10 Tranche 1 Implementation

10.1 Tranche 1 DHB Selection

Hutt Valley and Wairarapa DHBs have been selected for the first stage of the national roll-out because of a number of factors, including their strong clinical leadership, their history of working together and their strong primary care links. Both DHBs are able to begin screening in 2017. Other factors included their unique population mix that includes a rural component and their moderate to high bowel cancer incidence rates.

The small size of these DHBs will enable them to adapt more easily to the complex requirements of an evolving programme and trial new systems and processes for the national programme. Their size also makes it easier to adapt to changing IT requirements as they link to the Bowel Screening Pilot IT solution and then move to a national bowel screening IT solution. These DHBs will add to the wealth of information gathered through the Waitemata DHB pilot and will provide valuable insights for the national programme.

10.2 Tranche 1 DHB Support for Implementation

Hutt Valley and Wairarapa DHBs' written statements of support and commitment to implementing the National Bowel Screening Programme, as Tranche 1 implementers, are attached as Appendix 17.

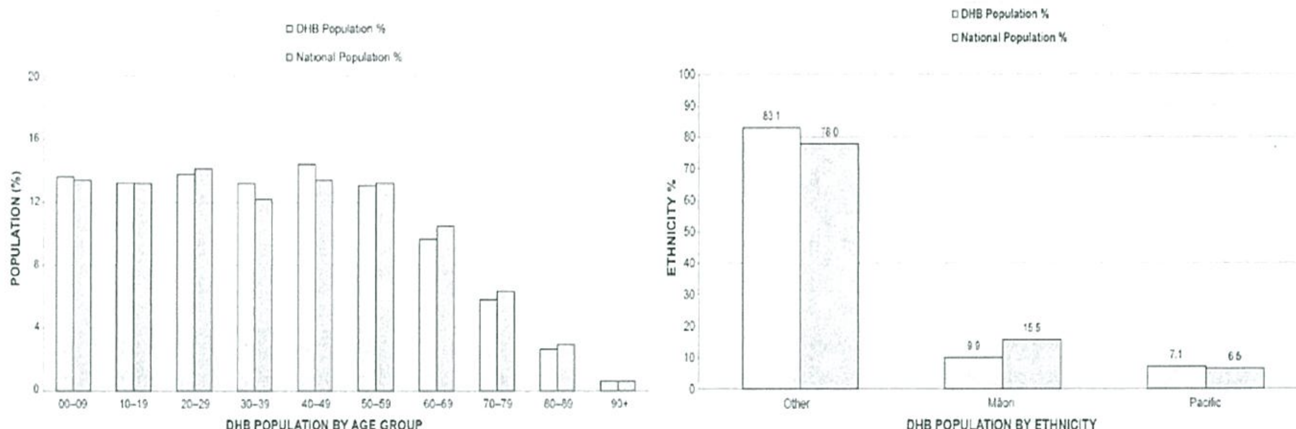
11 Tranche 1 Strategic Context

11.1 Tranche 1 DHBs Overview and Investment Context

Waitemata DHB

Organisation overview: Waitemata DHB is the largest DHB in New Zealand, with a population of more than 580,000 people. The DHB serves the communities of North Shore City, Waitakere City and the Rodney district.

The Waitemata DHB population tends to be similar to the national average. The DHB has a lower proportion of Māori and a similar proportion of Pacific people in comparison to the national average. It has a high proportion of people in the least deprived sections of the population when compared to the national average.



The population eligible for the National Bowel Screening Programme would be approximately 82,000[53].

Screening and treatment services: Waitemata DHB has been running the bowel screening pilot since late 2011, providing screening services for the DHB population aged between 50 and 74. The DHB provides or funds treatment services for its own population with bowel cancer, including surgery, oncology, and palliative care. The DHB provides symptomatic colonoscopy services at North Shore Hospital (two procedure rooms) and Waitakere Hospital (three procedure rooms, of which one was commissioned for the bowel screening pilot activity).

Screening colonoscopy numbers peaked in the second year of the pilot (2013) and have reduced each subsequent year, as shown in Table 34.

[53] Statistics NZ 2015 Update of DHB Population Projections (2013 Census base). This number excludes those aged under 60, who have previously been invited to the bowel screening pilot.

Table 34: Waitemata DHB Screening Colonoscopies per annum

Calendar Year	Number of Colonoscopies
2012	1418
2013	2289
2014	2055
2015	1880
2016 (to 31 May)	743

Bowel screening patients requiring surveillance colonoscopies are referred to the symptomatic service. The colonoscopies performed (or outsourced) by the symptomatic service by calendar year are shown in Table 35.

Table 35: Waitemata DHB Symptomatic Service Colonoscopies per annum

Calendar Year	Non Urgent	Surveillance[54]	Total
2014	2461	1006	3467
2015	2246	3421	5667
2016 (to 31 May)	1007	490	1497

Waitemata DHB has exceeded the target of 75 percent on the urgent diagnostic waiting list seen within 14 days since February 2016. The target of 65 percent on the non-urgent diagnostic waiting list and 65 percent within 84 days of due date for surveillance colonoscopies have both been achieved in the most recent month (June 2016).

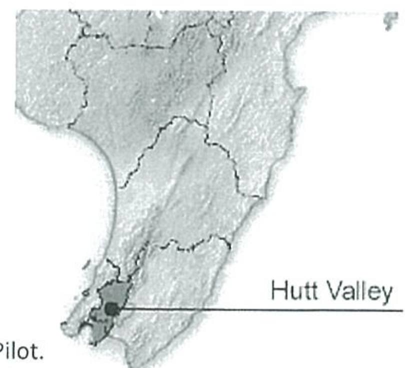
Alignment to existing strategies: The alignment of the NBSP with key local strategies is summarised in Table 36.

Table 36: Alignment of a National Bowel Screening Programme with key Waitemata DHB local Strategies

Strategy	Investment Delivers
Promise, purpose and Priorities	• NBSP is aligned to the DHB organisational purpose to Prevent, cure and ameliorate ill health and key priority to achieve better patient outcomes. o NBSP would improve, promote and protect the health of the community through early identification and treatment of bowel cancer – thus reducing morbidity and mortality from the disease; o NBSP is committed to equity of participation and the reduction of inequalities in health status. Steady progress has been made towards the goal of equity throughout the pilot term.
2016 Annual Plan	• The NBSP will support the achievement of two of the Outputs: o reduction in mortality from cancer; o increase in the 5-year survival rate.

Hutt Valley DHB

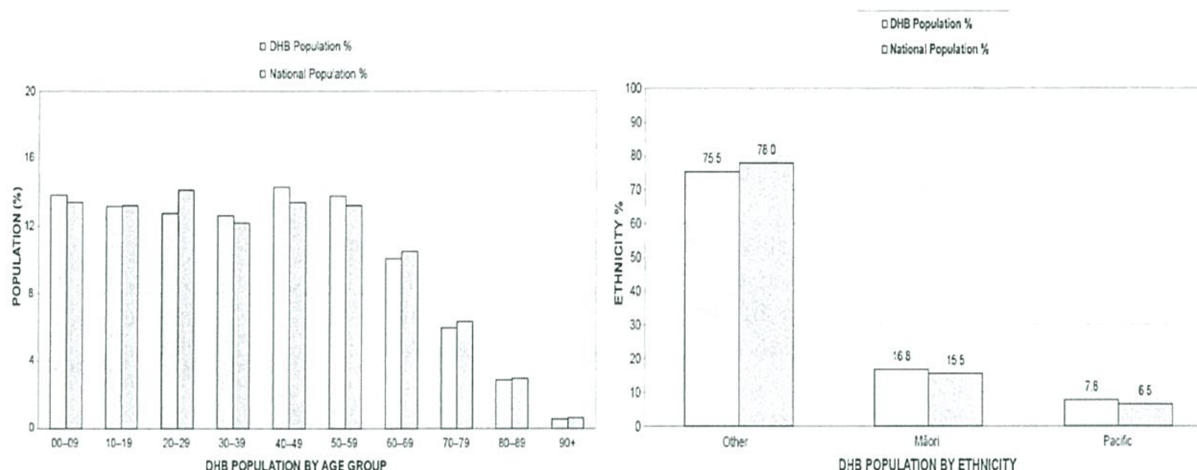
Organisation overview: Hutt Valley DHB is located in the Hutt Valley, on the northern shores of Wellington Harbour and a short drive from the centre of Wellington. It has a population of approximately 145,000, across Lower Hutt, Upper Hutt, Petone, Wainuiomata and Eastbourne.



[54] Note that not all of these colonoscopies are generated from the Bowel Screening Pilot.

Hutt Valley DHB provides secondary and tertiary, medical and surgical hospital services along-side community based health care. The main facility is Hutt Hospital in Lower Hutt, which has 260 beds.

Hutt's population tends to be in line with the national average for New Zealand. The DHB has a slightly higher proportion of Māori and Pacific people living there compared to the national average. It has a relatively equal proportion of people in each section of the population when compared to the national average, with a slightly higher proportion of people in the least deprived section.



The population eligible for the National Bowel Screening Programme would be approximately 21,000. Hutt Valley/Wairarapa volumes include Rimutaka prison inmates. A process would be put in place to identify eligible prisoners and how treatment would be delivered, as for other services.

Screening and treatment services: Hutt Valley DHB gastroenterology outpatient and endoscopies are undertaken in a new purpose-built gastroenterology and medical day stay facility at Hutt Hospital. The facility has three procedure rooms plus supporting facilities (recovery beds, plus rooms for isolation, scope reprocessing and outpatients). The majority of procedures are currently done by Gastroenterologists, with the support of a surgical workforce and a GP Endoscopist.

The Hutt Valley DHB scope volumes performed by calendar year are shown in Table 37.

Table 37: Hutt Valley DHB Scope Volumes

Calendar Year	Colonoscopies	Gastroscopies	Gastro/colon
2014	1624	791	157
2015	1237	825	161
2016 (to 31 May)	614	298	84

The number of people waiting for scopes is continuing to fall, along with wait times. Additional capacity has been implemented to support the department to meet waiting time indicators.

Hutt Valley DHB has exceeded the target of 75 percent on the urgent diagnostic waiting list seen within 14 days since February 2016. The target of 65 percent on the non-urgent diagnostic waiting list is being achieved. The target of 65 percent within 84 days of due date for surveillance colonoscopies is also being achieved (as at June 2016).

Alignment to existing strategies: The alignment of the proposed investment with key local strategies is summarised in Table 6.

Table 38: Alignment of a National Bowel Screening Programme with key Hutt Valley DHB local Strategies

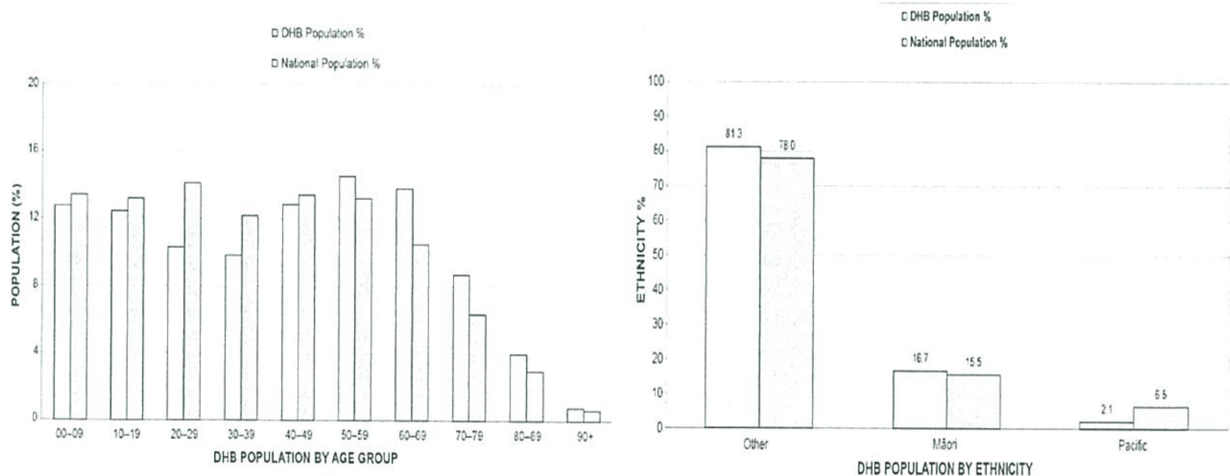
Strategy	Investment Delivers
Paolo mo tagata ole Moana: Pacific Health Action Plan 2015-18 *(joint plan with Wairarapa)*	Plan to enable Pacific communities to live longer and healthier lives. • Plan has specific actions related to health literacy and access to care which will be a solid platform for introduction of Bowel Screening in the DHBs.

Wairarapa DHB

Organisation overview: Wairarapa DHB is located 1.5 hours north of Wellington and Hutt Valley. The DHB has a population of approximately 43,880 (2015/16 estimate) and covers an area from the Rimutaka and Tararua ranges in the west, to the south and east coasts, and north to Mauriceville.

Secondary hospital services are provided from the 90 bed Wairarapa Hospital in Masterton.

The Wairarapa DHB population is significantly older than the national average. The DHB has a similar proportion of Māori and a much lower proportion of Pacific people in comparison to the national average. There is a slightly higher proportion of people in the more deprived section of the population when compared to the national average.



The population eligible for the National Bowel Screening Programme would be approximately 9,000.

Screening services: The Wairarapa DHB endoscopy unit is situated within perioperative services. The majority of endoscopies, outpatient and inpatient colonoscopies are undertaken in Theatre 3, which is also used for other surgical procedures. Patients are cared for in the co-located 9-bed day procedure unit, with a cleaning/reprocessing room situated adjacent to Theatre 3. Endoscopies are undertaken by four Consultant Surgeon Endoscopists.

The Wairarapa DHB scope volumes performed by calendar year are shown in Table 39.

Table 39: Wairarapa DHB Scope Volumes

Calendar Year	Colonoscopies	Gastroscopies	Gastro/colon
2014	740	292	N/A
2015	590	273	N/A
2016 (to 31 May)	293	108	N/A

Wait list targets are being achieved by the DHB and this is expected to be maintained. Wairarapa DHB has exceeded the target of 75 percent on the urgent diagnostic waiting list seen within 14 days since February 2016. The target of 65 percent on the non urgent diagnostic waiting list is being achieved. The target of 65 percent within 84 days of due date for surveillance colonoscopies is also being achieved (as at June 2016).

The Endoscopy User Group provides governance for endoscopy services at Wairarapa, and includes representation from primary care. This group has been instrumental in ensuring that quality standards are monitored and maintained.

Alignment to existing strategies: The alignment of the proposed investment with key local strategies is summarised in Table 40.

Table 40: Alignment of a National Bowel Screening Programme with key Wairarapa DHB Strategies

Strategy	Investment Delivers
2016-17 draft Māori Health Plan	Specific focus on men's health • The NBSP will support improvements in men's health, as bowel screening is the first national screening programme available for men, and bowel cancer affects more men than women.
Tihei Wairarapa workplan for 2016/17	Has a focus on engaging consumers with their health care home in primary care • Primary care supported structure of the NBSP is aligned with this focus area.
2016/17 Wairarapa Annual Plan	Five of the strategic goals stated in the Wairarapa DHB Annual Plan firmly align with the national bowel screening programme: • Commitment to a healthier population, with reduced disparities in respect to both access and outcomes • Development of health resilience within the community that is built upon strong health literacy and personal health responsibility as much as the provision of a robust and integrated system of delivery across primary and hospital care • Commitment to on-going engagement with the community in respect to the shape and the nature of the services provided • The progression of sub-regional and regional service delivery where it is appropriate and best for patients • Ensuring a whole of health and disability system approach, including care provided by other DHBs (especially Capital and Coast DHB and Hutt Valley DHB)

11.2 Tranche 1 Business Scope and Key Service Requirements

The business scope and key service requirements for Tranche 1 are summarised in Table 41. As the scope of Tranche 1 is limited, only minimum requirements (those that are essential to the success of Tranche 1) have been identified. There are no intermediate or maximum scope options for Tranche 1. Items that are determined to be out of scope are specified for clarity.

Table 41: Tranche 1 Scope and Key Service Requirements

Service Requirements	In Scope
Implementation in Tranche 1 DHBs	✓
Amendment to the coordination centre and laboratory procedures and processes at the Bowel Screening Pilot to provide coordination centre services to the Tranche 1 DHBs, including: • Scaling up administration and project management • Amended invitation letters • 0800 number • Active follow up • Additional kit processing • Results notification process	✓
Bowel Screening Pilot IT system scaled for Tranche 1 DHBs: • Minimum functionality to allow Tranche 1 DHBs to operate safely • Functionality to support operational management and monitoring of screening service provision • Functionality to support system administrator and maintenance • System interfaces for data transfer	✓
NBSP IT solution: • High level requirements • Solution designs	✓
National Coordination Centre (market engagement) Bowel Screening Regional Centres (market engagement)	✓

Tranche 1 EXCLUDES:

- development of the NBSP IT solution;
- rollout to Tranche 2 and 3 DHBs;
- the completion of commissioning for the National Coordination Centre, Bowel Screening Regional Centres and Quality Standards assessment services;
- transition to the bowel screening infrastructure in 2018.

11.3 Tranche 1 Interim Service Delivery Model

The National Bowel Screening Programme would have an interim service delivery model in place for Tranche 1, prior to the implementation of the final service delivery model from the commencement of Tranche 2. The final service delivery model is described in Section 5.5. The interim service model is described below.

- Waitemata DHB would provide the central laboratory/coordination centre services for Hutt Valley and Wairarapa DHBs as well as the Pilot site until a National Coordination Centre is in place. The DHB would manage the distribution of invitations as well as processing of iFOBT kits and results notification. The coordination centre would also provide the active follow up telephone calls to Māori and Pacific people who have not responded after a reminder letter. The coordination centre would coordinate the 0800 information line services for the Hutt Valley and Wairarapa DHBs populations. In addition, local activities would need to be undertaken to engage with Māori and Pacific people.
- Hutt Valley and Wairarapa DHBs would undertake colonoscopies for their populations and enter the results on the Bowel Screening Pilot register. This would include managing the receipt of referrals, nurse pre-assessments, procedure bookings, bowel preparation materials despatch, treatment referrals, surveillance referrals and discharge letters. Treatment data would be entered onto the register by Hutt Valley and Wairarapa DHBs. Hutt Valley and Wairarapa DHBs would also organise the histology and reporting of histology results through their own laboratory arrangements, with the data entered onto the register.
- Hutt Valley and Wairarapa DHBs would set up their own quality structures and requirements based on the quality standards established for the Pilot.
- Leadership would be through both the mandated positions of Clinical Director and Programme Manager at Waitemata DHB and the Joint Project Manager, nurse lead and endoscopy lead across Hutt Valley and Wairarapa DHBs.
- Hutt Valley and Wairarapa DHBs would liaise with their PHOs and set up systems for invoicing and payment to GPs for the management of positive results.
- Waitemata DHB would provide reporting services (such as on participation) to Hutt Valley and Wairarapa DHBs.
- Quality indicators would be monitored and published regularly at a national level by the Ministry of Health. There would be strong clinical leadership at all levels.

11.4 Tranche 1 Main Benefits and Dis-benefits

The three main benefits expected to be delivered by a National Bowel Screening Programme are improved health outcomes, improved service delivery (including improved IT infrastructure supporting service delivery) and more cost-effective healthcare. In addition, wider societal benefits are expected to arise from a national bowel screening programme. These include an increased contribution to society, increased participation in the workforce and Quality Adjusted Life Years (QALYs) saved.

Non-Monetary Benefits

The benefits have been split into monetary and non-monetary benefits. The Tranche 1 contribution to the NBSP benefits is summarised in Table 42 and Table 43.

Table 42: Anticipated Tranche 1 Benefits of NBSP, Not Financially Quantified

Benefit Name and Description	Measure Name	Measure Description		Total Measure Value
Improved Health Outcomes Screening should result in a reducation in bowel cancer mortality (and potentially in incidence) and an improvement in quality and length of life.	Reduction in bowel cancer mortality	That the current mortality rate from bowel cancer has decreased, 10 years following the commencement of screening.	Baseline target	Age standardised* colorectal cancer mortality rate per 100,000 population - Total population: TBC - Maori population: TBC - Non-Maori population: TBC
			Current Approved Target	10 years following the commencement of a national programme offered to all the eligible population with appropriate participation, the colorectal cancer mortality rate is statistically significantly lower than in 2012, for each of the 3 groups above.
			Actual achieved to-date	
	Reduction in bowel cancer incidence	That the current incidence of bowel cancer has decreased 10 years following the commencement of screening.	Baseline target	Age standardised* colorectal cancer registration rate per 100,000 population - Total population: TBC - Maori population: TBC - Non-Maori population: TBC
			Current Approved Target	10 years following the commencement of a national programme offered to all the eligible population with appropriate participation, the colorectal cancer registration rate is statistically significantly lower than in 2012, for each of the 3 groups above.
			Actual achieved to-date	
	Increase in proportion of people diagnosed with Stage I bowel cancer	That there is an increase in the current percentage of people diagnosed with bowel cancer at Stage I, which is more easily treated and results in increased survival benefits	Baseline target	TBC
			Current Approved Target	That once bowel screening is in place, at least 20% of NZ bowel cancer patients are diagnosed at Stage I.
			Actual achieved to-date	
	Increase in 5 year relative survival rate for colorectal cancer	Screening should result in an proportional increase of people diagnosed with bowel cancer at an earlier stage. This should translate into an increase in the 5 year relative survival rate.	Baseline target	5-year relative survival rate for patients with colorectal cancer - Total population: TBC - Maori population: TBC - Non-Maori population: TBC
			Current Approved Target	10 years following the commencement of a national programme offered to all the eligible population with appropriate participation, the 5 year relative survival rate is higher than in 2010/2011, for each of the 3 groups above.
			Actual achieved to-date	
Improved service delivery The implementation of a national screening programme would impact on wider service delivery, and should result in improved services including and beyond bowel screening.	Reduction in the proportion of colorectal cancers first identified through presentation at the Emergency Department	A national screening programme should decrease the proportion of colorectal cancers that are first diagnosed through the Emergency Department, which will reduce pressure on DHB EDs and reduce diagnostic and treatment costs.	Baseline target	TBC - Total population: TBC% of colon cancers and TBC% of rectal cancers were first identified through the ED - Maori population: TBC% of colon cancers and TBC% of rectal cancers were first identified through the ED
			Current Approved Target	10 years following the commencement of a national programme offered to all the eligible population with appropriate participation, the proportion of all colorectal cancers first diagnosed through ED will be lower than the 2008/2009 rates, for the total population and for Maori.
			Actual achieved to-date	
	Increase in the number of DHBs with endoscopy units using ProVation software	ProVation allows clinicians to monitor and potentially improve quality of the endoscopic procedure. National benefit from all DHBs using the same version.	Baseline target	In place
			Current Approved Target	N/A
			Actual achieved to-date	

Wider Social and Economic Benefits

The establishment of a national programme for bowel screening is expected to realise significant social and economic benefits. The estimated expected national value of the benefits was included in the Programme Business Case. As the estimated costs are indications of the wider social and economic benefits, and cannot be validated to a high degree of certainty, they have not been included in the financial analysis.

The estimated values for the Tranche 1 DHBs key social and economic benefits are summarised in Table 43.

Table 43: Anticipated Tranche 1 Social and Economic Benefits of NBSP

Main Benefits	Description	DHB Estimated Contribution	
		Hutt Valley DHB	Wairarapa DHB
Wider social and economic benefits	Examples of social and economic benefits include: • QALYs saved. The benefit for New Zealand is modelled at S9(2)(f)(iv) over the 20 year modelled period. • Contribution to society. The benefit to New Zealand is estimated at S9(2)(f)(iv) over the 20 year modelled period.	S9(2)(f)(iv S9(2)(f)(iv	S9(2)(f)(iv S9(2)(f)(iv

Monetary Benefits

There is potential for direct financial benefits to be realised from the implementation of a national bowel screening programme (Appendix 8, Option 4). The expected areas of financial benefit are:

- A reduction in the lifetime costs of treating bowel cancer.
- The reduction in subsequent treatment needed due to stage shift (cancers diagnosed at an earlier stage).
- The removal of pre-cancerous lesions before these can develop into bowel cancer.

These areas of financial benefit have been combined as 'more cost-effective healthcare'. The potential measures are shown in Table 12, section 4.4. These have not been split by individual DHB, on the assumption that there will be an equitable split of these benefits across the country.

Unquantified Benefits

The unquantified benefits described in the Programme Business Case include improved relationship/engagement with primary care, raised awareness of bowel cancer, increased identification of individuals and families with genetic bowel cancer syndromes and wider health benefits.

In addition to these Programme-wide unquantified benefits, the Tranche 1 DHBs have identified local benefits, as summarised in Table 44.

Table 44: Tranche 1 DHB Benefits

DHB	Local Benefit
Waitemata DHB	• Commencing January 2018 WDHB would invite fewer people to participate. This would generate a reduction in the number of screening colonoscopies (and surveillance referrals) and would free up resources (rooms and doctors) for symptomatic work. • Communications/letters to participants would in future be able to emphasise the benefits of regular screening. The pilot has been unable to promote this message because it only existed for a fixed term. Many 'non-responders' in round 2 expressed surprise at receiving a second invitation when they thought a negative result in round 1 meant they did not require further screening. Participation may rise as a result of promoting the importance of regular screening. • Anticipated enhancements to the existing BSP register to support the inclusion of Hutt Valley and Wairarapa DHBs in the programme would generate data management efficiencies.
Hutt Valley and Wairarapa DHBs	• The NBSP will increase overall endoscopy quality and standards. There is likely to be a flow-on improvement in symptomatic service provision, as seen in the pilot and other screening programmes. • The screening programme provides a platform to develop robust workforce plans specifically in the areas of Endoscopy and General surgery (both medical and nursing), thus improving the long-term sustainability of this service in an environment of increased demand. • The NBSP may increase awareness and uptake of other health screening initiatives. HVDHB already hosts Breast and Cervical Screening Services for the sub-region, and there is a strong synergy with these programmes. • Wairarapa is over-represented with bowel cancer – the NBSP rollout will, over time, increase awareness, resulting in earlier detection and better outcomes. • Raising awareness in the screening population is likely to increase the number of early symptomatic self-referrals, thus improving outcomes.

Dis-benefits

In any change process, there are benefits as well as dis-benefits i.e. the known downsides of investing. There are no significant changes to the Programme level dis-benefits identified in the Programme Business Case. These include: increased inequity between population groups, adverse health outcomes from the screening process, delays in diagnosing bowel cancer for some populations, some cancers will not be identified due to the programme parameters, opportunity cost and increased pressures on staff.

The programme level dis-benefits will apply to a greater or lesser extent to all DHBs as the programme is rolled out nationally. The key dis-benefits identified specifically for Tranche 1 are summarised in Table 45.

Table 45: Dis-Benefits of Implementing a National Bowel Screening Programme for Tranche 1

Dis-Benefit	Summary
Opportunity cost	• Prioritisation of capex/opex to implement the programme would preclude investment in other priority areas. • Increased endoscopy suite/theatre and consultant time allocated to screening programme activity would reduce capacity available for other patients/activities. The quantum of cost of treatment services can only be modelled and will not be known in advance, and could restrict activity in other surgical disciplines e.g. through access to theatre time.
Exclusion of 50-60 year age group	• Waitemata DHB will need to manage challenges from people turning 50 after December 31 2017 who will not be able to participate until they turn 60. • Wairarapa DHB is experiencing a number of newly diagnosed 50-60 year olds, who will be excluded from screening.

Dis-Benefit	Summary
Negative impact on achievement of elective targets	• The Programme will put further pressure on the achievement of electives targets and on the surgical workforce to deliver surgical interventions. There will be pressure on endoscopy and surgical treatment in this 'treatment' hump as part of the roll out timing. The demand variance will be smoothed as much as possible to match capacity.

11.5 Tranche 1 Key Risks

The key risks for Tranche 1 are recorded in the Tranche 1 Risk Register. Significant risks from the Tranche 1 implementation that could impact on the Programme have been included in the Programme Risk Register. Detailed risk management would continue during detailed planning and implementation.

The risks assessed as being the highest probability and highest impact for the success of Tranche 1 are summarised in Table 46. A summary of the Tranche 1 risks currently assessed as high and moderate is attached as Appendix 18.

Table 46: Tranche Key Risks

Key Risks	Summary and Risk Management Strategies
BSP+ is not available or cannot be implemented by the DHBs.	BSP+ roll-out to the Tranche 1 DHBs may be delayed, resulting in a knock-on impact on rollout to the remaining DHBs. This would be mitigated by: • Good governance and oversight of Programme and rigorous management of scope and schedule. • Clear scope control. • Good understanding of Tranche 1 DHB IT systems integration environment. • Ensuring adequate resourcing. • Broad stakeholder consultation, clear and detailed IT requirements documented.
Failure to retain key Pilot coordination centre staff towards the end of the Pilot.	If staff cannot be retained, knowledge, expertise and capacity would be lost, impacting maintenance of quality standards. This would increase pressure on remaining staff, may compromise functionality of the coordination centre and could increase costs if a high number of temporary staff are used to fill vacancies. This would be mitigated by: • Working with Waitemata DHB to ensure staff are kept informed of upcoming changes. • Facilitating access for staff to EAP programme. • Working with Waitemata DHB to provide change management support and access.
Loss of key Pilot staff during Tranche 1 roll-out.	Loss of staff would result in loss of programme knowledge and contacts and loss of institutional knowledge. This may impact timing and quality of project planning and implementation and may result in increased costs. This would be mitigated by: • Ensuring good programme documentation. • Identification and planning of succession options. • Working with Waitemata DHB to ensure staff are kept informed of upcoming changes.
Recent changes in pathology service provision impacts NBSP delivery	New staff, systems and processes may not be fully embedded into the new provider's BAU at the time of NBSP roll-out. This may cause difficulties in meeting additional NBSP workload requirements, and may create issues with quality and timeliness. This would be mitigated by: • Working closely with DHB providers to ensure robust plans are in place. • Relationship management activities with the DHB to ensure close monitoring of progress and identification of potential service issues.

11.6 Tranche 1 Key Constraints and Dependencies

The proposal is subject to constraints (limitations imposed on the investment proposal from the outset) and dependencies (external influences e.g. actions or developments outside the scope of the programme upon which success is dependent).

Specific constraints and dependencies have been identified for Tranche 1, in addition to those previously identified for the Programme (see Section 4.6). The key constraints and dependencies for Tranche 1 are summarised in Table 47.

Table 47: Key Tranche 1 Constraints and Dependencies

Constraints	Notes
Workforce and facility capacity	• Access to colonoscopists, pathologists and endoscopy nurses will continue to be a constraint for the screening programme and the symptomatic service. • Constrained capacity for Hutt Valley clinical leader to plan and implement the programme alongside clinical deliverables.
Timeline for go-live	• 2017 • BSP+ to be available in May 2017 to support the first go-live of Tranche 1 from July 2017.
Budget	• Financially constrained environment, with DHBs required to absorb ongoing treatment costs.
IT solution	• Funding approval is required to enable the work required to: o Develop the BSP+ (the expansion to the Bowel Screening Pilot IT solution). o Undertake requirements gathering, design and development for release 1 of the NBSP IT solution. • Alignment with Ministry's IT Strategic vision and integration and deployment practices – requirement to: o Reuse existing technology components where appropriate and leverage and extend existing integration patterns. o Adhere to Ministry best practice. • Resource (personnel and funding) to extend the screening pilot IT solution to support Tranche 1, and to develop BSP+ and to undertake requirements gathering, design and development for release 1 of the NBSP IT solution. • Confirmation that business model for Tranche 1 will be the same as the Bowel Screening Pilot.
Dependencies	**Notes**
Laboratory services	• High quality laboratory services for iFOBT testing and histology are fundamental to the safety of the programme.
NBSP IT Solution	• Business Operational Model: Confirmation that business model for Tranche 1 will be the same as the Bowel Screening Pilot. • DHB IT system integration with bowel screening IT system: IT solution to support the National Bowel Screening Programme must be interoperable with existing DHB IT systems.
ICT systems and local interface	• Extension to bowel screening pilot IT solution must be in place prior to go-live in mid-2017, to enable the DHBs to commence the programme safely.
Primary care engagement/pathway	• The role of primary care practitioners in positive results notification is a new role for them. Primary care will need to support and be active participants in the NBSP.
Theatre access and workforce to deliver surgery	• In order for the programme to be delivered successfully, the DHBs must ensure adequate access to theatres and surgery. This must be in place prior to go-live.

11.7 Tranche 1 Stakeholder Engagement

Tranche 1 Stakeholders

The key stakeholders for Tranche 1 are summarised in Figure 20 and Figure 21.

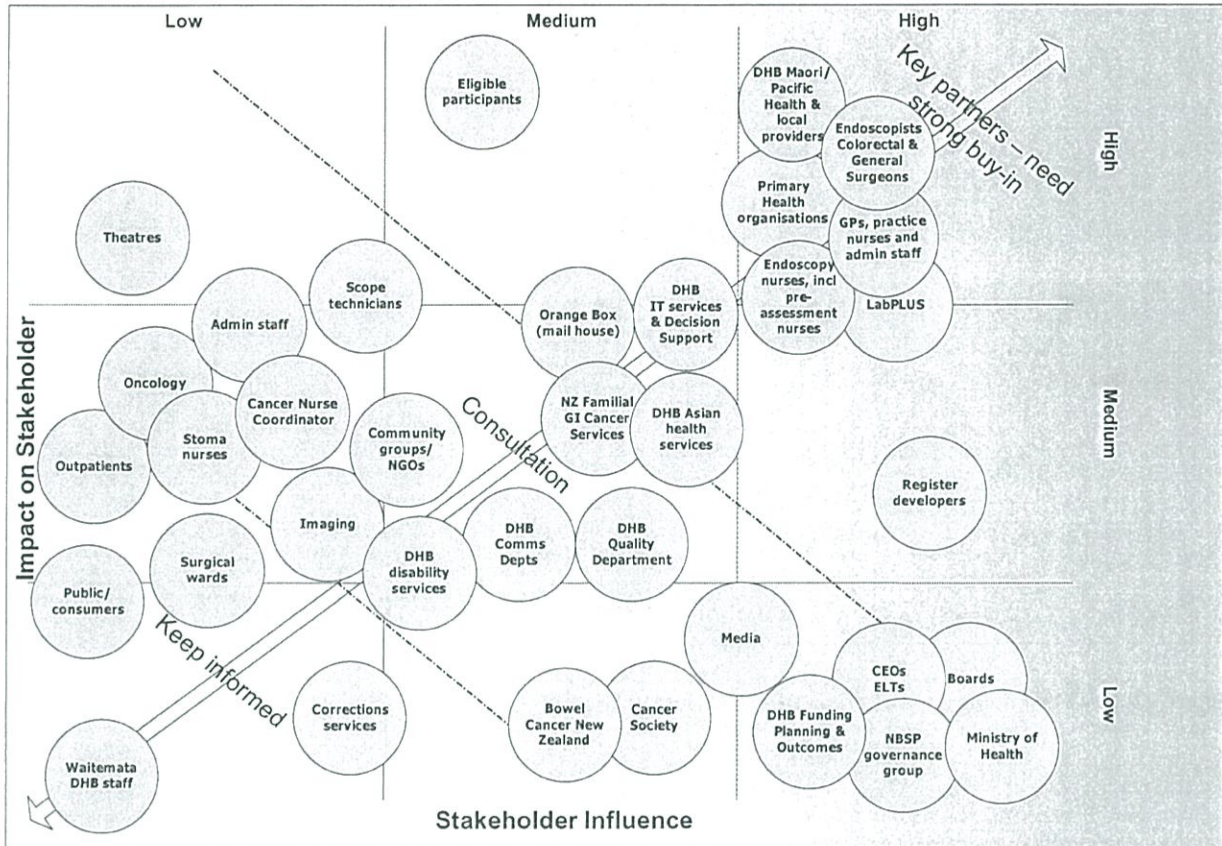


Figure 20: Key Stakeholders - Waitemata DHB

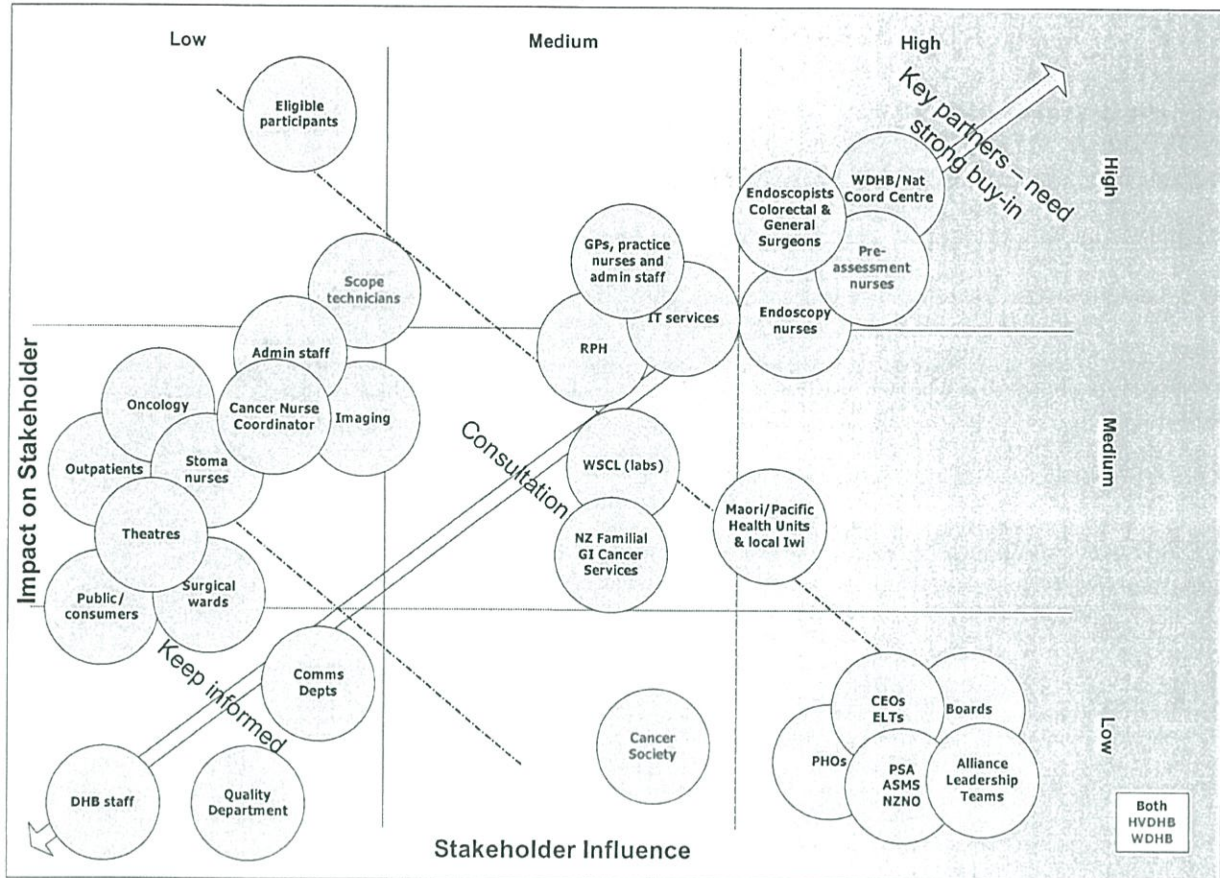


Figure 21: Key Stakeholders - Wairarapa DHB and Hutt Valley DHB