8 Management Case

8.1 Programme Governance and Management

Proposed programme governance arrangements

The proposed governance structure and the reporting arrangements for the programme, for the duration of the implementation period, are depicted in Figure 18. It is intended that the governance arrangements would be revised once the business case and implementation have been completed, for the ongoing governance of the NBSP. The groups and accountabilities for the implementation period are summarised in Appendix 14.

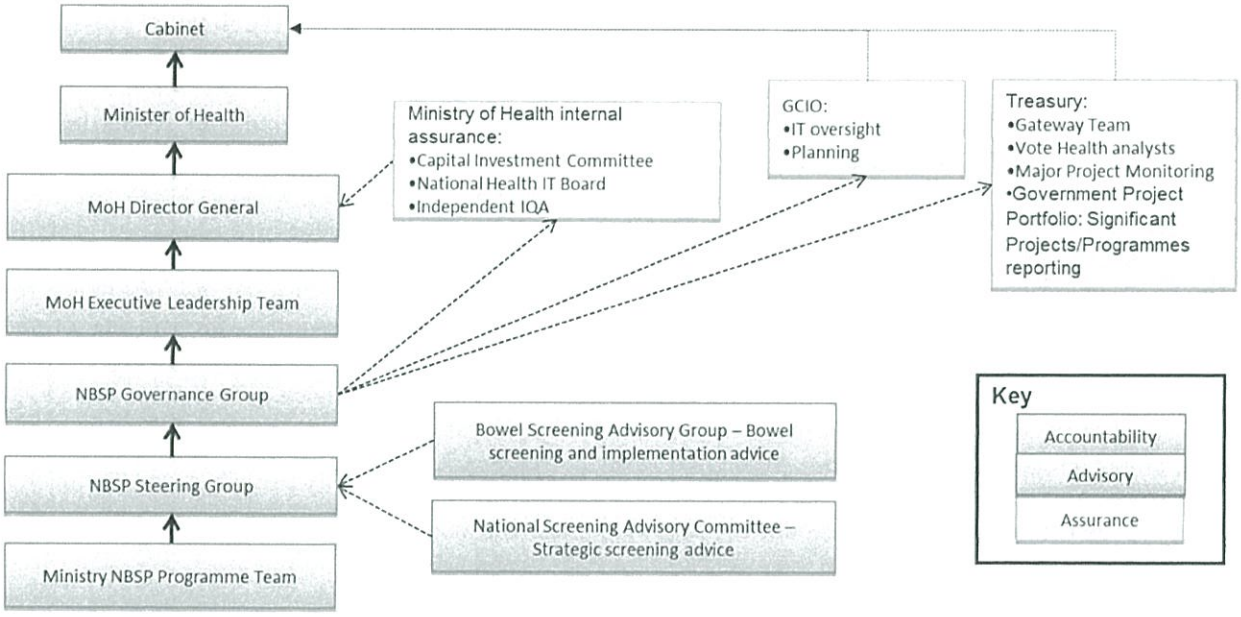

Figure 18: Proposed Governance Structure for the NBSP

The National Bowel Screening Programme (NBSP) Governance group would provide leadership and strategic direction for the implementation of the NBSP (i.e. until January 2020). Membership would include Ministry of Health senior (Tier 2) managers and representation from the sector including DHBs and Māori and Pacific health representation.

The NBSP Steering Group would oversee the operational aspects of the NBSP implementation. Possible membership could include Ministry of Health representation from the National Screening Unit, Technology and Digital Services, the Capital team, Finance and Performance, Health Workforce New Zealand, the Māori and Pacific health teams as well as representation for key stakeholders such as DHBs, PHOs and senior clinicians. It would have a rolling membership to ensure that the relevant DHBs are represented as each Tranche is progressed.

The Bowel Screening Advisory Group provides advice to the programme team on the clinical and implementation aspects of the programme. The membership and responsibilities would be expanded, with members at a technical level including key DHB staff, IT specialists involved in the implementation at a local level, clinical representation and key Ministry of Health staff.

There will be clear responsibilities to ensure that scope and capital expenditure, including that of the IT solution, remains within the funding envelope. A cross-Ministry focus will be on ensuring that access to

hospital services for non-screening patients is not adversely impacted by the introduction of the screening programme.

Architectural governance for the bowel screening IT solution would be undertaken through the NBSP Governance Group. Independent Quality Assurance would be delivered at the programme level.

The structure outlined above would ensure that appropriate governance is maintained throughout the life of the programme. The use of key decision points (including Gateway reviews) and the requirement for Tranche business cases for each implementation would ensure that there are appropriate opportunities for oversight and input into the programme as it is implemented.

Programme and project management approach

The programme would be managed in line with standard programme and project methodologies. The key principles from Managing Successful Programmes (MSP) and PRINCE2 (for projects) would be used. The Ministry's standard Agile-type approach would be used for the development of the IT solution.

There would be a structured approach to developing and managing both the programme and its constituent projects (the Tranche implementations), to ensure effective management of scope, budget, time, human resources, quality, communications and risk.

Programme and Project Structure and Staffing

The programme would make best use of existing knowledge, expertise and programme infrastructures already developed for screening programmes. It would have dedicated resources for the life of the programme implementation (i.e. to 2020). Some resource would continue into 'business as usual'. This would include resource to develop and implement the programme from a service delivery perspective, as well as for the bowel screening information system. Some of the roles would be in place for only part of the programme implementation period.

The proposed Programme team includes the following roles. The key programme roles and responsibilities are defined further in Appendix 14.

- SRO (Director Service Commissioning)
- Programme Executive (Group Manager Personal Health Service Improvement)
- Programme Director
- Clinical Director
- Programme Manager
- Project manager
- Programme coordinator
- Programme administrator
- Senior advisor
- Advisor
- Senior contracts and procurement manager
- Contracts and procurement advisor
- Accountant
- Business case writer
- Senior communications & stakeholder engagement advisor
- Relationship managers (x2)
- Quality manager
- Senior equity advisor
- Senior data quality analyst
- Senior data analysts (x2)
- Senior business focused business analyst
- IT project manager
- IT change manager
- IT project administrator
- IT contract management lead
- IT business analyst lead
- IT business analysts (x2)
- IT solution architect
- IT test manager
- IT test analysts (x3)
- IT developer lead
- IT senior developers (x3)
- IT intermediate developers (x2)
- IT infrastructure architect
- IT database administrator

The following assumptions have been made in determining the proposed Programme structure (based on the Ministry organisation structure as at June 2016):

- The Ministry Technology and Digital Services (T&DS) business unit and DHBs would provide system testers (both technical and user acceptance testing).
- T&DS would provide DHBs with training for new IT solution.
- T&DS would deliver IT architecture services.
- T&DS would provide realtime operational reporting.
- Customer Insights and Analytics (CI&A) would provide retrospective and analytical reporting, delivery of datasets for ongoing monitoring analysis, research and evaluation.
- DHBs would provide a Business Analyst to assist programme team with roll out.
- Ministry of Health Capital team would provide input in relation to capital investment.
- Finance would provide assistance for budget development in Implementation Business Cases.
- The project teams would be co-located to ensure cohesion and wider programme focus.
- The IT project element would include dedicated resource including an IT project manager, lead business analyst, solutions architect, test manager etc. Wherever appropriate, the IT solution development team would engage with the relevant DHB IT resources.

The proposed programme team would be in place from 2016 to 2020, at which point the programme team would be disbanded. Ongoing management and monitoring would be part of 'business as usual' within the NSU. Budget for this is included. The proposed Bowel Screening Business as Usual state structure is shown in Figure 19.

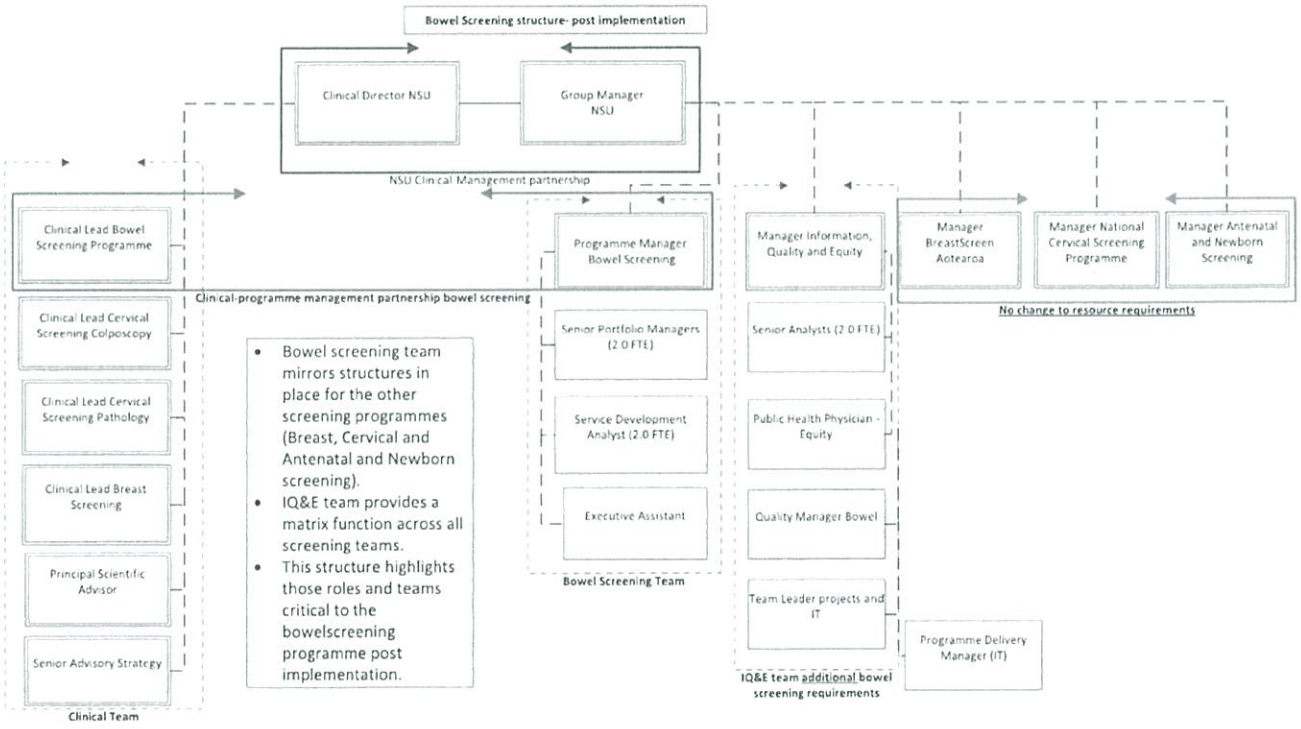

Figure 19: Bowel Screening BAU State Structure

Project Monitoring and Reporting

Reporting on Programme progress would be provided to the Ministry/Minister of Health by the Senior Responsible Owner at periods agreed as part of detailed implementation planning, including key agreed milestone points.

Programme Key Milestones

The proposed programme plan has been developed based on the proposed implementation approach summarised in Section 5.5. This shows that the programme is intended to roll out over 4 years, commencing in 2016 with the development of the Programme/Tranche 1 business case and commencement of the upgrade to IT systems. The DHB rollout would be completed over three years, commencing in 2017 with Tranche 1 and the two subsequent tranches going live in 2018 and 2019 respectively. The full rollout to DHBs would be complete by December 2019. The programme implementation is expected to conclude in March 2020 with handover to the National Screening Unit for 'business as usual'.

The key programme milestones and approximate timings are shown in Table 31 and a high level programme plan (Gantt chart) is included as Appendix 15.

Table 31: Key Programme Milestones

Key Programme Milestones	Approximate Completion Date
Gateway 0/1 (Programme Strategic Assessment/Business Justification)	Dec 2015
Budget 2016 bid, based on draft programme business case	Feb 2016
Re-stated Programme Business Case sign off (Cabinet)	Aug 2016
Budget 2017 bid (based on re-stated programme business case)	Oct 2016
Tranche 1	
Develop procurement plan for the NCC (with input from MBIE procurement) for signoff by the Director-General at the Ministry of Health	Sept 2016
T1 Business Case sign off (Cabinet)	Aug 2016
Gateway 4 (Readiness for Service)	Apr 2017
BSP+ available for T1 DHBs	May/Jun 2017
Hutt Valley and Wairarapa DHBs Implementation	Jul 2017
Waitemata transition from pilot to Programme	Jul 2017
Transition of Waitemata, Hutt Valley and Wairarapa DHBs to the national and regional infrastructure (NCC, BSRC, NBSP IT solution)	Jan 2018
Tranche 2	
Procurement of NCC	Feb 2017
Commissioning of BSRC	Feb 2017
NBSP IT solution: Detailed requirements and design	Feb 2017
Detailed impact analysis for DHBs 4-12	Feb 2017
T2 Business Case sign off (Joint Ministers)	Mar 2017
Gateway 4 (Readiness for Service)	Nov 2017
NBSP IT solution: Release 1 complete for DHBs 4-12 'go live'	Jan 2018
NCC 'go live'	Jan 2018
BSRC 'go live'	Jan 2018

Tranche 2a Implementation	Jun 2018
Tranche 2b Implementation	Dec 2018
NBSP IT solution: Release 2 complete for DHBs 13-20 'go live'	Jan 2019
Tranche 3	
Detailed impact analysis for DHBs 13-20	Nov 2017
T3 Implementation Business Case sign off (Joint Ministers)	Dec 2017
Gateway 4 (Readiness for Service)	Nov 2018
Tranche 3a Implementation	Jun 2019
Tranche 3b Implementation	Dec 2019
Gateway 5 (Operational Review and Benefits Realisation)	May 2020
Programme Implementation closure and handover to BAU	Jun 2020

8.2 Change Management

Effective change management is critical for the successful implementation of the programme, to ensure readiness for go-live and monitoring in the immediate post go-live period. This would ensure that any potential issues are identified and managed in advance of the programme rolling out, and that any issues that develop are successfully resolved.

The programme structure would include the following roles that would have responsibility for managing change throughout the programme:

- Programme Manager
- Project Manager
- IT Change Manager
- Relationship Managers
- Communications and Stakeholder Senior Advisor.

These roles would work closely with DHB change managers and other staff to ensure an efficient and effective transition to the new service delivery model. The Project Manager would be responsible for confirming that each DHB has a change management plan in place before their implementation commences.

To encourage continuous improvement for the Programme and for business as usual, the programme team would utilise existing regional and national forums where possible, to encourage sharing and learning.

8.3 Communication and Engagement

Communications for the programme would be led by the Programme's Communications and Stakeholder Senior Advisor. There would be close liaison between the Programme and the DHB communications staff to manage messaging at a local level to ensure a consistent national approach. Existing resources from the pilot such as letters, posters and brochures would be updated and used to minimise costs. There would be no national communications until the final DHB rollout in 2019, to manage expectations of service availability in the regions. Effective communication with the public and the health sector would be critical in managing demand and achieving successful implementation.

The approach for all communication would be proactive, timely and consistent. The principles for communication and engagement are:

- **Accountable and transparent** – focused on improving the quality of engagement, being mindful and confidential;
- **Clear purpose, scope and outcomes** – stakeholders are aware of constraints and conditions;
- **Open and collaborative** – open and genuine communication is fostered through a variety of channels;
- **Inclusive and balanced** – engagement processes and opportunities allow fair, equitable participation.

A summary of the Programme Communications and Engagement Strategy and key messages is attached as Appendix 16. The key stakeholders are described in Section 4.7.

8.4 Benefits Management

The benefits expected to be realised by the National Bowel Screening Programme are described in Section 4.4. These would be delivered incrementally as the programme rolls out through the Tranches.

The programme would develop a Benefits Realisation Plan and benefits register, detailing the measures and realisation against target. Indicative measures are described in Table 9 in Section 4.4. Each Tranche would have its own benefits realisation register and would report on the benefits realised to the Programme.

Identification, measurement and tracking of benefits would be undertaken to ensure that the expected outcomes are realised, including maximising participation to deliver the assumptions underpinning the cost benefit modelling. The Programme Senior Responsible Owner would have overall responsibility for the realisation of benefits. Monitoring and reporting would be the responsibility of the Programme Director. The benefits register would be created and maintained for the duration of the Programme, with responsibility reverting to the appropriate stakeholder(s) when the initiative moves from implementation to Business As Usual.

There would be agreed points in the programme implementation at which the benefits plan is reviewed. The final benefits review would be developed at the end of the programme implementation (i.e. January-March 2020) and would run alongside the programme evaluation and Gateway 5 review.

8.5 Risk Management

Standard risks and issues management methodologies would be used throughout the life of the programme. This would assure stakeholders and monitoring agencies that the programme and project teams are proactively identifying and mitigating risks as the programme progresses.

The Project Managers would have direct responsibility for the tracking and reporting of risks and issues to the Programme Manager, Senior Responsible Owner and the Bowel Screening Governance Group, with further escalation where required. Issues would have a deviation plan. The Project Manager would record, track and report on risks and issues in three levels, i.e. programme, Tranche and DHB, to ensure responsibility for mitigations and actions is allocated appropriately.

The key risks and issues identified for the Programme are summarised in Table 15 in Section 4.5 and detailed further in Appendix 5.

8.6 Monitoring and Evaluation

Programme monitoring

The programme has been assessed as 'High Risk' through the Treasury Risk Profile Assessment. It would be subject to Treasury Major Projects Monitoring Assurance, ongoing monitoring and Gateway reviews. Each

Tranche would be subject to external and internal monitoring and review, as agreed with the monitoring agencies.

Internal Quality Assurance (QA) would be provided by the Bowel Screening Steering Group and the Governance Group.

Independent Quality Assurance (IQA) would be ongoing through the life of the programme. The Ministry of Health Capital Investment Committee would review the programme business case, plus the implementation business cases if agreed.

Gateway review

A joint Gateway 0/1 was undertaken on the programme in December 2015. The review gave strong support for the proposal of a national bowel screening programme. The findings of the review have been incorporated into this business case and the planned next steps.

Further Gateway reviews would be undertaken throughout the life of the Programme. The reviews may be solely on the programme, or may be combined with a Tranche implementation Gateway if the timing was broadly aligned. In this way, the monitoring agencies would be able to keep good oversight of the programme, without the cost and time invested becoming too onerous.

Programme and project evaluation

The proposed programme and tranche evaluation process is as follows:

- **Programme monitoring:** Ongoing monitoring would be undertaken at national, regional and local levels. Key Performance Indicators (KPIs) would be monitored at a national level by the Ministry of Health and published regularly (4-6 monthly) on the Ministry of Health website. Bowel Screening Regional Centres (BSRC) would manage quality across the region, to ensure that service providers are meeting national quality standards. Providers would have continuous quality assurance processes in place based on findings from monitoring data. The Ministry would also monitor the evidence for different bowel screening tests, including emerging technologies. If new evidence supports a significant change to the screening pathway, a new business case would be presented by the Ministry.
- **Tranche Go-Live evaluation:** This would take place within a month of each DHB implementation. The evaluation would reconcile the implementation process to go-live, to plan and identify any key learning points which could be incorporated into subsequent DHB/Tranche implementation plans. Where possible, project budget and timelines would be reviewed.
- **Post-Tranche evaluations:** These would take place 12 months after each DHB implementation. The evaluation would assess the benefits realised compared to the benefits identified in the tranche business cases. The review would also identify potential opportunities for improvements in performance, either for that DHB or others.
- **Post-programme evaluation:** this would be undertaken in 2020/21, once the national implementation is complete and any outstanding issues are remediated. This would include a process evaluation and outcome evaluation and would build on the monitoring and evaluation work completed during the life of the programme. This would be the final evaluation of the programme rollout, prior to it transferring to Business as Usual. Whilst the life of this programme has been projected at 20 years, for costing and benefits purposes, the programme function (directing and managing the rollout) would cease once the final go-life is complete.
- **Ensuring quality:** Those involved in providing Bowel Screening services must comply with the Bowel Screening Quality Standards. At a national level, the Ministry would provide quality and clinical oversight of delivery and monitoring of the programme. A quality, monitoring and evaluation framework will underpin the programme. At a regional level, regional clinical and quality leads would provide this oversight. Quality assurance and controls would be in place to determine performance of

the bowel screening services and enable development and improvement. The Bowel Screening providers must ensure the provision of timely data, to enable evaluation and monitoring of the programme. Regular reporting to the Ministry would ensure Bowel Screening Quality Standards and monitoring indicators are met.

At an overall quality level, performance monitoring and ongoing evaluation activities will focus on:

- Delivery of safe, timely and equitable services
- Maximising participating to ensure that the assumptions that underpin cost benefit modelling are realised
- Ensuring the performance indicators and levers balance the needs of both screening participants and other symptomatic patients requiring services.