TATAU POUNAMU

Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

Friday 6 December 2019

@ 10.00 am Board Room, Corporate Services

Agenda and Meeting Papers

ALL INFORMATION CONTAINED IN THESE COMMITTEE PAPERS IS SUBJECT TO CHANGE

TATAU POUNAMU MANAWHENUA ADVISORY COMMITTEE AGENDA

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU ADVISORY GROUP MEETING
Board Room. Corporate Services – West Coast District Health Board
Friday 6 December, 2019
10.00 – 12.30pm

KARAKIA

ADMINISTRATION

Apologies

1. **Interest Register**
   Update Interest Register and Declaration of Interest on items to be covered during the meeting.
2. **Confirmation of the Minutes of the Previous Meeting**
   Minutes from Meeting 13 September 2019
3. **Carried Forward/Action List Items**
4. **Discussion Items**

▪ National Bowel Screening Strategy – Draft 1	10.10am
▪ Facilities Update – Tour of Te Nikau	11.00am

REPORTS

5. **Chairs Update – Verbal Report**	Susan Wallace, Chair
6. **GM Maori Health Verbal Update Report**	Gary Coghlan, General Manager

INFORMATION ITEMS

- 2019 Tatau Pounamu Meeting Dates
- 2019 Board Meeting Dates

ESTIMATED FINISH TIME 12.30pm

TATAU POUNAMU ADVISORY GROUP MEMBERS INTEREST REGISTER

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Member	Disclosure of Interest
Susan Wallace - Chair Te Runanga o Makaawhio	• Tumuaki, Te Runanga o Makaawhio • Member, Te Runanga o Makaawhio • Member, Te Runanga o Ngati Wae Wae • Director, Kati Mahaki ki Makaawhio Ltd • Director, Kōhatu Makaawhio Ltd • Co-Chair, Poutini Waiora Board ▪ Area Representative-Te Waipounamu Maori Womens' Welfare League ▪ Representative, Te Rununga O Ngai Tahu (Makaawhio) TRONT ▪ Member of Westland High School Board of Trustees ▪ Trustee, Te Pihopatanga O Aotearoa Trust
Ned Tauwhare	▪ West Coast community Response Forum (MSD) Ngai Tahu Rep ▪ Te Rununga o Ngati Waewae Member ▪ Te Rununga o Ngati Waewae Advisor – Kawatiri Role ▪ Te Rununga o Ngati Waewae Advisor – Te Ha o Kawatiri ▪ Te Rununga o Ngati Waewae Advisor – Buller Inter Agency ▪ Te Rununga o Ngati Waewae Advisor – Reefton Partership Forum ▪ West Coast District Health Board Consumer Council – Maori Representative ▪ Te Whare Akoanga Committee (Grey High School)

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING TEAM MEETING

Corporate Office Boardroom, Friday 13 September 2019
10.00 – 1.00pm

PRESENT:

Chris Auchinvole, WCDHB Board Representative
Maree Mahuika, Forsyth, Te Runanga O Makaawhio Representative
Ned Tauwhare, Te Rūnanga O Ngāti Waewae (Arrived 11.30am)
Joseph Mason, Ngati Waewae Representative
Richelle Schaper, Kawatiri Representative

APOLOGIES: Anne Ginty, Mawhera Community Representative
Susan Wallace, Te Runanga o Makaawhio

IN ATTENDANCE:

Gary Coghlan, General Manager Maori Health
Kylie Parkin, Programme Manager, Maori Health
Philip Wheble, General Manager West Coast District Health Board
Robin Rutter Baumann, Acting Operations Manager

MINUTE TAKER: Megan Tahapeehi

Mihi Whakatau/Karakia
Gary Coghlan

AGENDA/APOLOGIES

1. **DISCLOSURES OF INTEREST**
   Updates or amendments to be provided to Megan over email.

2. **MINUTES OF LAST MEETING**
   The minutes from the last meeting were agreed subject to the following requests:

   - Maori Representatives on working groups/committees.
     ACTION: Tatau Pounamu to be provided a list of all the groups and the participants.
   - Communications Strategy
     ACTION: Ongoing discussions to work towards the completion of this work.
   - Te Putahitangi Hui @ WCDHB on 24 September.
     ACTION: Invitation to be extended out to Tatau Pounamu members.

3. **CARRIED FORWARD/ACTION ITEMS**

   - Annual Plan **ACTION: Ongoing**
   - DNA Update **ACTION: Ongoing**
   - Improved Access to Hokitika services: **ACTION: Ongoing**

A G E N D A

DNA (Do Not Attend) Maori – Robin Rutter Baumann, General Manager Operations

The work is continuing to be looked at in this area and Robin has asked for Tatau Pounamu input to engage in further conversations around what solutions do we want to try and how could we measure these?

Approximately 15% of appointments sent to Maori are not attended in outpatient clinics.

The following points were talked about as potential ways forward:

- Posters DNA
- 2 DNA's result in a referral back to GP
- Engage with Poutini Waiora to assist in appointment reminders
- Arrange a hui with NGO's and DHB staff

There is a current policy that is being reviewed and feedback into this from Tatau Pounamu was also requested.

Jo Mason and Richelle Schaper will engage in any upcoming hui arranged by Robin to offer feedback from a Ngati Waewae and Kawatiri perspective alongside Kylie Parkin, Maori Health.

NOTE: There is a Buller Health Hui coming up in November where some discussions around DNA could be positive in this environment.

Philip Wheble – General Manager, Grey/Westland Update

Hospital Rebuild Update

- Feb/March potential hospital move
- Cowper Street extension looking to be completed towards the end of October.

Community Engagement

There was continued discussion around community engagement and how Tatau Pounamu alongside DHB teams can have a presence in this space. Buller continues to be seen as a good starting point of engagement. The following strategies and publications are potentially good areas to start to form some discussions around:

- Child & Youth Wellbeing Strategy
- West Coast Maternity Strategy
- West Coast Cancer Korero Booklet
- Kaumatua Hui

The GM Maori requested that Maori engagement with the community is prioritised over the next 12 months.

The new Locality Manager appointments in the central and Southern regions could also be useful avenues of community engagement.

The Consumer Council currently does not have a Maori representative and it was suggested that we invite the Chair Russ Aiton to one of our next meetings, as the Consumer Council is another area of engagement with the community.

Te Ora – National Bowel Screening Strategy, Peter McIntosh

West Coast is amongst the last group of DHBs to be staged by the Ministry of Health to "go live" in the programme in 2020-21. Implementation is to be in three phases, with the DHB required to work with the Ministry in each phase to ensure that the required resource and increase in services can be delivered to support implementation.

The three phases are as follows:

1. ***Phase One – Information***
   The DHB is required to provide detailed information to the Ministry to inform the Ministry's business case to Ministers of Finance and Health. Draft information is due in October
2. ***Phase Two – Planning***
   The DHB is required to plan for set up for establishing the service for 'go live'. This is to include various plans for workforce, equity, communications, primary care engagement, governance, leadership, accountability etc.
3. ***Phase Three – Establishment***
   The Ministry of Heath will assess our readiness and confirm that we can go live in the programme. Thereafter, the programme will be commenced locally.

Peter advised that he will continue to engage in the role out and the phases alongside Poutini Waiora as well.

Tatau Pounamu also confirmed that the letter from the Chair to MOH around the concerns of the age for screening has been actioned.

GM Maori Health Update – Gary Coghlan

Gary spoke briefly to his update that is provided regularly in the Tatau Pounamu papers.

The Hapu Wananga that was recently attended by Kylie Parkin and key Poutini Waiora staff in Christchurch was seen as a really successful programme being led from a Maori kaupapa setting. Poutini Waiora are looking to run a pilot of one here locally.

General Business

Marie Mahuika-Forsyth raised a point around inequity and pay parity from a recent Poutini Waiora board meeting. The GM Maori Health thanked Marie for the update and this point was noted.

Manaaki
It was raised and agreed that for future meetings we should provide kai and refreshments to all members. The GM Maori agreed and this would be actioned for meetings into the future.

MATTERS ARISING DECEMBER MEETING 2019

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
1.	December 2019	**Workforce Development Plans/Annual Plan** Regular updates provided. Awaiting formal MOH sign off.	Kylie Parkin	**2020 Meeting**
2.	December 2019	**DNA Update** Ongoing work and discussions continue in this area,	General Manager, Maori	**2020 Meeting**
3.	December 2019	**Improved Access to Hokitika Health Services** Ongoing.	Chair	**2020 Meeting**
4.	December 2019	**Hospital Rebuild** Positive engagement and korero continues to occur.. Local iwi continue to stay engaged with the facilities team as work progresses in these areas.	Gary Coghlan	**2020 Meeting**

Megan Tahapeehi

From: Peter McIntosh
Sent: Monday, 18 November 2019 2:00 p.m.
To: Wendy Stuart (Greymouth-Nurse Manager); Helen Reriti; Gary Coghlan; Louise Mclean; Brittany Jenkins; Cameron Lacey; Deborah Wright; Diane Pizzato; Ginny Brailsford; Graham Roper; Imogen Squires; Jacqui Lunday Johnstone; Jane George; Joanne Hopson; Julie Bell; Julie Lucas; Kylie Parkin; Neil De Goede; 'Norma Campbell'; Philip Wheble; Pradu Dayaram; Robin Rutter-Baumann; Rosalie Waghorn; Vicki Robertson; Megan Tahapeehi
Cc: Philip Wheble; Maria Petrovics-Edens
Subject: National Bowel Screening Programme - implementation on the West Coast. First Draft of Information Document.
Attachments: National Bowel Screening West Coast DHB implementation - FIRST DRAFT of....pdf

Hi There,

Please find attached the first draft of our **Phase One – Information** document prepared for the Ministry of Health as an initial starting point. This is currently with the Ministry of Health and we expect their initial feedback in late November. From there, we will look to finalise this for presentation by February. We would welcome your feedback and comments in this initial first draft in the interim, as we prepare our final draft.

West Coast is amongst the last group of DHB to be staged by the Ministry of Health to "go live" in the programme in 2020-21; with the Ministry having recently signalled April 2021 as the commencement time for the programme in our district. Implementation is to be in three phases, with the DHB required to work with the Ministry in each phase to ensure that the required resource and increase in services can be delivered to support implementation. The three phases are as follows:

- **Phase One – Information.** The DHB is required to provide detailed information to the Ministry to inform the Ministry's business case to Ministers of Finance and Health. The final Phase One information is due in February 2020.
- **Phase Two - Planning.** The DHB is required to plan for set up for establishing the service for 'go live'. This is to include various plans for workforce, equity, communications, primary care engagement, governance, leadership, accountability, etc.
- **Phase Three – Establishment:** The Ministry of Heath will assess our readiness and confirm that we can go live in the programme. Thereafter, the programme will be commenced locally.

Thank you. We look forward to receiving your thoughts and input that you might have to offer in preparation of the final draft of this **Phase One – Information** document our DHB

Kylie /Megan – could you be so kind as to forward this to the members of Tatau Pounamu for their consideration.

Many thanks – Peter McIntosh
Planning and Funding
West Coast DHB.

Appendix One: DHB Information template

National Bowel Screening Programme

West Coast 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 2020/21 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

	Position
Document ID	National Bowel Screening – Draft Business case WCDHB NBSP 20-21 Implementation
Document Owner	Peter McIntosh
Issue Date	31 / 10 / 2019
Last Saved Date	31 / 10 / 2019
File Name	National Bowel Screening – Draft Business case WCDHB NBSP 20-21 Implementation

Document History

Version	Issue Date	Changes
0.2	02 May 2019	Template for DHB completion
1.0	31 Oct 2019	WCDHB Draft Version 1 submitted to MoH

Document Review

Role	Name	Review Status
Research and Planning Officer	Peter McIntosh	31 / 10 / 2019
Operations Manager	Robin Rutter-Baumann	31 / 10 / 2019

Document Sign-off

Role	Name	Sign-off Date
General Manager	Philip Wheble	31 / 10 / 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.

[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. For West Coast DHB, a combined equity plan will be developed in partnership with Maori to ensure that Equity and Accountability principles are at the front and centre of everyone's minds. The combined plan will be developed alongside the Primary Care plan to enable equity activity and measures to be threaded through the Primary Care plan;
- 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;

[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

- 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. For West Coast, a local steering group will be formed with strong participation from Maori. Ethnicity data will be collected and mechanisms to monitor locally in place. Clinical staff will be engaged in the discussion around equity in bowel screening.

Regional strategies to address inequalities are described in Section 3.4.

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.

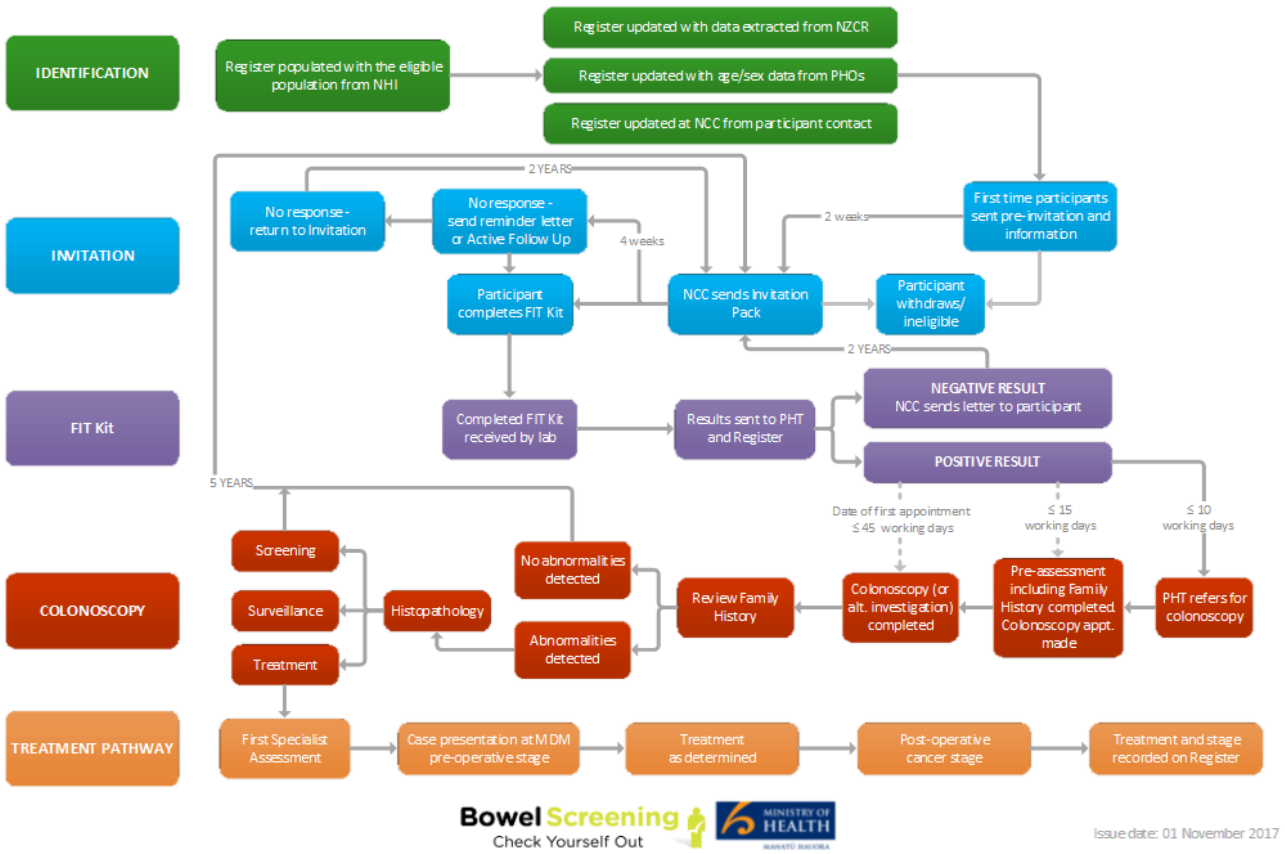

Figure 1: Bowel Screening Pathway, 1 November 2017

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.

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[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.

- **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 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 commenced in 2016 and will 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 West Coast DHB Overview

DHB population

The West Coast DHB (WCDHB) has the smallest DHB population with 32,475 people (Statistics New Zealand 2018 population projection), and the third largest geographical area. By road, WCDHB covers an area from Karamea in the north to Jackson Bay and Haast in the south, Otira in the east. In length, the distance from Karamea to Haast is similar to that between Auckland and Wellington. The east is bordered by the Southern Alps, which at times isolates the district from other areas; particularly during winter. The WCDHB is the most sparsely populated DHB in the country with only 1.4 people per square kilometre. 57% of the West Coast population lives in the largest town centres of Greymouth (9,700), Westport (4,660), Hokitika (3,090) and Reefton (1026); with the remaining 43% of the population widely spread in small, very rural communities across the district. There is no public transport between centres on the West Coast. **These distance and isolation factors create transport and travel issues for many West Coast people in accessing services.**

There are three Territorial Local Authorities within the WCDHB area: Buller, Grey, and Westland.

WCDHB own and manage three major health facilities in Greymouth (Grey Base Hospital), Westport (Buller Health) and the Integrated Family Health Centre in Reefton. These incorporate DHB-owned primary practices. WCDHB also own a primary practice in South Westland, and operate primary care clinics from centres across the West Coast, via a mix of rural nurse specialists and general practitioners. There are three private general practices on the West Coast, located respectively in Westport, Greymouth and Hokitika. All seven general practices on the West Coast are members of the West Coast Primary Care Organisation (West Coast PHO).

Since 2010, West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes a joint Chief Executive and clinical directors, as well as shared public health and range of corporate service teams.

While the West Coast has always had informal clinical arrangements with the Canterbury DHB, the shared model has allowed these to be formalised through clinically-led transalpine service pathways. This formal arrangement enables the West Coast DHB to develop the workforce and infrastructure needed to ensure we can meet the needs of our population, in a clinically and financially sustainable way.

WCDHB employs permanent resident Specialists in general medicine, general surgery, gynaecology and obstetrics. Canterbury Specialists provide regular outpatient clinics and surgical lists on the West Coast. Deliberate investment in telemedicine technology is also improving access to specialist advice while saving families the inconvenience of travelling long distances for assessment and treatment.

The overall resident population on the West Coast is predicted to decline slightly between 2018/19 and 2024/25 based on Statistics New Zealand population projection estimates and trends; dropping overall from 32,475 to 32,175 during these years.

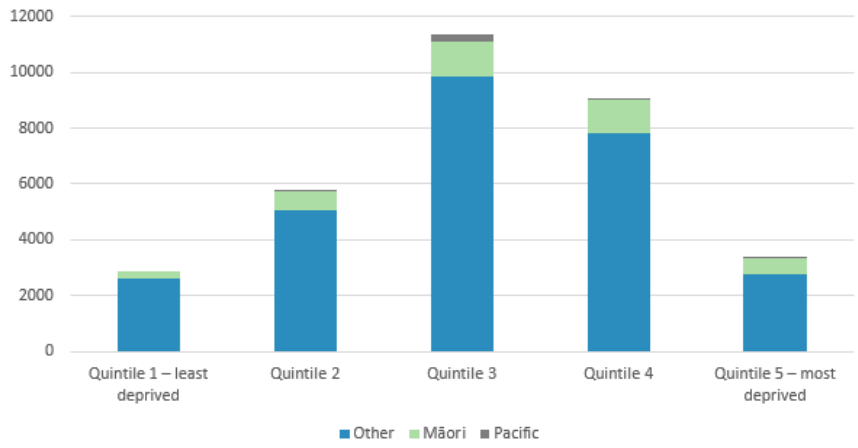
The West Coast's population tends to be significantly older than the national average.

West Coast has a lower proportion of Māori living there compared to the national average and very few Pacific people. Approximately 12 percent of the population is Māori, and 1.2 percent come from the Pacific Islands or are of Pacific Island descent.

West Coast has proportionally more people in the middle sections of the population, and fewer in the most and least deprived sections.

Deprivation, 2018/19

West Coast has proportionally more people in the middle sections of the population, and fewer in the most and least deprived sections.



NBSP Eligible Population

West Coast DHB has an eligible population (60-74 years) of 6,505 projected for the 2020/21 Financial Year, this is 20% of the total population.

As noted above, the West Coast's population tends to be significantly older than the national average. Proportionally, the percentage of West Coast people aged over 60 is predicted to increase against the overall resident population. Among those aged 60-74, the relative proportion is expected to rise from 20.1% (6,505) to 21.7% (6,990) by 2024/25. The split of total West Coast population aged 60-74 in 2020/21 is estimated at 3,455 males and 3050 females. This is anticipated to rise to 3,650 males and 3,340 females by 2024/25.

Māori and Pacific Island peoples are considered to be priority populations for the Programme. The current Maori population aged 60-74 years on the West Coast in 20120/21 is estimated to be 410; including 180 males and 230 females. This is estimated to rise to 530 by 2024/25; including 240 males and 290 females. The Pacifica population are estimated to be 0.6% of the total population aged 60-74 on the West Coast in 2020/21 (40 people), and rising slightly to 0.86% by 2024/25 (60 people).

The table below gives the projected NBSP eligible population size at the end of the planning period. This table uses Stats NZ estimates of population; so 2020/21 population is slightly variant (0.6%) from overall volumes used in Ministry of Health modelling:

West Coast DHB Eligible Population	2020/21	2021/22	2022/23	2023/24	2024/25
	60-74	60-74	60-74	60-74	60-74
Maori Male	180	200	220	230	240
Maori Female	230	230	250	270	290
Total Maori Population	**410**	**430**	**470**	**500**	**530**
Pacific Male	25	25	25	30	35
Pacific Female	15	15	15	25	25
Total Pacific Population	**40**	**40**	**40**	**55**	**60**
Asian Male	50	50	55	60	65
Asian Female	55	65	70	70	75
Total Asian Population	**105**	**115**	**125**	**130**	**140**
Other Male	3200	3250	3290	3300	3310
Other Female	2750	2820	2850	2910	2950
Total Other Population	**5950**	**6070**	**6140**	**6210**	**6260**
TOTAL ELIGIBLE MALES	3455	3525	3590	3620	3650
TOTAL ELIGIBLE FEMALES	3050	3130	3185	3275	3340
TOTAL ELIGIBLE POPULATION	**6505**	**6655**	**6775**	**6895**	**6990**

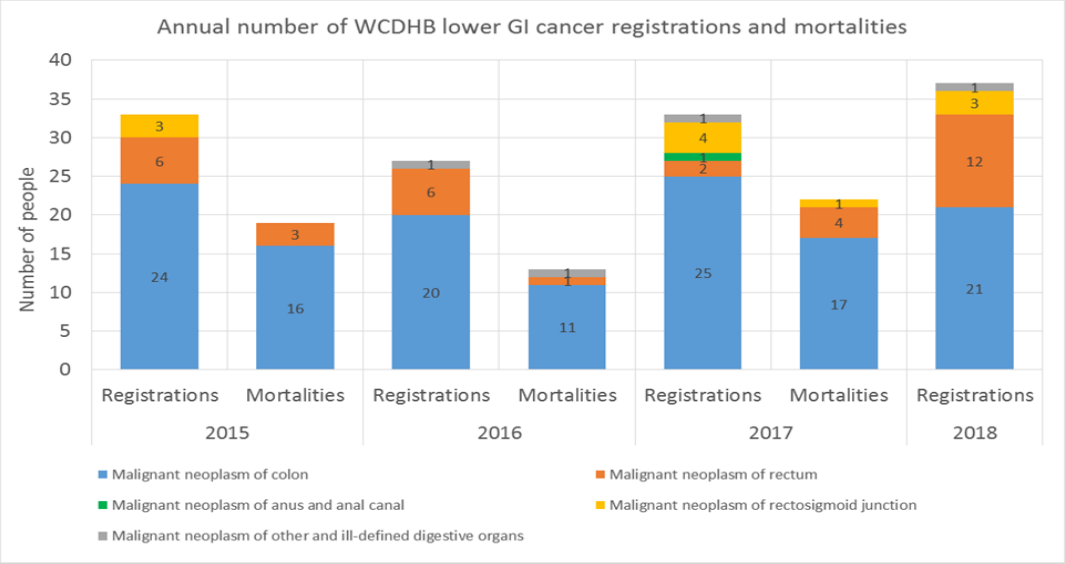
2.2 Bowel Cancer

Cancer Rates

Cancer registration and mortality data has been examined by the national Health Quality and Safety Committee (HQSC) for the five years 2009-2013 inclusive. West Coast DHB bowel cancer rates are statistically above the national average with 76.5 patients per 100,000 people, and as such, the region has the eighth highest rate in the country and the third highest mortality rate at 36.5 patients per 100,000.

West Coast DHB has the 3rd highest incidence rate for those ages 60-69 across the country, which is within the age range for the programme (60-74).

The table below shows lower gastro-intestinal and bowel cancer registrations by malignancy site for West Coast DHB residents during the past four calendar years to 31 December 2018; as well as the latest available confirmed bowel cancer mortality rates in the three calendar years to 31 December 2017.



Existing colonoscopy and treatment services

Service delivery:

Endoscopy Services: Colonoscopy is currently provided on the West Coast at Grey Base Hospital by three FTE General Surgeons; including two permanent resident General Surgeons (Mr Pace and Ms Mosher), as well as two visiting locum General Surgeons who job-share to make the third FTE position (Mr Naidoo and Professor Baxter). Professor Baxter is currently clinical lead for our Endoscopy User Group. This Group meet monthly at present, but is likely to need to scale up as the NSBP rolls out.

All the General Surgeons have colorectal skills and experience. None of the colonoscopy workload is currently outsourced. West Coast DHB is not a training centre and has no Surgical Registrars on staff. There are no GP trained endoscopists and no trained nurse endoscopists and no current need, or plans, to consider these workforce options.

Diagnostic services for symptomatic patients are provided on referral. Locally available diagnostic services at Grey Base Hospital include laboratory (for blood and faecal specs), CT (Computerized Tomography) and CTC (Computed Tomography Colonography), X-ray, ultrasound, and surgical colonoscopy and flexible sigmoidoscopy. Colonoscopy provision is based on the national direct access prioritisation guidelines. Prioritisation is undertaken by our permanent General Surgeons and reviewed for consistency. For all patients who do not meet criteria, the referrer receives a letter either requesting further information, suggesting alternative management or an alternative diagnostic test is arranged.

Surveillance colonoscopy provision is now guided by the 2015 NZ Guidelines Group document and recommendations from the New Zealand Familial Gastro-Intestinal Cancer Service (NZFGICS). The recall process is managed within WCDHB.

CTC (Computed Tomography Colonography) is available at Grey Base Hospital and national access guidelines determine acceptance of referrals to this service. Around 10 CTCs are currently completed per month at Grey Base Hospital. CT and CTC can usually occur on the day of colonoscopy if required. This can be done on the day of finding a tumour – to save the patient having to have a second bowel preparation; and then when the patient comes back for outpatient review, the required information from the CTC is already available well in advance for planning and undertaking the operation.

Familial services: With their consent, Category 3 patients are referred to the New Zealand Familial Gastro-Intestinal Cancer Service (NZFGICS) based in Christchurch. GPs on the West Coast may also refer patients to this service, and make quite a number of these. The Christchurch-based genetics service provides assessments for West Coast domiciled people; however they run outreach clinics in Greymouth three times a year for non-acute genetic health assessments and are seeing Lynch Syndrome patients.

Histopathology / Laboratory: Canterbury Health Laboratories (CHL) provide a complete range of laboratory services for West Coast DHB. These services encompass both core laboratory and specialist testing on a 24 hour, seven-day basis. As well as having its own laboratory at Grey Base Hospital, West Coast DHB also accesses Canterbury Health Laboratories' main site at Christchurch Hospital.

Multi-Disciplinary Meetings (MDMs): West Coast surgeons and Cancer Nurse Coordinator (CNC) are able to link into the Canterbury and South Island regional MDMs to discuss bowel and other tumour cases. The onsite General Surgeon and/or CNC refer and present cases for review via HealthConnect South MDM video-conference applications. Some 90% or more of our colorectal cancer patient cases are presented to MDMs held in Canterbury.

Surgery: Patients with colorectal cancer generally travel to Canterbury DHB for their surgery; although some limited surgery is now undertaken at Grey Base Hospital on cases of lower complexity (such as right side hemicolectomy) which are undertaken by our General Surgeons. Cancer Nurse Coordinators on the West Coast and in Canterbury work in the surgical space, providing support to patients as outlined in the Ministry of Health faster cancer treatment initiatives support programme: https://www.health.govt.nz/our-

work/diseases-and-conditions/national-cancer-programme/cancer-initiatives/cancer-nurse-coordinator-initiative Support is also provided through the West Coast DHB's National Travel Assistance (NTA) Coordinator for NTA-eligible people who have to travel to have specialist clinical assessment and surgery in Christchurch.

Oncology Services: Oncology services are delivered as an outreach service from Canterbury DHB and are provided primarily through a nurse led service based in Greymouth Hospital. West Coast DHB's oncology Clinical Nurse Specialists (CNS) provide an advanced practice level of care and coordination care of patients affected by cancer from early detection to diagnosis, treatment and transition through to discharge or palliative care. Chemotherapy regimes for patient are scripted by Oncologists in Canterbury DHB. The West Coast DHB oncology CNS team then deliver most of the chemotherapy in Greymouth autonomously, with MOSAIQ programme delivery ensuring clinical oversight. Monthly medical and radiation oncology outpatient clinics are provided at Grey Base Hospital by visiting Consultant Specialists for Canterbury, along with regular visiting Specialist Haematology outpatient clinics.

Radiation therapy treatment for West Coast DHB residents is undertaken in Christchurch through the services of Canterbury DHB and at St George's hospital.

Waiting times: Overall, colonoscopy waiting time targets have been met consistently since late 2016; any months of non-compliance were down for just one or two patients. (See Appendix 4 for our performance data by month over the past three financial years.) Our monthly volumes of patients waiting for colonoscopy are relatively low, so variance in wait time for a few cases can tip us into the "red" for non-compliance – but this is due to a temporary issue rather than a systems constraint.

To help inform theatre session planning and throughput to manage wait lists, weekly meetings are held with our Central Booking Unit and Endoscopy nurse to review surveillance and active endoscopy waiting lists and wait times. The Endoscopy nurse reviews the process of getting people ready for wait-listing underway. The performance against the waiting time targets is also discussed at the Endoscopy User Group (EUG), and the South Island Regional Centre Oversight group. It will be important for West Coast DHB to develop a NBSP Steering and Clinical Governance Group to monitor the achievement and maintenance of these targets, and to support the work of the EUG at an operational level. This Group will be important to ensuring the sanctity of theatre space for cancer scoping, resolving any potential encroachment issues that may emerge for competing surgical demands, as well as engaging collegial approaches to resourcing of further supports for patient found with a confirmed finding of bowel cancer. It is envisaged the Group would monitor progress on the NBSP both prior to and post-implementation, and report back to the General Manager – West Coast.

To help manage the endoscopy waiting list load and maintain patient wait times, extra theatre lists are added where required; usually on a Friday. Sometimes, an extra patient may be added to an arranged (elective) general theatre list. Where patients cancel appointments in advance with sufficient notice other patients can be brought on to replace them on lists as soon as possible. At times where scheduled general anaesthetic list numbers are low, then this can sometimes be converted in to an endoscopy list (either in part or in whole). **Further work will need to be undertaken as part of the NBSP roll-out to reach consensus on start times and numbers of procedures per session that can be put on theatre lists (and related support capacities) as part of our move to the new hospital at Greymouth in early 2020.**

There is some reliance on patient compliance too, that need to be taken into consideration to help keep the patient flow and timeliness to endoscopy; including returning their completed health survey questionnaire; confirming their appointments; taking bowel preparation and diet as directed; and turning up on the day for surgery.

A number of steps are taken by West Coast DHB to help mitigate these risks of patients becoming medically unsuitable for surgery, or a "Did Not Attend" on the day of their appointment. As noted above, our Endoscopy Nurse is actively involved in checking patient's physical preparedness in advance. The DHB's Central Booking Unit and Main Reception support staff actively phone patient in advance to check that they have received their notifications of appointment through the mail and confirm that they are able to attend

on the day scheduled, that they have transport and support person(s) to get them to hospital, if they need support, etc. In spite of these best endeavours, patients at times still do not attend for a variety of reasons beyond influence or control.

Given the frequency of mail turnaround and reduced numbers of mail delivery days to just three per week for town delivery, (and longer in more remote and rural areas of the West Coast), it is noted that there are still some gaps in getting patient health survey questionnaire out to some patients and returning them in a timely fashion – especially for urgent colonoscopies. **This is an area that we will need to bridge with additional phone calls and discussion with patients, with permanent additional in-house resourcing**.

In supporting the programme and the work of the Endoscopy Nurse, Faster Cancer Treatment Waiting time results for people accessing cancer services are reviewed by our Cancer Nurse Coordinator (CNC). Patients who breech the timelines are reviewed and their delay events are explained to the DHB board and the Ministry of Health. Where themes occur, projects are undertaken by the CNC or the Southern Cancer Network to work to address these issues. The West Coast DHB's Local Cancer Team will also be kept up to date on the progress of patient waiting times and any emergent systems issues that might arise in regard to delivery of the NBSP for West Coast residents

Endoscopy Delivery: It is expected that there will be capacity in-house for the additional colonoscopies generated by the NBSP, using resident and visiting Specialist General Surgeons as provided at present. However, credentialing requirements in terms of meeting minimum endoscopy surgical volumes per Specialist, is likely to require support to local services from other visiting Specialists, and/or for our resident Specialists to spend some time in other DHB districts undertaking procedures to ensure ongoing accreditation in the NSBP. Shared services of this nature will need to be further considered as part of the ongoing South Island approach to managing the NSBP over time. **This will be an important feature for the West Coast DHB's continued readiness and ongoing need for capacity for the NSBP to be sustainable, given the relative number of cases in our district.** This will come at an additional financial cost over time to provide.

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; New Zealand Cancer Action Plan 2019-2029; Bowel Cancer Quality Improvement Report 2019; National Bowel Screening Programme endoscopy Manual (September 2019); Fast Cancer Treatment Programme; 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
New Zealand Cancer Action Plan 2019 – 2029 (*released 31 August 2019*)	This will be a critical overarching document to the direction, development and future implementation of West Coast DHB's future Annual Plans, System Level Measures Improvement Plan, as well as regional strategies. NSBP will contribute to the delivery of the Action Plan strategy and goals at a local level. West Coast DHB has committed to work with the Ministry of Health to support progressive implementation to deliver on the local actions from within the Cancer Action Plan.
West Coast DHB Annual Plan 2019/20	Our Annual Plan outlines our commitments to align and to help support and deliver national strategies to improve cancer awareness, service responsiveness, and equity for our population. To achieve this, West Coast DHB's 2019/20 Annual Plan includes a specific section on our focus on Cancer Services and a specific section on our steps for preparation for initiating local roll-out of the National Bowel Screening Programme (NSBP) on the West Coast in 2020/21, in line with Ministry of Health timeframes. The Plan includes our actions and investments to improve and maintain local service

Strategy	Summary of Alignment
	performance; actions arising from our System Level Measures Improvement Plan; meeting set milestones toward supporting the path to roll-out of the NSBP; engagement with local iwi towards achieving equity; as well as engagement with partner agencies to promote screening and seeking early advice and intervention. In addition to local initiatives, the Plan also outlines our commitment to working with the regional Southern Cancer Network to achieve goals and strategies for achieving timely access to diagnosis and treatment, consistency and quality of care for people with cancer. (*see South Island Health Services Plan 2019-22 strategy note below.*) Our measures for success in the NSBP are identified as being: • 90% of people accepted for an urgent diagnostic colonoscopy receive their procedure with 14 days, 100% within 30 days. • 70% of people accepted for a non-urgent diagnostic colonoscopy receive their procedure within 42 days, 100% in less than 90 days. • 70% of people waiting for a surveillance colonoscopy receive their procedure within 84 days, 100% in 120 days. Note: West Coast DHB has not produced a specific Strategic Plan since its 2005-2015 Plan - with our Annual Plans incorporating longer term strategies.
Maori Health Plan	West Coast DHB has not produced a separate Maori Health Plan since 2016/17. However, Maori Health goals, objectives and actions are co-linked and woven throughout our DHB's Annual Plan. The Plan includes development of a reporting framework to track equity for Maori. Equity Outcomes Actions from the Annual Plan are overseen and monitored quarterly by our DHB Operational Leadership Group and by Tatau Pounamu – our manawhenua Advisory Group to the DHB Board.
South Island Health Services Plan 2019- 2022	South Island Alliance plan is to support DHBs to implement the national bowel screening programme and manage the impact of implementation on delivery of cancer care and treatment through the following approach (reference: page 40 of the draft South Island Alliance Health Services Plan. This is currently awaiting sign-off by the Minister of Health): • Regional vision: A connected equitable South Island health and social system that supports all people to be well and healthy. • Priority focus areas: e.g. turning data into information that supports decision making; acute demand management, improving whole of system patient flow; improving equity for Māori. • Development of clinical leadership and linking clinician and operational leaders. Equity of access is a key priority for the Southern Cancer Network (SCN), with a focus through the Network and its steering and leadership groups on o pathways to achieve more timely access to diagnosis and treatment o consistency and quality of care.

2.3 Main Benefits and Dis-benefits

Approach

In addition to contributing to the Programme-wide benefits (see appendix 1), local benefits and dis-benefits are outlined below in Table 2.

Table 2: Local Benefits of Implementing NBSP

Benefit	Summary
Promote bowel health and	• The West Coast DHB population often present late or acutely across a

encourage symptomatic presentations.	range of services. There are local models where the community has been successfully engaged to increased public awareness of the need to get screened which will be reviewed for their applicability to bowel screening e.g. urology. • Effective community engagement about bowel health and encouragement of patients to present if symptomatic, or have family history or any other concerns will be key to saving lives.
Increased focus on endoscopy services and quality standards	• The Gastroenterology service is improving documentation to ensure consistency of service provision. This will need to follow the National Endoscopy Quality Improvement Programme guidelines and documentation (including global rating scale) and ensure quality of the programme and the service's wider quality management systems.
Mutually positive relationship with primary care	• Close working relationships already exist between primary and secondary care, and this will continue to be an essential component of a successful bowel screening programme. The West Coast has a unique primary care system with the DHB owning 5 out of the 7 general practices that operate on the West Coast, and services being provided by a mix of rural nurse specialists and general practitioners. • Seek interest of a General Practitioner to be part of our DHB Endocsopy User Group. • Our Electronic Records Management System (ERMS) supports initial GP referral. Letters are sent to General Practice for surveillance patients needing re-scope. This latter group of patients are all now wait-listed at West Coast DHB on our inpatient management system without the need to refer.
Mutually positive relationship with Māori	• Prioritising equity will enable meaningful engagement with Māori to make bowel screening a success and will lead to stronger relationships with Māori, with our two local runaka (Ngati Waewae and Makaawhio) and our district-wide Māori health provider (Poutini Waiora) and with Tātau Pounamu, our Manawhenua Advisory Group.
Support the ongoing development of system wide, multidisciplinary teamwork and development of cancer pathways	• Implementation of bowel screening programme will support this aim, both within West Coast DHB and between regional DHBs as well as the interface with primary care providers. • Communication is key. Good liaison exists between the West Coast DHB's Cancer Nurse Coordinator, our Central Booking Unit, the Endoscopy Nurse and EUG for patients with a high suspicion of cancer and those with confirmed cancers. This will be further strengthened with the implementation of the NBSP.
Enhance IT system utilisation and information quality.	• Quality standards required for bowel screening necessitate the ability to extract data from ProVation® endoscopy reporting system. Our Inpatient Management System is currently used for surveillance patient waitlists managed by West Coast DHB, rather than getting GPs to re-refer, saving unnecessary time and resource for general practice. Direct referral is automated for these patients. • Data from ProVation is being pulled and analysed by our EUG. Our DHB inpatient management system and HealthConnect South are also a key information technology enablers in this space.
Dis-Benefit	**Summary**
Cost to the DHB of the additional colonoscopies that occur as a result of the NBSP that is unfunded by the project	• An additional colonoscope has to be added to our fleet to cater for the increased demand required to deliver the NBSP volumes. • As shown in section 4 the indicated cost of patient medication, consumables, cleaning etc., per additional colonosocpy is considerable when multiplied by the approximately 110 additional colonoscopies per annum (expected to be rising to 120 by 2023/24). This cost will

	potentially not be offset for some years but our funding is fixed at the present time.
Cost of providing increased additional services within fixed revenue	• The need to undertake additional bowel cancer surgery and related support services such chemotherapy and/or radiotherapy (which is provided by Canterbury DHB as a tertiary provider) will result in reallocation of existing resources – and this will negatively impact on delivery of other elective surgical volumes and on our financial position. • Funding for surveillance scopes is not at National Pricing may not cover the total cost of service provision. • The time required to complete the NBSP patient colonoscopies impacts on the number of colonoscopies able to be completed per session (and increases relative theatre costs per procedure as a consequence).
Increased contracting NBSP accredited endoscopists	• With only 3 FTE of WCDHB endoscopists accredited to provide NBSP colonoscopies we are vulnerable to any change in personnel (due to retirement or resignation). If any one of our team was to cease working the remaining staff would not be able to manage the volume of endoscopy and other surgical work and maintain a roster for on call service, we would therefore need to outsource procedures and NBSP colonoscopies would be amongst these.
NBSP colonoscopies will commence during a time of generalised increase in demand for endoscopy services – both locally and at Canterbury DHB	• Increased awareness of bowel cancer/screening is driving increased demand for colonoscopy service in other DHBs that have gone live with the programme and this will need to be factored into West Coast DHB planning. • Increased awareness of the Bowel Cancer from the roll out of the Bowel Screening Programme in other South Island areas, as well as increased media coverage and public awareness campaigns of those not part of the target population for NBSP will provide an increased demand for colonoscopy service locally as well as clinical supports West Coast DHB is reliant upon through Canterbury. • 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 due to simultaneous competing demand for resources (especially theatre resource). This is likely to be an added impact on Canterbury DHB, where most of the follow up bowel surgery is undertaken for West Coast residents • Most of these surgeries will also require chemotherapy (which is primarily delivered locally) and/or radiotherapy (which is provided by Canterbury DHB as a tertiary provider). Tertiary radiotherapy services, in particular, are an area that is 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. • The same resource required to meet current demand is also required to meet NBSP demand. • Other elective services may have to be delayed due to competing resources, pushing out ESPI compliance timeframes for some elective cases.

2.4 Key Risks

Table 3 following summarises the 5 highest rated (highest impact and likelihood) risks to the success of the National Bowel Screening Programme on the West Coast. See **Appendix 2 : Key Risk and Issue Register** for other factors identified as risk to the programme roll-out and sustainability.

Table 3: Key Risks

Key Risks	Likeli hood	Impact	Summary and Risk Management Strategies
If the population is not engaged then participation will be lower than the targets, and more importantly - cancers will go undetected, leading to unnecessary deaths.	Medium	High	• The West Coast is sparsely populated, with areas with limited, or non-existent, cell phone or internet coverage. This means some promotional activities from other DHBs will not be transferable and new strategies will have to be deployed (eg. Use of phone book advertising) • The DHB will actively test, review and modify their promotional/community and equity engagement methodologies to continually improve participation. • Primary health care services such as General Practice and Poutini Waiora, and support agencies and community groups such as the West Coast Cancer Society, Iwi networks, Grey Power, Rotary, Lions, etc., will be critical in helping to gain and maintain community awareness and engagement in getting screened.
If communication with patients is not timely and effective, then this may result in patient treatment delays and failure to provide care in a timely fashion, exacerbating the progress of disease	Medium	Medium	• There are a number of people on the West Coast who live with limited social connections; live alone; and/or are living in particularly isolated areas. As well as physical communication barriers, understanding is another communications-related barrier for many individuals when engaging with health services for new and threatening disease such as cancer. • Physical visits to patients by the Cancer Nurse Coordinator, District Nurses, PHO navigators, etc., may be required where telephone connections with patients are poor and/or non-existent. • Close communications will be required at a personal, individualised level to work wit those people who are hard to reach or engage in health services (including individual reluctance to use or refer to health services until they perceive it to be “absolutely necessary” – which is often too late) • Use of navigators and other supports to help assist individuals seeking assistance in health literacy and understanding around processes, their diagnosis, their treatment options, and during their active

			progress through the treatment pathway. • Improved individualised communications and support for those who have poor social supports, and those who live alone or in remote / isolated areas can impact on having bowel preparation prior to endoscopy screening, and to help overcome isolation post-sedation and recovery. • Close communication between trusted clinicians and those pockets of special nature in our community with particular views about engaging certain elements of formal health services, to encourage them to seek early assessment and treatment.
If space for endoscopy lists in theatre space are not available, then this may result in avoidable treatment delays for patients, as well as failure to meet FCT targets	Medium	Medium	• West Coast DHB currently only requires 4 to 5 endoscopy sessions per week on a roster. Demand modelling shows additional sessions are not required to accommodate the NBSP volumes but this can be affected by disruptions due to inability to deliver a session • Ensure dedicated endoscopy theatre sessions are made sacrosanct and not given over to other demands from other services (cancer screening and treatment to be put ahead of demands of other non-acute and non-cancer services in order to meet ESPI compliance, for example). • Allow for Friday morning meetings and weekly surgical peer review and EUG. • Ensure there is sufficient theatre space and time for conducting bowel screening for people presenting with a suspicion of cancer who do not fit into the NBSP target age cohort, so that they are not inadvertently disadvantaged from receiving timely diagnosis and treatment.
If strategies with regard to kit returns are not put in place then the number of spoilt kits on the West Coast will be high.	Medium	High	• Rural postal services are currently problematic • WCDHB will work with the NZ Post/ courier companies and the National Coordination Centre (NCC) to inform of, and test, timeframe requirements. • Before go-live work with NZ Post and NCC on a trial to determine postage time. • Monitor spoilt kits returns based on location. • Consider drop off site, monitor if this strategy is implemented.
If there is periodic influxes of referrals that are not evenly spread then this could create a bottlenecks and delays in patient	Medium	Medium	• This will need to be closely monitored by Grey Base Hospital Clinical services, Endoscopy Nurse Coordinator and Endoscopy User Group, and factored into weekly West Coast DHB theatre session planning and booking to ensure timely and equitable access for patients to services according to their triage of

care.			relative urgency; ensures continued ESPI compliance; and services are rescheduled if necessary, in a way that minimises impact on delivery of other elective and planned care services as best possible. • Close liaison and factoring of potential impact on other locally delivered support services such as chemotherapy and radiology will also need to be undertaken; as well as liaison with services provided by and/or supported through Canterbury DHB where such bottlenecks may be potentially material to individual patient care and/or to wider systems process.

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
Personnel Resourcing	• Additional staff will need to be recruited to support the patient volumes generated by the NBSP (see section 4) • Endoscopists will need to demonstrate they meet the Quality Standard. • Staff resource back-up from Canterbury DHB (or other South Island DHBs as part of a South Island solution) to help cover sick and annual leave, etc., and vice versa - with the opportunity for our staff to work and credential in other DHB services. • Limited capacity to expand theatre sessions due to staff resource – set numbers of qualified nurses, anaesthetists, and anaesthetic technicians.
Theatre Capacity	• West Coast DHB has the resourcing capacity to run two theatres at a time, with an on-call available theatre for acute emergency presentations. New hospital to be opened in early 2020 has 3 theatres (compared to four in the current facility)
Dependencies	**Notes**
Surgery capacity at Canterbury DHB – sustainability and timeframe	• Canterbury DHB still able to take our complex surgery cases (both open and endoscopic) for scopes for patients with complex co-morbidities and/or polyps that are complex to remove by scopes alone, while not impacting on waiting time for patients, and being able to be delivered alongside Canterbury's own increased demand for more endoscopy arising from the NBSP for its population.. • As our lead tertiary provide for West Coast residents, Canterbury DHB interventional colonoscopy, general surgery, pathology, radiology and oncology services capacity is limited to absorb short-term increases 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. • **See also section 2.3 Dis-benefits above regarding the wider impact and implications on services supported by and through Canterbury DHB for West Coast residents.**
IT platform is workable and data is 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. (which is the system West Coast DHB is currently using for current endoscopy) • 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

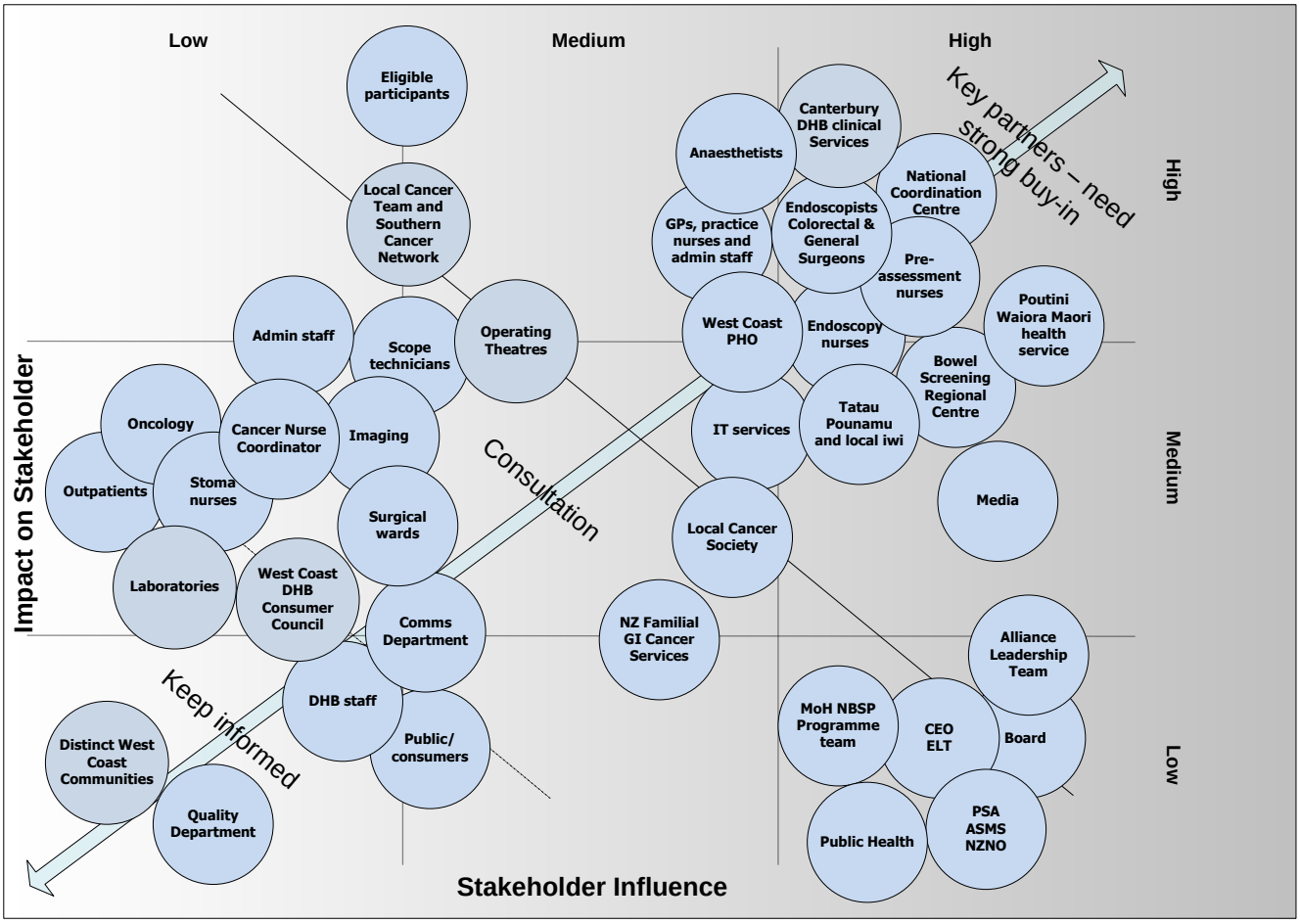
	software package.
National Screening Solution (NSS)	• The National Screening Solution must be in place by "go live" for our district. This is outside of West Coast DHB control and is being managed by the NSU. • If the NSS is delayed, it will affect our go-live date.
Primary care	• Primary care agreement must have been reached for Bowel Screening to commence. This will be formulated as part of the Phase 2 of the roll out of the NSBP on the West Coast; although implementation of the programme has been mutually discussed already through our Local Cancer Team meetings. There is 1 PHO on the West Coast
Staff recruitment	• Appropriate staff must continue to be engaged and recruited – especially important in any succession planning
Business case sign-off	• The business case for bowel screening at West Coast DHB is completed and signed off in the appropriate timeframe; specifically Final Draft of Phase One – Implementation by February 2020.
Treasury business case	• Treasury business case must be approved as part of Phase One – Implementation, for NBSC bowel screening to commence.
Funding	• Appropriate funding must be made available both for implementation and for ongoing costs associated with the Programme

2.6 Stakeholder Engagement

Key Stakeholders

The diagram below represents key local stakeholders who will be key to successful delivery of the National Bowel Screening Programme on the West Coast. These stakeholders are to be analysed to determine impact (the degree to which their business activities are required to change as a result of the implementation of the NBSP) and influence (the degree to which they can positively or negatively influence the development and implementation of NBSP).

Figure 2: Key Stakeholders



Stakeholder Communication and Engagement Approach

In preparing this business case and undertaking initial planning for the implementation, the main meetings and workshops have been held to date with key stakeholders. This process is ongoing and iterative.

Table 5: Key Stakeholder Communication and Engagement Activities to Date

Event	Purpose	Period/Date
Grand Round	Presentation at the West Coast DHB grand round on NBSP by Maree Duncan.	Sept 2018
South Island regional bowel screening workshop	South Island regional bowel screening workshop undertaken in Christchurch 20 February 2019. Workshop aim was for South Island regional bowel screening stakeholders to discuss sustainability, collaboration and consistency across the South Island. Key West Coast DHB stakeholders attended workshop	20 February 2019
Implementation planning meetings	Ongoing engagement between the clinical, service financial leads, SIRC and the Ministry NBSP team, to ensure understanding of the NBSP within the DHB, undertake initial high-level planning activities and develop the DHB inputs required for the Ministry Business Case.	13 May 2019 then on- going
Maori Health Team and South Island Bowel Screening Regional Centre (SI BSRC)	Engagement with Maori Health Team	13 May 2019
Local Cancer Team	Ongoing engagement with the Local Cancer Team about the roll-out and timeframes of the NBSC programme for the West Coast. Local Cancer Team includes several consumer representatives, as well as representatives from West Coast DHB oncology nursing and palliative care nursing teams, Cancer Nurse Coordinator, West Coast PHO clinical manager, Poutini Waiora (Māori health service) nurses, community pharmacy, general practitioner, local branches of the Cancer Society, Southern Cancer Network, West Coast DHB General Manager – Maori Health, and West Coast DHB Planning and Funding.	• 6 March 2019; • 22 May 2019 • 14 August 2019 • 9 October 2019
Tatau Pounamu meeting	Engagement with Tatau Pounamu - our manawhenua Advisory Group to the DHB Board – to inform them of the timeframes and process, and to seek their support for the NSBS roll-out.	13 September 2019
West Coast DHB Endoscopy User Group (EUG)	Discussion and meetings with EUG and its chair, Professor Baxter, on the timeframes, process, and engagement for the NSBS roll-out. EUG representatives include our permanent general surgeons, main operating theatre manager, Endoscopy coordinator, Operational Manager, as well as other clinical endoscopy staff as available.	September 2019; then ongoing.
Meeting Professor Baxter	Meeting with Professor Baxter to discuss implementation of the NBSC programme and his involvement in it as Lead Specialist for the West Coast. Meeting with Maree Duncan, Bowel Screening Regional Centre Project Manager; Robin Rutter-Bowman and Peter McIntosh, Planning and Funding, West Coast DHB.	14 October 2019
Endoscopy User Group (EUG)	Monthly meetings of the EUG (including general surgeon, theatre teams representatives, and Endoscopy coordinator) have widely discussed NSBP on the West Coast among their deliberations and continue to be closely engaged.	Regular monthly meetings conducted

Stakeholder Support

For the West Coast DHB, the most influential and impacted stakeholders include internally the endoscopists/surgeons, operating theatre staff including anaesthetists, pre-assessment and endoscopy nurses, local IT services, Māori health team, GPs, practice nurses, rural nurse specialists and administrative staff. External linkages include the South Island Screening Bowel Regional Centre (SI BSRC) and the SI BSRC Oversight Group (including via email and phone via Maree Duncan) which includes clinical leads from all SI DHBs. The SI BSRC Oversight group meets 6 weekly and offers support to SI DHBs in their implementation of the NBSP.

Key engagement and communication activities to date include: exploratory discussions and implementation planning meetings, regular updates at the Clinical Leads Group Meeting, communication/meeting with

West Coast PHO and general practices, Māori health leaders via Tatau Pounamu and Poutini Waiora, and engagement with West Coast DHB endoscopists and anaesthetists, gastroenterology nursing team, SMOs and surgical services. As noted above, this process is ongoing and iterative, with future plans for further consultation with Māori via iwi networks; South Island regional networks for support; and with Canterbury DHB Planning and Funding, histology, and surgical services for complex and high risk patients - especially where this may add to their clinical and related support services burden arising alongside increased demand from other DHBs reliant upon Canterbury. (- which Canterbury DHB have already signalled as challenges in meeting the requirements of the programme particularly in relation to facilities and workforce resources in their NBSC Information statements). These will be important connexions to work upon as we move forward with our implementation plans.

3 Local Implementation of NBSP

3.1 Projected Demand

Based on the modelling provided by the Ministry of Health in the table below, it is predicted that WCDHB will generate 109 NBSP colonoscopies in the first year of implementation, planned to commence from April 2021 (FIT-positive plus surveillance colonoscopies generated from the NSPB). This volume data includes the expected volumes of colonoscopies and projected volumes which will move on to treatment.

This number is in addition to colonoscopies volumes currently being undertaken through West Coast DHB surgical services. The additional volume equates to an average of 9 NBSP-generated colonoscopies per month; or an average additional 2 patients per week in the first year. The number of FIT positive and surveillance colonoscopies generated through the NSBP is anticipated to rise to 120 cases per annum by the fifth year of the programme on the West Coast.

The number of NBSP-generated surveillance colonoscopies will rise comparatively over time (in the first year, there are far fewer expected – being only those recalled within 3 or 6 months).

Start Date	Jul-20				
West Coast DHB	20/21	21/22	22/23	23/24	24/25
Eligible Population age range	60-74	60-74	60-74	60-74	60-74
Eligible Population	6,545	6,695	6,815	6,945	7,030
Number of invites per annum	3,963	3,622	3,952	3,459	4,069
Number of positive FITs	119	108	90	86	93
Number of cols	107	98	80	76	83
Number of surveillance cols	2	9	15	36	37
Number of cancers	8	7	4	4	5
Number of Months	12	12	12	12	12

Data Source: National Bowel Screening Programme forecasting model, May 2019.

Notes on Projected Demand Data table above:

- Eligible population – the number aged 60- 74
- Number of invites per annum – the number invited over two years along with those turning 60
- Number of positive FITS – number of anticipated positive FITS
- Number of cols - resultant number of colonoscopies from NSBSP – not all positive FIT go to colonoscopy (CTC or not suitable)
- Number of surveillance cols – expected proportion of NBSP colonoscopies that are due surveillance in the year. It is not those put onto surveillance.

The National Bowel Screening Programme Interim Quality Standards (July 2017) Standard 7.2 b outlines the maximum number of screening colonoscopies procedures performed over a standard a four-hour screening endoscopy list.

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 may increase 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.

It is anticipated that based on the current working model, there will be sufficient in house capacity available to cater for the additional scopes anticipated to be generated by the NSCP, so long as the criterion outlined in the Plan are met. Use of private capacity or joint working with other DHBs has also been considered, and included in the options described below. A second (outplacing contract) has also been considered and if required may be deployed to assist with meeting increased spikes in patient demand for colonoscopy as a result of the NBSP and will also provide an option for on-going sustainable capacity in the medium-term.

Canterbury DHB provides considerable assistance to the West Coast DHB for the provision of complex endoscopy and gastroenterology services. West Coast will continue to rely on Canterbury and its systems for the implementation and support of our NBSP, and for patient follow-up services generated from it, such as provision of major bowel surgeries that are beyond local capacities.

Patient wait times for Endoscopy are currently managed by the service with close input form our Endoscopy Coordinator, and overseen by the Service Manager, Clinical Director and Charge Nurse Manager.

Option	Strategic fit and business needs	Potential value for money	Supplier capacity and capability within timeframe	Potential affordability	Potential achievability
1. Single service provided from Grey Base Hospital (current model). **PREFERRED**	Allows for business as usual to continue but does not grow capacity or capability for the West Coast DHB.	Fee for service model. No capital outlay required.	No local alternative exists. Outsourcing does not build capability or capacity of the West Coast DHB workforce to address future needs.	Prices fixed internally. Pricing may be difficult to control if there is a dependence on outsourcing of services	Current model.

OPTION					
2. Primary service provided from Grey Base Hospital, but with partial outsource to facilitate increasing volumes of endoscopies where required; in Canterbury and/or Nelson	Allows for business as usual to continue but does not grow capacity or capability for the West Coast DHB.	Fee for service model. No capital outlay required. Likely increase to costs in patient claims for travel and accommodation assistance under NTA scheme	Outsourcing does not build capability or capacity of the West Coast DHB workforce to address concurrent of future needs. May result in loss of skilled staff to other areas; particularly to the private sector in other locations as the demand for private services increase.	Pricing may be difficult to control as dependence on outsourcing increases. Additional costs would accrue from patients who would be eligible for National Travel Assistance	Would need support from other DHBs, and comes at additional cost to system
3. Outsource to another DHB or private provider	Does not grow capacity or capability for the West Coast DHB.	Poor for patient – in terms of equity, access, time, financial cost. Fee for service model. No capital outlay required (but would need to be confirmed in respect of impact on other DHBs). Likely increase to costs in patient claims for travel and accommodation assistance under NTA scheme	Poor for patient – in terms of equity, access, time, financial cost. Unlikely to be able to be absorbed by DHB – so would likely require to be outsourced entirely Likely to result in loss of skilled staff to other areas; particularly to the private sector in other locations as the demand for private services increase. We suffer severe difficulties in attracting Specialists to live locally as it is.	Pricing may be difficult to control as dependence on outsourcing increases. Additional costs would accrue from patients who would be eligible for National Travel Assistance	Would need support from other DHBs – even if outsourced to entirely to private provider; and comes at additional cost to system

On the basis of the analysis described above, the preferred option was ***Option 1*** above for in-house provision of NBSP colonoscopies, because it is well aligned strategically with our current service model and focus on providing equity and access for our resident population, and there is sufficient capacity in-house to manage the projected increase in demand overall.

Option 2*,* for the partial outsourcing of NBSP colonoscopies, was rejected as our main approach because whilst it would be achievable, this approach is not aligned with the NBSP strategic requirements. Outsourcing does not build capability or capacity of the West Coast DHB workforce to address concurrent of future needs. It may additionally result in loss of skilled staff to other areas; particularly to the private sector in other locations as the demand for private services increase. We suffer severe difficulties in attracting Specialists to live locally as it is. This would be an option to deploy in part, to cope with any shortfall in resource and/or backlog in cases that may negatively impact on patient access to services in a clinically appropriate timely fashion.

Option 3, for the total outsourcing of NBSP colonoscopies, was rejected because it would add significant burden to patients and their families/whanau; would come at significant additional costs on numerous fronts; would place additional burden on other DHB services (both in terms of delivering colonoscopy as well as upon their other elective services); and is not well aligned with the NBSP strategic requirements.

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

Greymouth Hospital moves into a new facility early 2020, while the endoscopies will be carried out in the theatre suite, this will meet the required facility standards.

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.

Locally, West Coast DHB has some anticipated challenges for FTE support to set up and initiate the programme, as well as some ongoing additional resource considerations. These are listed below as anticipated for West Coast DHB.

These are separate to any resource considerations that might prove to be emergent at Canterbury DHB in terms of impact on tertiary services and support that they provide for West Coast and other South Island DHB regions in respect of the NSBP roll-out. As such impact is as yet untested, this does not include possible need for Canterbury DHB to increase in-house, or outplaced and outsourced capacity and services from private providers to be available, and that West Coast DHB would be expected to either pay for contract in its own right, or as part of Canterbury DHB or wider collaborative South Island solution.

Anticipated additional staffing required for West Coast DHB	***2020-2021 FTE***	***2021-2022 FTE***	***2022-2023 FTE***	***2023-2024 FTE***
1. Clinical				
Clinical Lead Specialist	*0.1 (from Q2)*	*0.1*	*0.1*	*0.1*
Endoscopist	*0.1 (from Q4)*	*0.1*	*0.1*	*0.1*
Gastroenterologist	*0*	*0*	*0*	*0*
Clinical / Rural Nurse Specialist	*0.25 (from Q3)*	*0.25*	*0.25*	*0.25*
Endoscopy Nurse	*0*	*0*	*0*	*0*
2. Clinical Support Services				

Sterilising	*No additional FTE – will be absorbed within current service arrangement for FTE*			
Radiologist	*Provided by Pacific Radiology – so may be a cost incurred for additional services that they provide for our DHB that they seek to recover over current arrangements - TBC*			
Pathologist	*Provided by Canterbury DHB – so may be a cost incurred for additional services that they provide for our DHB that they may need to recover - TBC*			
3. Support Services				
Administration	*No additional FTE – will be absorbed within current service arrangement*			
Programme Lead/Manager	*1.0 (from Q2)*	*1.0*	*0.5*	*0*
Primary care practice / GP activity	*No additional FTE within current service – but we expect to be charged per patient contact and administrative follow-up undertaken by primary care practices*			
Community Promoter/Outreach	*0.5 (from Q3)*	*0.5*	*0.5*	*0.5*
Total FTE increase	***1.225 (annualised***	***1.95***	***1.45***	***0.95***

3.4 Implementation

IT Capability

This section to be completed once the IT design for the NSS is confirmed.

Engagement with the National Coordination Centre (NCC)

The NBSP Endoscopy nurse will engage with the NCC about participants along the pathway via regular phone calls.

Engagement with Bowel Screening Regional Centre

The West Coast DHB has been active in the SI BSRC Oversight Group, dating back prior to the formation of the SI BSRC when the focus was on Colonoscopy waiting time indicators. Regular communication, including site visit by the SIBSRC team, has been occurring since 2018. WCDHB enjoys the full support of the SI BSRC and all SI DHBs in the roll out of the NBSP.

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.

West Coast DHB enjoys a good, collaborative working relationship with the West Coast PHO through the West Coast Alliance. The West Coast PHO and its primary care providers across the district will be consulted with and supported though established mechanisms and relationships already in place.

The South Island-wide Bowel Screening HealthPathway, electronic referral system and primary care support will be utilised by West Coast DHB.

Engagement with the Laboratory

There are well-established relationships and service mechanisms in place between Canterbury Health Laboratories and West Coast DHB which will be useful for easy inclusion of the bowel screening programme's histopathology requirements.

Engagement with the Regional Tertiary services

As noted above, as our regional lead tertiary provider, Canterbury DHB provides considerable assistance to the West Coast DHB for the provision of more complex endoscopy and gastroenterology services. West Coast will continue to rely on Canterbury and its systems for the implementation and support of our NBSP, and for patient follow-up services generated from it, such as provision of major bowel surgeries that are beyond local capacities.

Radiotherapy and medical oncology is also provided for West Coast DHB residents through the services provided by Canterbury DHB. We are aware the Canterbury DHB has estimated an increase of about 2% in overall Radiation Therapy demand arising from the NBSP from both its own population as well as regional load. Canterbury DHB 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, they plan to use both local capacity at St Georges Cancer Centre and Southern DHB to meet the demand. While Canterbury DHB have indicated that they do not see an issue with the medical oncology work force at this point, the pharmaceutical cost impact of this increase to the West Coast DHB is not known.

West Coast DHB will continue to work closely with the tertiary services in Canterbury DHB to ensure additional West Coast demand arising from the screening programme can be best balanced with ensuring appropriate and timely access to diagnostics and treatment in concert with wider regional load, and that the impact on the colonoscopy and histopathology services and workforces is managed to retain overall equity between symptomatic and screening services.

Quality

The Endoscopy User Group with Clinical Governance support, will ensure the NBSP is implemented, and the ongoing service is delivered, in accordance with the NBSP National Quality Standards. The Project Manager, working across the whole pathway including contracted providers, will facilitate programme quality reporting.

Driving Equity

Addressing inequities in screening participation and access across the screening pathway will be critical to the success of our programme in terms of reaching out to engage our target populations and saving lives. Priority populations for our District are identified in Section 2.1 above.

Key actions to achieve equity include:

- **Overall Approach**: strategies include:
    - West Coast DHB has the benefit of being in the Southern Region BSRC area and will build on successes already being established in the other South Island DHBs.
    - West Coast DHB will engage with as many members of the priority populations through personal Kanohi ki te Kanohi (face to face) communication as possible
    - Health equity assessment tools will be applied to proposed actions to ensure that there is no resulting negative impact or marginalisation on any population, specifically; Māori, Pacific Island people, the disabled, those living rurally and those living in high deprivation areas within the district. We are determined to apply this methodology to ensure equity is achieved.
    - Equity will be a standing agenda item at West Coast DHB Steering Group and the Alliance Leadership Team and West Cosat DHB's Operational Leadership Group.
    - Ongoing analysis of NBSP uptake by ethnicity, domicile and any specific high needs populations will be undertaken, and strategies will be put in place to address identified inequities
    - Identification of champions to promote the value of bowel screening.
- **Māori:** strategies include:
    - Working in partnership with local runaka through the Manawhenua Hauora committee, to ensure the needs of local iwi hapu and whanau are met.
    - Working with our Māori Health providers, particularly Poutini Waiora, to promote the NBSP and connect with some of the harder to reach populations.
    - Identification of, and active engagement with, Māori support networks in secondary, primary and community settings.
    - Engagement with Māori Managers and teams in the hospital sector, as well as community providers on the West Coast, Community and Public Health and Māori staff in the West Coast PHO and Poutini Waiora and as many members of the priority population through Kanohi ki te Kanohi communications as often as possible.
- **Pacific peoples:** strategies include:
    - Working in partnership with Pacific Island People to ensure the needs of local Pacific Island people are met.
    - Working with local churches to promote the NBSP and connect with the local Pacific Island community.
    - Identification of, and active engagement with, Pacific support networks in secondary, primary and community settings.
    - Engagement with Pacific leaders and teams in the hospital sector, as well as community providers on the West Coast, Community and Public Health and Pacific staff in the West Coast PHO and Poutini Waiora and as many members of the priority populations through personal face to face communications as possible.
- **Those living in deprived areas (NZDep 9 and 10):** strategies include:
    - Working with government and non-government organisations locally as a conduit to actively and passively promote the NBSP.
    - Working with the West Coast PHO navigators, Poutini Waiora nurses and Kaimahi, and West Coast DHB community nursing to engage with people in deprived areas as well as those living in very isolated, remote areas up and down the West Coast.

- **DHB identified other population:** strategies include:
    - Working specifically with the West Coast PHO and Poutini Waiora to link up with patients in more remote areas and males within the target age population who are traditionally more reluctant to seek early screening and intervention.
    - Working with other agencies to understand the population who are not enrolled with the West Coast PHO and how we can look to engage with them.
    - Working with service groups and community agencies e.g. Aged Concern, Grey Power, local West Coast branches of the Cancer Society, Maori communities and local Iwi, and other similarly influential agencies, to raise the profile of the NBSP.
    - Working with large local employers and with Ministry of Social Development to raise the profile of the NBSP.
    - Working with providers/ key stakeholders / identified champions to raise awareness of NBSP and reduce barriers to participation; and when finding innovation solutions – encourage promotion of these to champion as great an uptake as possible for NBSP.

Management of Conflict of Interest

West Coast DHB will manage any conflicts of interests as they arise. A process for this will be established as the programme is developed.

As at the time of planning for Phase 1 - Information, the only potential conflicts of interests identified are that some SMOs that we might call upon to help deliver services on the West Coast, and/or are reliant upon for services delivered in Canterbury, who are 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 any outsourced work. The tendering process will therefore be managed by Planning and Funding to ensure Government Rules of Sourcing are followed.

4 Financial Case

4.1 Funding

Provisional Estimate of Input Costs for the Service:

Personnel Costs	FTE	Year 1 2020/21	Year 2 2021/22	Year 3 2022/23	Year 4 2023/24
Clinical Lead (*from Q2, 2020/21*) *	0.1				
Endocsopist (*from Q4, 2020/21*) *	0.1				
Clinical / Rural Nurse Specialist (*from Q3, 2020/21*) *	0.25				
Programme Lead / Manager (*from Q2, 2020/21*) *	1				
Community Outreach (*from Q3, 2020/21*) *	0.5				
Employee overheads (ACC levies, superannuation contribution, leave cover, holiday pay, etc.); being Personnel Costs at 10%					
Personnel Costs Sub Total	**1.95**				
Non-personnel Costs					
Recruitment for additional staff / office fit-out					
Office rental for Programme Project Manager (excluding GST)					
Laboratory *					
GP communication/management of positive results					
Bowel Preparation activities *					
Sterilising consumables *					
Consumables used in each Endoscopy procedure *					
Colonscopy Service Provision *					
Community consultation, incl. Initial equity work					
Ensuring equity (Fono, Hui etc) **					
Impact on National Travel Assistance (NTA) costs					
Advertising - General Promotional advertising					
Advertising- Front page and insert of Yellow Pages					
Travel - Project Manager ***					
Engagement/training/communications					
IT configuration ****					
Purchase of Motor Vehicle for Project Manager (includes depreciation and annual servicing fee for out years)					
Depreciation on colonoscopes, driven by increase in additional volumes					
Non-Personnel Costs Sub Total					
NBSP Implementation Cost Total					
Funding					
NBSP – Ministry					
DHB					
TOTAL					

Notes:

* Assumes 3% price increase each year (from 2019 base price starting point). For bowel preparation medications, sterilising consumables and consumables used in the actual undertaking of each procedure – these are marginally priced up against direct cost per endoscopy procedure only; it does not include overheads such as steriliser processing costs, staff time, depreciation on equipment, etc. Expenditure against these is thus calculated, using an average of 110 additional

procedures arising from the NBSP to derive the annual costs for these three line items above.

** Includes funding for navigators, etc., to support assistance to travel outside NTA for older people in target population who do not have access to their own transport.

*** Estimated based on anticipated mileage per annum required for travel to various venues and events around the West Coast, at current 2019 IRD rate of 79 cents per kilometre.

**** Includes purchase of laptop and cell-phone for Project Manager, along with annual computer program licencing fees and monthly cell-phone charges. **Excludes any IT design or configuration costs that may accrue once NSS is confirmed. Also excludes any reconfiguring costs that might need to be added for IT systems vendors may charge for developing new reporting or of linking other IT systems interaction costs for the overall NSBP roll-out and any ongoing charges, as these are completely unknown. Such IT-related costs can be quite extensive.**

4.2 Management of Financial Impact

Indicative volumes have been provided, that will put a load on treatment services, the endoscopy unit and radiology. Due to partial reliance on services and support provided through Canterbury DHB, some costs are not yet able to be determined in order to be able to embed these in our Annual Plan and the DHB production planning. However, we note the following in regard to complicating factors arising from the implementation of the NSBP:

- Funding offered is based on previous years cost which do not take into account new MECA settlements or year on year cost pressures. This is further complicated by our use of locums and visiting specialists to provide services on the West Coast.
- Funding for surveillance colonoscopies is only 77% of national pricing – it is assumed that this counts on marginal pricing being able to be offered by the DHBs. When a DHB is facility constrained this is not a valid assumption.
- The reimbursements provided per procedure for the screening colonoscopies will not offset the additional costs required.
- Additional costs may be borne by West Coast DHB by Canterbury DHB's need to outplace/outsource some services provided to West Coast residents needing tertiary level services and support in Christchurch (or to Southern DHB for services accessed through Dunedin)
- As noted above, impact on medical oncology pharmaceutical costs to the West Coast DHB arising from the NBSP roll out is not known.

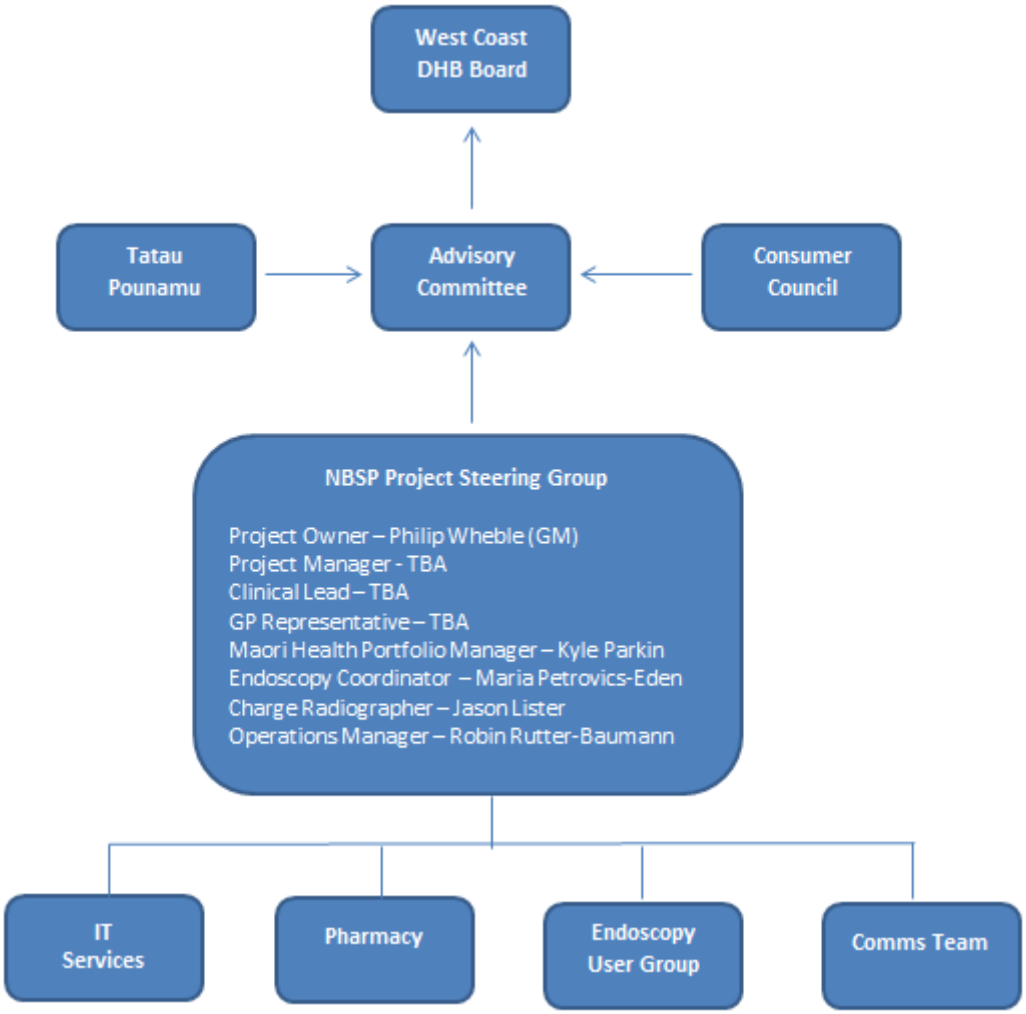
5 Management Approach

5.1 Governance

The governance arrangements for the implementation of the NBSP in West Coast DHB are outlined in the diagram below. Overall accountability for the programme sits with the NBSP Project Steering Group who report to the West Coast DHB Board through the Executive Sponsor and the West Coast DHB Board Advisory Committee.

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

Figure 3: Structure for the NBSP Implementation Project



5.2 Project Management

Approach

The implementation of the NBSP on the West Coast will be coordinated by the Project Manager. The Project Manager will work closely with the NBSP Project Steering Group, the Endoscopy User Group, the Clinical Director, Service Manager and Clinical Nurse Manager, our surgical/oncology teams as well as other services (such as Radiology and Pathology), and primary care services.

The Project Manager will be accountable to the Project Owner and ultimately to the NBSP Project Steering Group who report to the West Coast DHB Board through the Executive Sponsor and the West Coast DHB Board Advisory Committee.

Project Structure and Staffing

The key roles and responsibilities in implementation of the NSBP on the West Coast are summarised below in Table 6. Further identification of the specific personnel to undertake these roles and accountabilities to the NSBP Steering Group and to West Coast DHB service management will be developed as part of the NSBP Phase 2- Implementation.

Table 6: Key Roles and Responsibilities

Role	Responsibilities
Project Owner – Phil Wheble, GM – West Coast	The role of the Accountable Person is to champion and provide support to the project team, to ensure ongoing alignment between the Programme and organisational priorities. The Accountable Person 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.
DHB NBSP Clinical Lead - To be confirmed	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 - To be confirmed	The Project Manager reports to Accountable Person. The purpose of this role is to lead the implementation of the Project within the DHB. The role is accountable to the Accountable Person. 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 alignment with related services provided in and supported by Canterbury DHB • Maintains a risks and issues register, for internal management of the implementation project and for escalation to the Ministry NBSP team as appropriate.

Role	Responsibilities
NBSP IT Representative	• Lead the integration of NSS and other IT requirements • Support the use of Provation in Gastroenterology • Liaising with the MoH Data team as required
NBSP Nurse /Endoscopy Coordinator	• 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 and confirming 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
General Practitioner Representative	• Represent local General Practitioner views in the NBSP (linked via the West Coast PHO).
Equity Lead	• Ensure Equity is a core component of all aspects of the local NBSP
Finance Representative	• Provide Financial expertise into Steering Group
Laboratory Clinical Lead	• Provide Histology and Pathology expertise into Steering Group
Radiology Lead	• Provide Medical Imaging expertise into Steering Group
West Coast DHB Director of Nursing	• Professional oversight and support of Nursing personnel engaged with NBSP

Project Monitoring and Reporting

Local project monitoring and reporting arrangements are to be developed and confirmed. However, as outlined in Section 2 above, it is anticipated that an escalation pathway for emergent issues during the implementation phase of the NSPB roll-out would include is:

- The Project Manager will escalate the issue to the Endoscopy User Group with a recommendation on required/proposed actions and timeframes.
- If the issue cannot be resolved by the Endoscopy User Group, the NBSP Clicnial Lead will escalate to West Coast DHB NBSP Steering and Clinical Governance Group or the Ministry of Health NBSP Team as appropriate, with a recommendation on the required/proposed actions and timeframes.

5.3 Key Milestones

Approximate dates for key milestones for implementation of the NSBP Phase 1 and 2 contract are outlined below in Table 7. These milestones will be detailed once the project management function is in place. See also Appendix 3: *West Coast DHB Implementation Project Programme Plan*.

Table 7: Key Milestones

Key Milestones	Approx. Date
Output 4: Project Management and Governance Framework in place	December 2020
Output 5: Primary Care arrangements in place	February 2021
Output 6: Diagnostic Services in place	February 2021
Output 7: Histopathology Services in place	February 2021
Output 9: IT Integration Workplan confirmed	February 2021
Output 9: Readiness Assessment(s) completed satisfactorily	February 2021

Key Milestones	Approx. Date
Go-live	April 2021
Outputs 4-10: Final Report for Phase 2	June 2021

5.4 Change Management

Change management at the West Coast DHB (related to the implementation of the NBSP), will be led jointly by the West Coast DHB Project Owner and the Operations Manager, with support from the Project Manager and the NBSP Endoscopy Coordinator. 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 will be managed by the Project Manager, in association with the West Coast DHB Endoscopy Coordinator, the West Coast DHB NBSP Steering and Clinical Governance Group, Planning and Funding Portfolio Managers and other channels, such as the West Coast Alliance, West Coast PHO primary care networks, Poutini Waiora networks, Local Cancer Team, and the use of HealthPathways and HealthInfo websites.

5.6 Benefits Management

Programme benefits will be monitored through regular analytical channels such as Planning and Funding Analysis and ProVation reporting tools data analysis. The Project Manager, the West Coast DHB NBSP Steering and Clinical Governance Group 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 West Coast DHB Risk Management framework will be applied to the implementation of the NBSP both at a project and service level as appropriate.

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 NBSP monitoring and assurance.

The West Coast DHB NBSP Steering and Clinical Governance Group will monitor the Implementation of the NBSP on the West Coast

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 2 months 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 Disbenefits

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 the population is not engaged then participation will be lower than the targets, and more importantly - cancers will go undetected, leading to unnecessary deaths.	Medium	High	• The West Coast is sparsely populated, with areas with limited, or non-existent, cell phone or internet coverage. This means some promotional activities from other DHBs will not be transferable. • The DHB will actively test, review and modify their promotional/community and equity engagement methodologies to continually improve participation. • Primary health care services such as General Practice and Poutini Waiora, and support agencies and community groups such as the West Coast Cancer Society, Iwi networks, Grey Power, Rotary, Lions, etc., will be critical in helping to gain and maintain community awareness and engagement in getting screened.
If communication with patients is not timely and effective, then this may result in patient treatment delays and failure to provide care in a timely fashion, exacerbating the progress of disease	Medium	Medium	• There are a number of people on the West Coast who live with limited social connections; live alone; and/or are living in particularly isolated areas. As well as physical communication barriers, understanding is another communications-related barrier for many individuals when engaging with health services for new and threatening disease such as cancer. • Physical visits to patients by the Cancer Nurse Coordinator, District Nurses, PHO navigators, etc., may be required where telephone connections with patients are poor and/or non-existent. • Close communications will be required at a personal, individualised level to work wit those people who are hard to reach or engage in health services (including individual reluctance to use or refer to health services until they perceive it to be “absolutely necessary” – which is often too late) • Use of navigators and other supports to help assist individuals seeking assistance in health literacy and understanding around processes, their diagnosis, their treatment options, and during their active progress through the treatment pathway. • Improved individualised communications and support for those who have poor social supports, and those who live alone or in remote / isolated areas can impact on having bowel preparation prior to endoscopy screening, and to help overcome isolation post-

			sedation and recovery. • Close communication between trusted clinicians and those pockets of special nature in our community with particular views about engaging certain elements of formal health services, to encourage them to seek early assessment and treatment.
If space for endoscopy lists in theatre space are not available, then this may result in avoidable treatment delays for patients, as well as failure to meet FCT targets	Medium	Medium	• West Coast DHB currently only requires 5 endoscopy sessions per week. Demand modelling shows additional sessions are not required to accommodate the NBSP volumes but can be affected by disruptions due to inability to deliver a session • Ensure dedicated endoscopy theatre sessions are made sacrosanct and not given over to other demands from other services (cancer screening and treatment to be put ahead of demands of other non-acute and non-cancer services in order to meet ESPI compliance, for example). • Allow for Friday morning meetings and weekly surgical peer review and EUG. • Ensure there is sufficient theatre space and time for conducting bowel screening for people presenting with a suspicion of cancer who do not fit into the NBSP target age cohort, so that they are not inadvertently disadvantaged from receiving timely diagnosis and treatment.
If strategies with regard to kit returns are not put in place then the number of spoilt kits on the West Coast will be high.	Medium	High	• Rural postal services are currently problematic • WCDHB will work with the NZ Post/ courier companies and the National Coordination Centre (NCC) to inform of, and test, timeframe requirements. • Before go-live work with NZ Post and NCC on a trial to determine postage time. • Monitor spoilt kits returns based on location. • Consider drop off site, monitor if this strategy is implemented.
If there are periodic influxes of referrals that are not evenly spread then this could create a bottlenecks and delays in patient care.	Medium	Medium	• This will need to be closely monitored by Grey Base Hospital Clinical services, Endoscopy Nurse Coordinator and Endoscopy User Group, and factored into weekly West Coast DHB theatre session planning and booking to ensure timely and equitable access for patients to services according to their triage of relative urgency; ensures continued ESPI compliance; and services are rescheduled if necessary, in a way that minimises impact on delivery of other elective and planned care services as best possible. • Close liaison and factoring of potential impact on other locally delivered support services such as chemotherapy and radiology will also need to be undertaken; as well as liaison with services provided

			by and/or supported through Canterbury DHB where such bottlenecks may be potentially material to individual patient care and/or to wider systems process.
Maori do not engage sufficiently in the programme leading to lower coverage and increased inequities	Medium	High	• The focus on equity must be deliberate and overarching across the planning and implementation phases of this project. • All activity should be tailored to work for priority populations: Maori, PI and Quintile 5. • Sufficient resource should be allocated to engaging these populations and reduce the inherent risk.
If there is insufficient throughput, then local general surgeons might not meet volumes for achieving and maintaining endoscopist accreditation.	Low	High	• Risk mitigation options to be explored would include: - exploring if there might be options for West Coast surgeons to travel periodically to Canterbury or other DHBs for "upkeep" of clinical training and credentialing as part of a South Island solution. This would require local leave cover arrangement s to be put in place; so would come with additional financial costs – especially if locums are used (but may equally provide some reciprocal experiential training and credentialing opportunities for direct "staff swaps" if clinicians are amenable to exchange. - explore bringing accredited endoscopists from Canterbury periodically to back-fill any local service gaps. • Consider currency of and opportunity for endoscopy accreditation in any succession planning and appointments to resident Specialist General Surgeon roles. • Explore South Island regional solution to longer-term clinician recruitment to roles that can travel and cover multiple districts to provide local bowel screening services.
If transport to treatment is a barrier, then this may result in patient treatment delays and failure to provide care in a timely fashion, exacerbating the progress of disease.	Low	Medium	• Risk of people not being able to get access to transport due to barriers such as availability, cost, lack of options, reliance on friends or family – which some don't have. This would be made all the more difficult for patients – both physically, and in terms of time and financial cost - if the bowel screening service was not able to be delivered locally on the West Coast. • Public transport on the West Coast is very limited (especially between centres) and many people have no private transport of their own – creating difficulties in getting to Greymouth (or other DHBs) for assessment and treatment. • DHB to continue to cluster patients from furthest

			reaches of the district in to "mid-morning to mid-afternoon" time slots at Grey Base Hospital where possible, to assist with patient-focussed suitable travel times and coordination with services such as the Red Cross shuttle from Westport. • Use of Navigator services to help support physical patient transport for those without other transport means (where practical). • National Travel Assistance (NTA) offered to those patients who may be eligible for the scheme. • Cost remains a barrier to those not eligible for NTA – so a need to liaise with DHB social work services, with WINZ and with local volunteer social agency networks recognised as a cognisant part of the programme connectivity.
If staff don't have sufficient cultural awareness then they may miss important queues to individual patient care and support needs	Medium	Low	• Cultural competency training to be provided to DHB staff and offered to wider clinician and administration support staff serving in primary care settings. • Clinicians encouraged to offer cultural service options for support to patients and their family/whanau – with these options promulgated through cultural competency training, published on Healthpathways, as well as identified through Cancer Korero. • Actively engage clinicians and wider DHB staffing in equity conversations throughout the development of the programme and subsequent implementation.
If endoscopists at West Coast DHB are not able to maintain NSBP accreditation to perform NBSP colonoscopies* then the participants have to travel. **Low numbers of patients may impact on our accreditation compliance achievement by West Coast DHB endoscopists.*	Low	Medium	• As noted above for transport – this would further add to the risk of people not being able to get access to transport due to barriers such as availability, cost for travel and accommodation, cost in terms of time away from work for those still in the workforce, lack of options, reliance on friends or family – which some don't have. This would be made all the more difficult for patients – both physically, and in terms of time and financial cost - if the bowel screening service was not able to be delivered locally on the West Coast. • The preferred risk management strategy to this will be to seek bringing visiting endoscopists other DHBs (or locum agencies) to come to Grey Base Hospital to operate and provide services locally. This would come at a considerable financial cost to the DHB however. • Where not possible, consider National Travel assistance scheme for those people who might meet eligibility for financial support (see transport issues related key risk above).

If referrals are not phased and managed then the wait list could be inundated and may result in failure to meet FCT and ESPI targets	Low	Medium	• Close liaison with General Practice and West Coast PHO in terms of prioritisation and priorities to understand process around NBSP letters of invitation to participate in the FIT testing and follow-up with Bowel Screening for positive results (and not just unilateral "open" referral) • Risk of Delay in Patient Journey through Programme Timeliness of the turnaround for ERMS referral will be critical thereafter to ensure patients are seen within the timeframes (the FIT test / Lab test and involvement of anaesthetist in the process of getting the patient into clinic. (have to be treated within 45 days of positive Laboratory test result)
If NBSP colonoscopies commence during a time of generalised increase in demand for endoscopy services, then other services will be impacted – both locally and at Canterbury DHB.	Low	Medium	• Increased awareness of bowel cancer/screening is driving increased demand for colonoscopy service in other DHBs that have gone live with the programme and/or through media coverage or public awareness campaigns, and this will need to be factored into West Coast DHB service planning for the NBSP programme support and for local delivery of elective and planned care services. • There will need to be close liaison and collaboration with services provided by, or supported through, Canterbury DHB for early identification of trend variances in demand so that these do not negatively impact on other co-dependent services, and try to smooth these wherever possible. This includes services such as additional bowel cancer surgery that result in need for reallocation of existing resources; negative impacts on delivery of other elective surgical volumes; access to tertiary radiotherapy services; and other such resource required to meet concurrent demand and those required to meet additional NBSP demand. • Consider outsourcing of services where this may be possible and/or practical.
Resignation of endoscopists	Low	High	• With only 3 FTE of WCDHB endoscopists accredited to provide NBSP colonoscopies we are vulnerable to any change in personnel (due to retirement or resignation). If any one of our team was to cease working the remaining staff would not be able to manage the volume of endoscopy and other surgical work and maintain a roster for on call service, we would therefore need to outsource procedures and NBSP colonoscopies would be amongst these.

Appendix 3: West Coast DHB Implementation Project Programme Plan

	Oct-19	Jan-20	Jul-20	Sep-20	Oct-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Project Deliverables	First Draft Treasury Information	Final - Treasury infomation		Steering Group formed	Quality assurance forums Project Documentation Intergrated plan including : Equity Plan Primary Care Plan Community Engagement Plan Comms Plan IT Integration Plan Workforce Plan	Project Management and Governance Framework in place	Pre-readiness assessment	Readiness Assessment NBSP Quality Standards Post Go Live Plan Transition Plan Primary Care Payment Plan Diagnostics Plan Phone Line Audit Processes in place CTC plan SOP in place Risk Plan Histopath Plan HP/ ERMs MDM process GRS assessment	Primary Care Training Starts	Go Live - APRIL 2021
Project workforce	Business Owner Identified		Project Manager in place	Clinical Lead in place IT Lead identified Primary Care Lead identified Comms support identified		Lab support indentified Radiology support identified				

Appendix 4: Colonoscopy Waiting Times Performance for West Coast DHB

The following series of tables show our DHB performance in achieving required maximum wait timeframes for patients receiving diagnostic colonoscopy against targets (urgent, non-urgent and surveillance) over the past three financial years.

12 months to 30 June 2019: (Data Intervals in tables: Monthly, July – June; with annual summary in last column)

Urgent Colonoscopy	Waiting or scoped in 14 days (2 weeks) or less	5	2	1	3	2	2	0	7	3	1	6	5	37
	Total number waiting or scoped	5	2	1	4	3	3	0	7	3	1	8	5	42
	% of urgent colonoscopies in less than 2 weeks (14 days)	100.0%	100.0%	100.0%	75.0%	66.7%	66.7%	#DIV/0	100.0%	100.0%	100.0%	75.0%	100.0%	88.1%
Non-urgent Colonoscopy	Waiting or scoped in 42 days (6 weeks) or less	106	78	74	82	84	62	46	48	46	59	45	46	776
	Total number waiting or scoped	110	93	92	92	89	64	47	48	46	59	45	46	831
	% of non-urgent colonoscopies in 42 days (6 weeks) or less	96.4%	83.9%	80.4%	89.1%	94.4%	96.9%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	93.4%
Surveillance Colonoscopy	Waiting or scoped in 84 days (12 weeks) or less	22	30	28	24	18	16	27	28	36	40	50	54	373
	Total number waiting or scoped	24	33	34	31	22	18	27	29	37	43	56	63	417
	% of surveillance colonoscopies in 84 days (12 weeks) or less	91.7%	90.9%	82.4%	77.4%	81.8%	88.9%	100.0%	96.6%	97.3%	93.0%	89.3%	85.7%	89.4%

12 months to 30 June 2018: (Data Intervals in tables: Monthly, July – June; with annual summary in last column)

Urgent Colonoscopy	Waiting or scoped in 14 days (2 weeks) or less	1	4	1	3	2	5	5	7	8	6	6	7	55
	Total number waiting or scoped	3	5	1	3	2	6	6	8	8	6	6	7	61
	% of urgent colonoscopies in less than 2 weeks (14 days)	33.3%	80.0%	100.0%	100.0%	100.0%	83.3%	83.3%	87.5%	100.0%	100.0%	100.0%	100.0%	90.2%
Non-urgent Colonoscopy	Waiting or scoped in 42 days (6 weeks) or less	45	64	54	66	56	36	54	53	67	81	93	81	750
	Total number waiting or scoped	51	68	57	66	56	36	59	57	70	83	103	87	793
	% of non-urgent colonoscopies in 42 days (6 weeks) or less	88.2%	94.1%	94.7%	100.0%	100.0%	100.0%	91.5%	93.0%	95.7%	97.6%	90.3%	93.1%	94.6%
Surveillance Colonoscopy	Waiting or scoped in 84 days (12 weeks) or less	5	2	11	11	5	8	13	15	18	14	17	16	135
	Total number waiting or scoped	5	3	12	12	6	9	15	17	19	15	18	19	150
	% of surveillance colonoscopies in 84 days (12 weeks) or less	100.0%	66.7%	91.7%	91.7%	83.3%	88.9%	86.7%	88.2%	94.7%	93.3%	94.4%	84.2%	90.0%

12 months to 30 June 2017: (Data Intervals in tables: Monthly, July – June; with annual summary in last column)

Urgent Colonoscopy	Waiting or scoped in 14 days (2 weeks) or less	2	5	6	0	1	2	1	2	9	1	3	4	36
	Total number waiting or scoped	3	6	6	0	2	3	1	2	9	1	3	4	40
	% of urgent colonoscopies in less than 2 weeks (14 days)	66.7%	83.3%	100.0%	#DIV/0	50.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%
Non-urgent Colonoscopy	Waiting or scoped in 42 days (6 weeks) or less	58	59	69	60	53	44	44	62	70	63	54	49	685
	Total number waiting or scoped	70	72	78	65	61	48	48	67	75	69	57	53	763
	% of non-urgent colonoscopies in 42 days (6 weeks) or less	82.9%	81.9%	88.5%	92.3%	86.9%	91.7%	91.7%	92.5%	93.3%	91.3%	94.7%	92.5%	89.8%
Surveillance Colonoscopy	Waiting or scoped in 84 days (12 weeks) or less	9	24	6	14	14	5	13	13	7	6	12	18	141
	Total number waiting or scoped	26	37	9	17	15	5	13	13	7	6	12	18	178
	% of surveillance colonoscopies in 84 days (12 weeks) or less	34.6%	64.9%	66.7%	82.4%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	79.2%

CHAIR'S UPDATE

TO: **Members**
Tatau Pounamu Advisory Group

SOURCE: **Chair**

DATE: **Friday 6 December 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

Verbal Update

2. RECOMMENDATION

That the Tatau Pounamu Advisory Group notes and approves any verbal discussion of update.

GM UPDATE TATAU POUNAMU

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

TO: **Tatau Pounamu Chair & Members**

SOURCE: **General Manager, Maori Health**

DATE: **Friday 6 December 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to Tatau Pounamu Manawhenua Advisory Group as a regular update

Tikanga Best Practice: Maori Values and Concepts

Moe Milne, Maori Advisement Specialist spent 3 days at the West Coast DHB delivering cultural competency sessions to approximately 20 mental health workers. Feedback has been really positive and we anticipate that a good portion of these people will undertake Takarangi Cultural Competency training next year.

Moe also provided a session with Maori workers within the DHB. An informal roopu (group) has been established and we will continue to meet to provide support and share ideas and learnings.

Takarangi Cultural Competency - Australasian Nurse Educators Conference (ANEC) 2019

GM Maori Health, Director of Nursing and Moe Milne will be presenting at this conference. The presentation will share with others within the sector the West Coast DHB's experience of introducing Matua Raki's cultural competency framework, including impact on everyday practice. Findings intend to encourage others to consider implementing cultural competency frameworks within their organisations.

Workforce Development

The South island Workforce Development Hub is currently preparing to recruit a Maori Workforce Facilitator Manager.

This role will support a three year project involving collaboration between the South Island DHBs facilitated by SIAPO (Workforce Hub) and Kōhatu, Centre for Hauora Māori in the University of Otago. Kōhatu will support the background, design, implementation and evaluation of a strategy to grow the South Island Māori health workforce and ensure that workforce is well supported and thrives.

Key in this area is that of relationship development and management and the ability to work in this way across the South Island health sector in partnership with Kōhatu, Centre for Hauora Māori in the University of Otago.

Also key in this role is the ability to engage with the Māori health workforce including in District Health Boards (DHBs), Primary Health Providers (PHOs), Māori Health providers and Iwi. They will report to the Programme Director SIWDH and closely with South Island Managers Maori health.

Ministry of Health Publication – Achieving Equity in Health Outcomes

The Ministry has launched a new publication 'Achieving Equity in Health Outcomes'. In 2018 the Ministry of Health initiated a work programme on achieving equity in health outcomes. Specifically this programme of work aims to ensure that equity is at the heart of the way New Zealand's health and disability system operates and to promote the cultural shift needed to achieve that. This report summarises the 'discovery phase' of this programme of work with the next phase looking at supporting an integrated collaborative whole of system approach to achieving equity.