Support to screening services

Consultation Summary Paper

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Executive summary

The National Screening Unit (NSU) has undertaken a review of and consultation on support to breast and cervical cancer screening services. The aim of this latest review was to obtain feedback from key stakeholders about how to improve the current service model and optimise support for priority women in the cancer screening programmes.

Three options were outlined for consideration in a sector consultation paper sent to providers and other stakeholders in October 2014. Significant feedback was received via regional meetings around New Zealand in 2014, and via 28 written submissions.

This paper summarises the process undertaken to review support to screening services. A detailed review of the rich narrative of feedback from all those who provided submissions is summarised, with information on key themes highlighted in both the verbal and written submissions. There was an overall preference for both option two (DHB planning and funding model with optional subcontracting for integrated services) and option three (DHB planning and funding model with subcontracting for integrated services required). However, it became apparent when looking at the feedback that further time was needed to consider the shape of the services, as it is clear that a one-size-fits-all approach is unlikely to work.

The NSU would like to strengthen the focus on measuring outcomes, with a new model for service delivery that will ensure optimal quality, with collaboration, integration and successful uptake of services. The NSU will work closely with the sector to look at ways of designing services with a focus on flexibility in achieving the desired results.

Current support to screening services contracts will be extended until 31 October 2016. New purchasing and funding arrangements will be implemented in contracts from 1 November 2016.

Background

The NSU, within the National Health Board of the Ministry of Health, is responsible for the development, management and monitoring of population-based screening in New Zealand. The NSU funds some providers to improve the participation of priority group women within the breast and cervical cancer screening programmes. Priority group women include Māori and Pacific women, women who have never been screened, and women who are under-screened. The NCSP service also prioritises Asian women. These services are known as support to screening services.

Support to screening services have been funded by the NSU since 2002. For the BreastScreen Aotearoa (BSA) programme, support to screening services offer recruitment and retention activities, supporting women to attend mammography screening, assessment and treatment appointments. For the National Cervical Screening Programme (NCSP), support to screening services cover invitation and recall activities, and support women to access smear-taking and colposcopy services. Previous reviews have recognised the importance of support to screening services in supporting Māori and Pacific women's participation in BSA and NCSP.

Currently, support to screening service providers are contracted by the NSU, with services provided in 10 DHB areas for NCSP and 16 DHB areas for BSA. Services are provided in geographical areas with high numbers of priority group women.

Purpose and introduction

This paper summarises the process undertaken to review support to screening services, and summarises the feedback received.

Past reviews of support to screening services have found a lack of clarity from the NSU and differing understanding from providers about what they were contracted to do. Previous contracting arrangements have also not provided the opportunity for the NSU to fully assess service and cost effectiveness, or value for money.

Concepts of Whānau Ora (placing families at the centre of service delivery) and holistic care are important in the current environment. DHBs are working closely with their primary care colleagues to align arrangements, and offer a coordinated service across regions for BSA and for NCSP. While health promotion is important, the NSU is keen to re-focus on more individual support for women.

The purpose of the latest review into support to screening services was to:

- Evaluate the current delivery and funding model for these services.
- Assess who would be best placed to deliver services and what should be contracted for to ensure effective service delivery.
- Improve regional collaboration and integration with other health services.
- Increase access to breast and cervical cancer screening for priority group women.
- Implement new contracts that have clear definitions and expectations of service delivery, and specific reporting requirements.

Appropriate and consistent reporting will be a requirement of future contracts. Feedback received from this latest review into support to screening services will guide future service provision.

Process

The NSU held a stakeholder workshop in October 2013 to discuss options for support to cancer screening services. Six options were discussed at the workshops; of these three were not supported by the NSU or by stakeholders and were not included in the review. Options that were not supported included having no contracting; maintaining the status quo; and contracting with BSA lead providers and NCSP regional services to provide support to screening services within their own organisations.

The three options considered in the review were:

- Option 1: Lead provider/regional coordination model – subcontracting with independent service providers (ISPs).
- Option 2: DHB planning and funding model – subcontracting with integrated services optional.
- Option 3: DHB planning and funding model – subcontracting with integrated services required.

In February 2014, the NSU met with the Māori Monitoring and Equity Group (MMEG). The group supported the process, and agreed with the approach for the proposed consultation. There was support for integrated service delivery, although logistical problems were identified. MMEG was in favour of options two and three, but was not in favour of option one, which was viewed as potentially creating a power imbalance. Concerns were expressed that in some areas of New Zealand relationships with local DHB planning and funding units could be improved.

In October 2014, the NSU published the sector consultation review paper on support to screening services. The eight-week consultation period that followed ended on 1 December 2014. Key stakeholders were contacted as part of the consultation process, including DHBs, currently contracted non-government organisations, and breast screening lead providers.

Eight meetings held around the country provided verbal feedback and 28 written submissions were received. There was good representation across current providers, breast screening lead providers, and DHBs.

There was a wide variety of feedback from the meetings and the submissions. This will help to inform the decision making and will guide the implementation process.

Consultation feedback

Below is a summary of the written submissions in relation to each of the three options presented.

There is also a more detailed review of some of the key themes raised both verbally during the meetings, and in the written submissions.

Options

There was some support for all three options. In addition some respondents suggested maintaining the status quo.

Option one: Lead provider/regional coordination model

The lead provider/regional coordinating model was supported by just four of the written submissions. Support for this option came largely from BSA lead providers, with one DHB, and one provider not currently contracted, offering their support. There was limited support for this option in the submissions, and from MMEG.

Options two and three: DHB planning and funding model

Options two and three, which both support a DHB planning and funding based service, were together supported by 16 of the written submissions.

Option two

This option received support from five respondents, mostly DHB planning and funding units. Feedback in favour of this option suggested support for local service management with a need for flexibility in service provision. Some respondents felt that although they could largely implement an integrated service, this would present too big a challenge at the current time, and could impact on delivery.

Option three

This was supported by eleven of the written submissions; those in favour of this option were mainly current providers, but also some DHBs and primary care organisations. Supporters of option three welcomed the opportunity to provide an integrated BSA and NCSP service. It was suggested that DHBs have a good understanding of regional needs and good relationships with local primary health organisations and non-government providers, which could be further strengthened with this option. It was proposed that there could be advantages with having a single point of accountability for screening outcomes within the DHB, and that this would make use of existing knowledge and expertise.

Status quo

The remaining eight submissions did not support a particular option, or were in favour of retaining the 'status quo', where the NSU contracts directly with service providers.

Themes

Following the consultation meetings and the submissions, a number of themes emerged. Some of these themes were directed by the consultation questions, and some were introduced by those involved in the consultation process.

A number of the themes raised both pros and cons, which shows the range of feedback as well as the complexity of the support to screening service provision. Key themes are highlighted below.

1. Contracting and funding

The issues around contracting and funding attracted more comments than any other theme during the consultation process, with numerous concerns raised about how contracts and funding would be managed. Some providers raised the possibility of losing contracts and, as a result, losing some high-level expertise and long-standing relationships.

There were a number of comments about the procurement processes, and the financial implications of the different options were widely discussed. Some suggested that option three could add an extra layer of administration, bureaucracy and increased costs, and that sometimes DHB planning and funding can feel distanced from a local level. An alternate view was expressed that DHBs are in a good position to understand providers at a local level.

There were concerns that option three may lead to less money going to the frontline for service delivery. For a contract that is already relatively small in value, it was suggested that any reduction in funding will make this contract less appealing for a provider to take up. Others suggested that option three offered a more integrated service and would streamline services and save costs, which would mean money could be invested elsewhere. One example given was that of sharing transportation services for BSA and NCSP.

Also in relation to funding, there was concern about how funders (but particularly DHBs) would manage the funding it received, and whether this funding would be passed on to providers for service delivery in its entirety. There were questions about whether the funding could be ring-fenced to ensure it is used for the intended purpose. There were concerns about the level of top-slicing, or using part of the budget for other purposes. Funding for support to screening services would need to

be considered in conjunction with other funding that the DHB receives for breast and cervical screening, such as cervical screening regional coordination funding.

DHBs raised questions about the expectations that the NSU will have if DHBs are managing the contracts, and the funding and other support that may be required. This will be addressed during the development of the new service specification. The new specification will require greater clarity around service delivery, reporting, eligibility, and how the support to screening services link with other parts of the screening pathway. Clear expectations are needed with reporting against agreed outcomes.

2. Integrated service delivery

Implementing closely integrated service delivery was also a common theme.

Some providers, especially those holding multiple DHB or Whānau Ora contracts, indicated integrated service provision was already in place. A number of DHB and Māori providers commented that integrated service delivery was in line with their kaupapa.

Comments in favour of integrated service delivery suggest this would enable increased collaboration, close service alignment, and streamlined reporting. A single point of accountability was viewed as an advantage by some.

Some providers, however, highlighted practical issues associated in the delivery of integrated services or a 'one-size-fits-all' approach. For example, different skills and knowledge are needed for the different services and some respondents felt combining programmes and services may dilute key messages. Also there were concerns that more focus may be given to one programme than the other. Logistical issues raised included the different age ranges for the two programmes (45 to 69 years for BSA and 20 to 70 years for NCSP), different intervals for screening (every 2 years for BSA and every 3 years for NCSP), and different ways of operating and making referrals.

3. Relationships

The importance of communication, collaboration and building strong relationships both between DHBs and service providers, and with women using the screening services, was a common theme.

Positive relationships with whānau and communities were noted as a key success factor in supporting women to attend screening. Single focus campaigns were suggested to be more effective, particularly in rural areas.

In some regions, excellent working relationships were reported between DHBs, non-government providers and other screening service providers. In other regions there

were concerns from providers about working with planning and funding teams. Some of the feedback received suggested that option three could provide an opportunity to strengthen relationships between providers and DHBs. Education and training may be needed, however, to ensure improved knowledge among planning and funding staff of screening services.

4. Regional collaboration

Regional collaboration is considered important by the NSU and this issue was raised during the consultation process to ensure all those involved in service provision are working well together; for example DHBs, lead providers, non-government providers, primary health organisations (PHOs), health professionals and support workers.

Feedback about collaboration was largely positive; although some people identified that some relationships are a work in progress. There was clear feedback that population characteristics are best understood at a local level and there was consensus that collaboration among screening providers should be promoted.

It was proposed that a better model that is more closely aligned with service delivery is required. There was some support for working more closely with PHOs, although some respondents saw this as a potential issue. It was suggested that PHO involvement aligns more closely with NCSP than with BSA, given the delivery of most cervical screening services in primary care.

5. Training and upskilling staff

Workforce issues, both for existing staff who are highly skilled, and for those who may need support to upskill, were discussed by several respondents.

There were comments received that the skills needed for breast and cervical screening support are very different, and there may be some need for further staff training. It was also suggested that the NSU may need to invest time upskilling DHB contract managers to be able to offer an adequate level of feedback and support to providers.

It was highlighted that all those involved in support to screening services should have the relevant skills, knowledge and tikanga to deliver optimal services.

6. Reducing inequalities

It was reported in some submissions that there is variable service delivery throughout the country with limited evidence in some areas that services are improving outcomes.

It was proposed that different approaches are needed for women who are enrolled with a PHO and those who are not, and that this needs to be a consideration which ever model is adopted moving forward.

Women with special needs were highlighted as needing particular attention, for example those with low health literacy, those with physical and cognitive challenges (physical disabilities, lack of mobility, obesity and mental health issues), immigrant populations and low-income groups for whom cost and access are a barrier (for example costs involved with having a smear).

It was suggested that specific iwi need to be recognised and priority groups need one-to-one consultations and support. Services need to be adaptable and accessible to all cultures and religions and need to cater to women living in both urban and rural areas.

7. Flexibility

In terms of service delivery, flexibility is important so the best possible service can be provided. For example, offering extended hours and providing contracts that are not based solely on geography. Feedback from Northland reported that the engagement of kaiāwhina has been shown to be successful where used in other health programmes and would assist in reaching priority group women in this region.

Flexibility in implementation was also considered to be important so that development of the services is not rushed, and important relationships are maintained.

8. Implementation

Feedback on how implementation would work, and some potential challenges, was another key theme of the feedback. It was suggested by some that 12 months would be required to plan and implement new services, and concern was expressed that some vulnerable women may be negatively impacted during the transition phase. Continuity of care was viewed as being very important.

Next steps

Following detailed analysis of the feedback, it has become apparent that further time is needed to consider the shape of the new services, as it is clear that a one-size-fits-all approach is unlikely to work.

The NSU is keen to develop a new model for service delivery that will ensure optimal quality, and will promote collaboration, integration and successful uptake of services. The focus on measuring outcomes within the contract will be strengthened.

The NSU will work closely with the sector to look at ways of designing services with a focus on flexibility in achieving the desired results.

Purchasing and funding arrangements will be implemented in contracts from 1 November 2016. The NSU will support the implementation of new contracts and provide further training and information where needed.