(a)

Population Health and Prevention
Ministry of Health
s9(2)(a)

http://www.health.govt.nz
mailto:s9(2)(a)[redacted]@moh.govt.nz
****

****

XXXX DHB

RECOVERY PLAN TEMPLATE – Radiation Oncology Waiting times

Implementation Strategy and Plan

Purpose

In a sentence or two, briefly outline why the recovery plan is being developed. Please directly link to the performance expectation/s the plan seeks to drive improvement against.

For example:

"To outline <XX DHB's> plan to recover <XX performance issue> in <XX service> by <xx date/timeframe>".

Context and constraints (optional)

You might like to highlight any relevant dependencies and constraints to the achievement of your plan. Some examples might include finalising recruitment of a specific role/s; completion of capital works; etc. These should be factors outside your control and/or deliverables that you identified as being at risk. Factors or deliverables within your control should be addressed in the plan itself.

Recovery plan and strategies

Please provide an overview of the strategies you will be adopting to recover performance. For example demand management; capacity management; increasing capacity; outsourcing; etc.

Strategies to manage clinical risk and patient experience

Please briefly outline your strategies and assurance mechanisms to manage clinical risk and patient experience while you implement your recovery plans.

For example, ensuring that all patients waiting over XX period are clinically reviewed; writing to all patients advising them of anticipated waiting times and how/when to communicate any concerns or changes in their condition; etc.

Recovery plan implementation

You can use this table to outline your plans in detail, as well as provide updates to your management team and/or the Ministry of Health at an agreed frequency.

Planned Action	Person Responsible	Time frame	Progress/Outcome (as at xx date)

Projected waiting list position

Please use this table to outline your expected trajectory to regain radiation treatment waiting times compliance.

Radiation waiting times			
Service			
Month	**Expected inflows**	**Expected activity/ outflows**	**Expected waitlist position**

CHIEF EXECUTIVE'S OFFICE

Tel: s9(2)(a)
E-Mail:chiefexecutive@cdhb.health.nz

22 May 2019

s9(2)(a)
Population Health and Prevention
Ministry of Health

Email: s9(2)(a)@moh.govt.nz

Dear s9(2)(a)

Your Email – 07 May 2019 – Radiation Oncology Wait Times

I note your correspondence dated 7 May 2019 where you have requested that we utilise information Ministry of Health (MOH) provided in a recent Official Information Act (OIA) request to the APEX union to ensure that people within our DHB are receiving radiation therapy within the recommended timeframe.

There are a few issues which I wish to bring to your attention.

Canterbury DHB meets its commitment to start radiation therapy within four weeks of FSA

Firstly, at Canterbury DHB we have continued to utilise the previous MOH reporting scheme internally and can ensure you that Canterbury DHB is meeting its commitment to start radiation therapy treatment within four weeks from FSA under the rules that were established.

The main reason the OIA data doesn't look as positive for Canterbury (and other DHBs for which we provide radiation therapy services) as one would expect, is that the MOH released data includes those patients that have delay codes attached to them for either:

- Clinical & other management considerations - the decision to treat has been made between the doctor and patient however we are waiting on dental extraction, healing, seroma problems, extra surgical procedure – (patient fit to have radiation therapy).
- Patient choice – wants to go on holiday first, can't start until golf tournament or white bait season finished – (patient ready to have radiation therapy)

If we removed those patients with delay codes from the data as allowed in previous health target calculations, all patients would have received their treatment within 4 weeks of FSA. That is the main commentary/context that is missing from the data that has been provided by the MOH in the OIA.

An excerpt from Canterbury DHB data for Q3 2018 is shown below as **Figure 1** to illustrate.

Leading Indicators and Targets
Priority B within two weeks figures were always a leading indicator – a guideline if you will to assist in the prioritisation of who would start treatment first within four weeks. Two weeks has never been a target. If MOH is now suggesting that it should be a target, a massive increase in both physical facilities and associated human resources are required. It is estimated that to meet such a target, Canterbury DHB would require an additional three LINACs in addition to its current four LINACs for a period of up to four months to reduce current wait time from four weeks to two weeks. In addition, we would also need to bring forward the 5th LINAC immediately to ensure we could maintain two week waits with the predicted growth in demand.

Context and DHB Support
Canterbury DHB always stands ready to assist MOH in providing context to any OIA request made for DHB data. Established procedures have been in place for a long period now where there is sharing of information being released under OIA. To have had the opportunity to review this data and provide you with this context would have been beneficial for all involved.

Given that Canterbury DHB meets its wait time priorities for radiation therapy, we will not be completing a recovery plan. Note this extends to Nelson Marlborough DHB, South Canterbury DHB and West Coast DHB as well.

I trust this answers your questions.

Yours sincerely

David Meates, MNZM
Chief Executive

Canterbury DHB
PO Box 1600, Christchurch, New Zealand 8140

Figure 1 - CDHB Wait Time 2018 Q3

	Time between decision-to-treat and the start of radiation treatment		2012/13 Health Target: Everyone needing radiation or chemotherapy treatment will have this within four weeks		
			Jul-18	Aug-18	Sep-18
Treatment	Treatments started in current month **(number of people)**		Total treatments for priority A to C	Total treatments for priority A to C	Total treatments for priority A to C
		Waited < 2 weeks ***Total***	42	48	40
		Maori	2	3	3
		Pacific	2	1	0
		Other	38	44	37
		Waited 2-4 weeks ***Total***	41	52	35
		Maori	1	2	2
		Pacific	0	1	1
		Other	40	49	32
		Waited 4-6 weeks ***Total***	2	1	6
		Maori	0		0
		Pacific	0		0
		Other	2	1	6
		Waited > 6 weeks ***Total***	1	0	2
		Maori	0		0
		Pacific	0		0
		Other	1	0	2
		Total treatments	***86***	***101***	***83***
Delays	**Reasons for delay**		Priority A to C	Priority A to C	Priority A to C
	Where patients wait 4-6 weeks identify the number in each delay code for priority A to C	*Capacity constraint **	0	0	0
		Clinical considerations	1	0	3
		Other management	0	0	2
		Patient choice	1	1	1
		Extraordinary circumstances	0	0	0
	Where patients wait >6 weeks idenify number in each delay code for priority A to C	*Capacity constraint **	0	0	0
		Clinical considerations	0	0	1
		Other management	1	0	1
		Patient choice	0	0	0
		Extraordinary circumstances	0	0	0
	Number of priorty D patients starting treatment in the month		12	11	11
	Health target: Percentage of patients treated within 4 weeks **		**100**	**100**	**100**

Canterbury DHB
PO Box 1600, Christchurch, New Zealand 8140

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
s9(2)(a)

11 June 2019

David Meates
Chief Executive
Canterbury DHB
PO Box 1600
Christchurch
New Zealand 8140

Dear David

Thank you for your letter dated 22 May 2019 responding to the email that I sent to District Health Boards (DHBs) regarding radiology waiting times. I note in your letter that you are also responding on behalf of South Canterbury, Nelson Marlborough and West Coast DHBs.

Based on the information you have sent to us *Canterbury DHB Wait Time 2018 Q3* your DHB are seeing patients within acceptable timeframes which is really good to hear. We remain committed to ensuring cancer patients are seen as priority patients.

I would like to take the opportunity to address some of the points that you have made in your letter.

- Delay codes – You are correct that the data we released under the OIA did not take into account delay codes. The Radiation Oncology Collection (ROC) does not currently collect this information and I agree having this information would have made a difference to the results for some DHBs.

  The Radiation Oncology Working Group met on 29 May 2019 and discussed whether the ROC should include provision for delay codes. At this point it has been agreed that we will not include delay codes in ROC. Therefore in the future similar requests for information from this collection will be referred to the Radiation Centres for a response.

- Targets - Radiation Treatment Targets were replaced by Faster Cancer Treatment some time ago, as you rightly point out. Also the prioritisation as categorised and referenced in my email are guidelines. However we do expect that patients are seen within the appropriate clinical timeframes and are seeking reassurance of this through the recovery planning process. All DHBs have submitted recovery plans working with their Radiation Provider and see this as an opportunity to drive quality improvement in their DHB.

- Context and DHB Support - I appreciate your comments that Canterbury DHB have always been willing to support and give context to any OIA regarding DHB data. We will work to ensure in the future that this is rectified.

We look forward to an ongoing relationship with you and your teams particularly as we undertake further work in Cancer Treatment which will improve outcomes for Cancer Patients.

Yours sincerely

s9(2)(a)

Population Health and Prevention

Out of scope

[redacted]

From: s9(2)(a) [redacted] @health.govt.nz [mailto s9(2)(a) [redacted] @health.govt.nz] **On Behalf Of** s9(2)(a) [redacted] @health.govt.nz
Sent: Thursday, 27 June 2019 2:15 p.m.
To: s9(2)(a) [redacted] @health.govt.nz
Cc: s9(2)(a) [redacted] @health.govt.nz
Subject: NBSP Sector Update 2019 - Update 5

Kia ora koutou,

As always, there is lots going on in the National Bowel Screening Programme. We are supporting the progress of DHBs who have been live for screening for several months, while our next DHBs to go live are preparing for their readiness assessments on the not too distant horizon.

Next month we have some anniversaries coming up: one year of screening for Counties Manukau, and Hutt Valley and Wairarapa DHBs reach their two year anniversary, completing one full round of screening. Congratulations to those teams reaching these important milestones and for all the work you are doing to encourage your communities to participate in screening.

We have a number of updates to share this month:

1. **Website updates**

A few key documents have been added to the Ministry's website recently:

- Quarterly reports are available on the NSU site: https://www.nsu.govt.nz/health-professionals/national-bowel-screening-programme/publications-and-reports/dhb-quarterly Quarterly reports are being produced for DHBs which have been live for at least eight months, which for the March 2019 cohort of reports included Hutt Valley, Wairarapa, Waitemata, Southern and Counties Manukau DHBs.
- The 2018/19 NBSP Business Case is available on the Ministry site: https://www.health.govt.nz/our-work/preventative-health-wellness/screening/national-bowel-screening-programme/key-documents-national-bowel-screening-programme
- Colonoscopy diagnostic wait time indicator 3 month trends. The 3 month trend tables are now available to April 2019. https://www.health.govt.nz/our-work/preventative-health-wellness/screening/national-bowel-screening-programme/key-documents-national-bowel-screening-programme

2. **Regional Centre service review**

We have engaged s9(2)(a) [redacted] Specialists s9(2)(a) [redacted] to undertake a service review of the regional centres. In particular, we are interested in learning how well the regional centres are achieving the objectives in the agreed service specifications, what lessons can be learned from the regional support model, and recommendations for the future role of the regional centres following the national roll-out. The review commenced in May, and information gathering activities are planned for June and July 2019. This activity started with a discussion with the regional centre managers in early June.

In addition to the regional centre and ministry teams, s9(2)(a) [redacted] intend to interview people who are delivering or preparing to deliver the bowel screening programme in eight DHBs (two DHBs from each of the four regions), with the remaining DHBs invited and encouraged to participate in the review via an online survey.

Thank you in advance for your involvement in this review. We will keep you updated as the work progresses.

3. Active follow up – text before call

The National Coordination Centre has piloted an additional step in their active follow up process. They sent a text message before making the telephone call to individuals who have yet to return their FIT kit. The pilot shared some positive results. For example, very early data from the trial period showed 19% of those people who received an SMS message before their active follow up call returned a completed kit, compared to a completion rate of 11% where an SMS text was not used. These return rates are expected to grow because the figures included recent contacts which could still result in kits being returned. We will continue this initiative for a further 12 month and assess the benefit again.

4. Colonoscopy wait times

From 1 July the Sector Deployment Team is implementing a new CWTI performance monitoring process. CWTIs provide information on how well DHBs are managing symptomatic colonoscopy patient flow.

It is important that the introduction of the bowel screening programme does not negatively impact on a DHB's ability to provide timely access to symptomatic colonoscopies.

A guidance document will be made available (and will be published on the Ministry's website) to support DHBs in their understanding of the rationale behind the escalation process that occurs when colonoscopy wait time indicators are not met.

5. BSP+ security enhancements

The final stage of the BSP+ Enhancement project is underway, and will deliver security enhancements to the BSP+ application and infrastructure. Delivery of this release is planned for end of June 2019. As a result of the recent changes, BSP+ provides some much needed operational functionality for the NCC, as well as a more stable and secure platform for BSP+ to sit on.

6. Provation

The Provation Centralised Database Privacy Impact Assessment (PIA) has been finalised following review and approval by the NSU Clinical Reference Group, the Ministry of Health Chief Legal Advisor and EGGNZ.

The programme has also been working with Canterbury DHB, who host one of the Provation Regional Instances. This work includes testing the set up and data integrity, through the transfer of test data from Canterbury.

Questions about the relationship between NSS and the Provation centralised database, and what this means from a DHB perspective, will be added into a Q&A document which is in development.

7. Histology standard

We have worked with the Health Information Standards Organisation (HISO) to develop a data standard and message implementation guide for Bowel Screening histology data.

The data standard - issued for public consultation in March 2019 - identifies and describes the data elements that need to be captured in laboratory information systems contracted to perform NBSP histology services. The message implementation guide identifies and describes the messages that the histology labs will send to the National Screening Solution (NSS), which will free up DHB clinicians from manually entering pathology information.

The purpose of both standards is to ensure data is consistent and supports NBSP monitoring, operational and quality purposes.

To enable the electronic messaging of histology data, laboratories and their information system providers will work together with the NBSP to configure their systems to send information to the NSS. Final HISO endorsement is expected this month.

8. What do we call the NSS?

We have been asked about what the National Screening Solution should be called when it is rolled out. Although referred to as NSS in this project/deployment phase, the solution will ultimately replace the enhanced bowel screening pilot register (BSP+). Therefore, when NSS is live supporting the NBSP, this IT system will simply be known as the bowel screening register.

9. Recent progress for NSS

- *Engagement of stakeholders - Establishing a change network*

The NSS Change team are managing the impact that the NSS will have on the NCC, DHBs and FIT Lab. The team have been planning to ensure current state processes are captured accurately to measure and communicate future changes. A change network is being established, with representatives from the Regional Centre Managers, the NCC, DHBs (technical and clinical representation), the FIT lab and the Ministry.

The change network will consider the NBSP, and the change required to implement the NSS replacing BSP+. Whilst this change network is not yet formally established, representatives have already been involved in a change impact assessment session providing feedback as input into planning.

Once the change network has started to meet formally, there will be further communication about how the wider sector can engage with it.

- *Integration of systems*

The NSS integration build has achieved integration with relevant Ministry web services, including: NHI (for patient queries), NES (for national enrolment information) and eSAM (for address validation). Work continues on refining the requirements for the interfaces with the NZ Cancer Register and NZ Familial Gastrointestinal Services.

We have been working with the FIT lab and their laboratory information system provider, on the specification for the transfer of FIT test results to GPs and the bowel screening register. Connectivity testing is underway.

- *NSS demonstration*

A recent demonstration of the functionality built in the NSS so far was great to see, the dream becoming a high quality reality. It demonstrated for the first time the connectivity with the NHI and the eSAM. The demo was well received by those attending, including the NCC.

- We have a Q&A sheet in development which will be shared via the Shared Workspace. We will add questions to this as they come in and can be responded to. If you would like to ensure that your question is included, please email s9(2)(a) [redacted]@health.govt.nz and include "NSS – Q&A" in the subject line.

Please feel free to share this information with your networks.

With best wishes for the next few weeks. Stay warm and dry!

Kind regards,

s9(2)(a) [redacted]
National Bowel Screening Programme
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