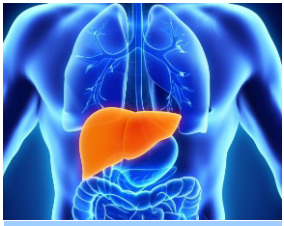
New Zealand Society of Gastroenterology Inc

2019 Annual Report



President's Report

by Dr Malcolm Arnold

It's been a busy old year. In the past twelve months the NZSG executive have attended five teleconference meetings and three face to face meetings, the last of those being on November 26th. We have discussed and debated a large number of issues including concerns around workforce pressures, including those resulting directly and indirectly from the rollout of the NBSP, and the ever increasing need to provide colonoscopy services; collegiality amongst endoscopists; credentialing of endoscopists, recognition of training, and definition (in conjunction with EGGNZ and the Conjoint Committee) of what constitutes a trained endoscopist; concerns regarding pressures placed on our nursing teams; training issues, including talks about what we need in terms of a national endoscopy training centre; bullying; representation of the voices of our members and attempts to stick up for them when faced with strategically unhelpful, bean counting DHB directives and personnel, and a variety of other topics which we are asked to consider as an executive. We discussed the Nurse Endoscopist prescribing issue and made attempts to follow up with NZ Nursing Council. Dr Walmsley and EGGNZ are making progress with this.

Professor Murray Barclay, GE and chair of ASMS, joined the Exec meeting in March to discuss job/service sizing and we subsequently wrote to all DHBs encouraging them to contact ASMS and do it. Several DHB units seem to have gained some extra FTE allocation (though not in every case funding!). In a conversation with Murray last week he pointed out that if there is a recognised and funded case for more FTE the funds should, pending further appointments, be distributed pro rata amongst those in post.

The exec was approached by one of our members seeking clarity on whether patients with a family history compatible with Lynch syndrome should have colonoscopy before genetic evidence was available (on the basis that a potentially dangerous expense- and resource- limited procedure maybe be unnecessary if genetic studies were favourable) and we have sought advice on this from Prof Susan Parry and the NZFGICS team.

Anna Clark, Deputy Director-General, Health Workforce, MOH met with the Exec on 20 September and agreed to take our Peripheral Fellowship paper to DHBs' Workforce Strategy Group to see if it can be implemented in Taranaki DHB and beyond.

The exec members put together a strongly worded letter to the executive board

and the CEO of Southland Health in response to a report on endoscopy services in that DHB, seeking surety of action regarding collegiality of and respect for GE and surgical colleagues, the standard of training for advanced trainees, and equitable healthcare for all patients in that DHB.

On behalf of the executive of the NZSG I attended the Cancer at a Crossroads Conference in January held in Te Papa, Wellington, where there was a great deal of talk about how best to address the huge burden of cancer in NZ, and the fact that in many respects NZ lags well behind other OECD countries in funding and availability of what are considered in the modern day to be essential for managing patients with malignant disease. Some important messages came through and as a result of some of those and other actions by some lobbyists the MoH has put together a package which may help address some cancer related issues.

On 21 March 2019 I attended the International Medical Education Leaders Forum (IMELF) in Auckland, with many eminent educators in many medical fields from Canada, Australia and NZ, where artificial intelligence and its medical uses was discussed. Watch this space for amazing developments.

From 1-4 April 2019 Mr Mike Hulme-Moir (GI surgeon, North Shore) and I attended the WGO train the trainers course in Bucharest, Romania. This was a course incorporating all aspects of training of registrars and fellows, was highly educational and culturally very enjoyable. Members are encouraged to apply for this annual WGO-sponsored course.

Dr John Wyeth, ex Medical Director of Pharmac was invited to and met with the Exec on 3 May to advise about how to engage with Pharmac. We have learned some valuable approaches, thanks John.

Over the past few months I have written to Pharmac about delivery and availability problems with several drugs including Ursodeoxycholic acid, Colifoam enemas, Ranitidine, with varying degrees of engagement and feedback. We have also requested of Pharmac information about endoscopy Medical Devices procurement, and have expressed interest (read insisted) in being involved. Pharmac have informed us this will be happening late 2019- early 2020. Dr Rees Cameron has kindly offered on NZSG's behalf to be part of the NZ Health Partnerships Endoscopy Procurement Project.

On 31 May 2019 I met Michelle Arrowsmith, Deputy Director-General, DHB Perfor-

mance, Support and Infrastructure, at MOH in Wellington, and discussed with her the workforce issues faced by gastroenterology throughout the country.

I was sponsored to attend AGW in Adelaide between 8-10 September 2019 and delivered the Trans-Tasman Lecture entitled "Quality in Endoscopy – A New Zealand Perspective" as well as delivering another lecture regarding colonoscopy quality indicators. It was a great meeting and we were met with much admiration for the stand NZ has taken on quality issues in endoscopy.

Members of the exec (predominantly Zoe) have been putting together a variety of guidelines for a variety of GI conditions which will be available via the NZSG website for use by members in any DHB.

The year of the trainee saw us try to enhance feedback from trainees about what is good and what can be improved in GE training in NZ. We are endeavouring to improve training altogether, are adding to the curriculum (with some element of training in ultrasound being part of the possible curriculum) and are negotiating incorporating e-learning modules into the introduction to endoscopy course, so that background work can be done online before the course, allowing more hands-on learning on the course itself.

Our long serving and hard working exec member Jeff Wong is leaving after 9 years as treasurer. He has done a sterling job and will be sadly missed but we hope to soon have a new treasurer in place.

Executive Priorities 2020 and beyond
The exec members are well aware that we face a variety of challenges in our day to day practice and that there may be many around the corner which need to be addressed on a large scale. To that end we have decided to hold a strategic planning day on Saturday November 30 and will keep members informed of discussions and plans resulting from the day. A survey was sent to all members via external consultant Allen & Clarke to seek members' feedback and we will take the messages from the survey on board.

The exec are engaged, along with several of the Society's members, in ongoing discussions with PHARMAC re biologic agents and other GE drugs not currently readily available in NZ. As mentioned above we are also discussing medical devices with the NZ Health Partnerships Endoscopy Procurement Project.

Workforce issues: following production of our paper in 2017 Michael Schultz is working on a publication on issues in this arena.
National Training Centre: The Executive are in strong support of the concept sug-

gested by EGGNZ and endorsed by MoH of establishing a national training centre which we foresee will provide basic endoscopy training courses, upskilling of practice including polypectomy courses for endoscopists, training of nurse endoscopists and of endoscopy nurses. This is in concept phase only at the moment but we hope to make considerable progress in the next few months.

Issues were raised by a group of gastroenterologists with regard to selection processes for advanced trainees with regard to equity and the need to represent the diversity of the NZ population and we are aiming to address these issues.

Appointments

- NZ Health Partnerships Endoscopy Procurement Project – Rees Cameron appointed
- NZ Conjoint Committee –NZSG Surgical Rep Michael Booth has left the exec and we are pleased to welcome Bevan Jenkins in his place.

Courses in 2019

- Nutrition course 25-27 April University of Auckland
- Hepatology Network Meeting 10 May Auckland
- Train the Colonoscopy Trainer course 26-27 May WDHB and Olympus Live
- Introduction to Endoscopy course 18 June Christchurch
- Hepatology Network Meeting 26 November Wellington
- NZSG NZgNC ASM 27-29 November TSB Arena Wellington
- Introduction to Endoscopy course 11 December Auckland
- Train the Colonoscopy Trainer course 8-9 December WDHB and Olympus Live

Quite a list of activities and more to come – watch this space.

I would like to acknowledge the invaluable work done by the NZSG Executive Officer Anna Pears who amongst all her other talents, has managed to keep your President on track and up to speed. I am also immensely grateful to the commitment and hard work done by all the members of the exec.

Thanks one and all.

Malcolm

Secretary's Report

by

Dr Campbell White

Membership numbers have increased since last year with more regular, research and scientist members. Trainee members have dropped by one. We currently have 176 members, 117 full members, 29 trainees and 18 researchers. This also includes 12 honorary members.

We continue to foster the links with our international sister Societies with official representation on committees of the Asia-Pacific Association of Gastroenterology (APAGE), the Asian-Pacific Society of Digestive Endoscopy (PSDE) and on the editorial and outreach committee of the World Gastroenterology Organisation.

Dr Malcolm Arnold delivered the Trans Tasman Lecture at Australian Gastro Week in Adelaide in September. His focus was the quality initiatives in endoscopy being developed in NZ. The newsletters continue to be an important vehicle to communicate with our members. We have had a great response for requests to contribute to the newsletter and the 2019 editions have been informative and varied.

Research grants from NZSG and assisted by industry have delivered to the tune of $83750 (Janssen Research Fellowship $65,000, Small Research Grants $15,750 and ASM awards $3000.)

NZSG has been continuing to work in partnership with industry sponsors to secure research funding. This is an increasingly difficult area with budgets becoming more restricted.

Treasurer's Report

by Dr Jeffrey Wong

The year ending 30 June 2019 is reported.

Attached are:

- Statement of financial performance for the year ended 30 June 2019 with the previous year for comparison
- Statement of financial position as at 30 June 2019 with the previous year for comparison
- Budget for 01 July 2019 to 30 June 2020

Operationally there was a deficit of $101,588 against a budgeted surplus of $11,970. This was principally due the Janssen Research Fellowship from 2018 being paid out in 2019 and final costs relating to the workforce survey.

Previous Year's Operational Surpluses (deficit)							
2011	2012	2013	2014	2015	2016	2017	2018
51,277	46,682	42,028	(49,322)	(17,330)	(100,697)	31,110	54,856

Previous Year's ASM surpluses							
2011	2012	2013	2014	2015	2016	2017	2018
103,845	65,350	62,633	55,786	29,964	81,314	64,676	34,671

Our financial position as at 30 June 2019 was $441,537

Previous years financial position							
2011	2012	2013	2014	2015	2016	2017	2018
519,416	582,380	624,408	575,087	557,756	457,059	488,169	543,025

The society finances remain secure.

The budget for the year ending 30 June 2020 is attached. We are conservatively budgeting for a deficit of $35,095.

- The membership fees have not been revised for two years and we propose raising the membership fee to $475.00 ($150 trainee/other).

Entity Information

New Zealand Society of Gastroenterology
For the year ended 30 June 2019

'Who are we?', 'Why do we exist?'

Legal Name of Entity

New Zealand Society of Gastroenterology

Entity Type and Legal Basis

Incorporated Society established 15th October 1992 and the Incorporated Societies Act 1908

Registration Number

CC46030

Entity's Purpose or Mission

The advancement of knowledge of Gastroenterology in New Zealand

Entity Structure - Executive

Michael Schultz
Malcolm Arnold
Campbell White
Helen Evans
Thomas Caspritz
Zoe Raos
Dominic Ray-Chaudhuri
Judy Huang
Andrew McCombie
Karen Kempin
Karen Clarke
Amanda Chen
Charlotte Daker

Main Sources of Entity's Cash and Resources

Grants, Subscriptions and an annual conference

Main Methods Used by Entity to Raise Funds

Application for grants and running courses/meetings for members

Entity's Reliance on Volunteers and Donated Goods or Services

The society does not rely on volunteers

Statement of Service Performance

New Zealand Society of Gastroenterology
For the year ended 30 June 2019

'What did we do?', 'When did we do it?'

	2019	2018
Description and Quantification of the Entity's Outputs		
Janssen Research Fellowship	130,000	-
NZSG Small Research Grants	15,750	11,213
Best Paper/Poster ASM awards	3,000	3,750
Grant to EGGNZ	-	5,000

The Janssen Research Fellowship of $65,000 each was paid out in August 2018 and March 2019.

Description and Quantification of the Entity's Outputs

One of the key objectives of the Society is to conduct scientific and educational meetings and in November 2018 the Society convened the NZSG NZNO Gastro Nurses' College Annual Scientific Meeting in Dunedin.

There were also two Hepatology Network Meetings (November 2018 and May 2019), a Clinical Nutrition course and a Train the Colonoscopy Trainer course.

Another objective of the Society is the promotion of improved standards in the practice of gastroenterology. The Society coordinated the Gastro Advanced Training Selection Interviews which enable the selection of the most skilled applicants for gastroenterology training. The Society facilitated an Introduction to Endoscopy Course to increase the endoscopy skills of all physician, surgical and nurse endoscopist trainees.

Additional Information

The quantity of grants and fellowships awarded by the Society varies from year to year. The Society wishes to acknowledge the generous financial contribution of the pharmaceutical companies toward these grants for research and the advancement of knowledge in the field of gastroenterology.

Additional Output Measures

The Society works closely with Pharmac, Medsafe and the Ministry of Health to ensure the best outcomes for the practice of Gastroenterology. The Society published a book " A Critical Analysis of the Gastroenterology Specialist Workforce in New Zealand Challenges & Solutions" in November 2018.

Statement of Financial Performance

New Zealand Society of Gastroenterology
For the year ended 30 June 2019

'How was it funded?' and 'What did it cost?'

	NOTES	2019	2018
Revenue			
Donations, fundraising and other similar revenue	1	30,000	30,000
Fees, subscriptions and other revenue from members	1	43,131	41,848
Revenue from providing goods or services	1	96,281	103,099
Interest, dividends and other investment revenue	1	8,740	21,901
Total Revenue		**178,153**	**196,849**
Expenses			
Costs related to providing goods or service	2	130,991	122,030
Grants and donations made	2	148,750	19,963
Total Expenses		**279,741**	**141,993**
Surplus/(Deficit) for the Year		**(101,588)**	**54,856**

This statement has been prepared without conducting an audit or review engagement, and should be read in conjunction with the attached Compilation Report.

Statement of Financial Position

New Zealand Society of Gastroenterology
As at 30 June 2019

'What the entity owns?' and 'What the entity owes?'

	NOTES	30 JUN 2019	30 JUN 2018
Assets			
Current Assets			
Bank accounts and cash	3	424,235	504,742
Debtors and prepayments	3	26,172	37,728
Total Current Assets		**450,407**	**542,470**
Non-Current Assets			
Intangibles	3	3,943	7,886
Other non-current assets	3	15,920	17,045
Total Non-Current Assets		**19,863**	**24,931**
Total Assets		**470,270**	**567,401**
Liabilities			
Current Liabilities			
Creditors and accrued expenses	4	28,833	23,463
Other current liabilities	4	-	913
Total Current Liabilities		**28,833**	**24,376**
Total Liabilities		**28,833**	**24,376**
Total Assets less Total Liabilities (Net Assets)		**441,437**	**543,025**
Accumulated Funds			
Accumulated surpluses or (deficits)	5	441,437	543,025
Total Accumulated Funds		**441,437**	**543,025**

This statement has been prepared without conducting an audit or review engagement, and should be read in conjunction with the attached Compilation Report.

NZSG Budget

For financial year ending 30 June 2019

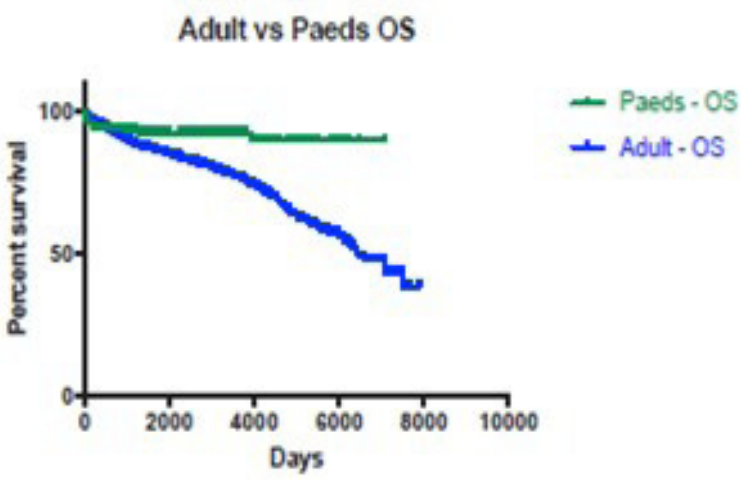
	Budget 2019-20	Actual 2018-19
Income		
ASM Surplus	40,000	34,671
Australasian Viral Hep Conf	0	2,814
Nutrition Course	0	18,856
Interest	7,000	7,885
Investment Income	855	855
Janssen Research Fellowship	30000	30,000
NZSG Run Courses	18000	18,000
Hep Network Meeting	1000	-150
IBD Symposium	0	9,783
Subscriptions	61375	43,131
Gastro Match Fees	5000	4,783
Total Income	**163,230**	**170,628**
Expenditure		
Accounting Fees	2500	2,000
ASM Expenses	0	0
Bank Charges	1400	1,366
Committee Meetings - Catering	1000	0
Committee Meetings - Travel	7300	7,253
IT Expenses	1600	1,524
Insight Mtg Sponsorship	0	4,348
Gastro Match	900	921
Indemnity Insurance	1625	1,565
Publications	0	15,144
Strategic Planning Day	7500	0
Membership Int Organisations	1500	1,403
NZgNC share of ASM profit	10000	10,131
NZSG Run Courses	12500	12,345
Research Fellowship	65000	130,000
Awards & Prizes	18000	18,750
Secretariat Costs	70000	66,728
Total Expenditure	**198325**	**273,478**
NET	-35,095	

New Zealand Liver Transplant Unit Report

by Professor Ed Gane

Liver Transplant Activity

In 2018 we undertook 96 liver transplant assessments and did 49 transplants in 48 patients, 8 of which were children. The average waiting time was 156 days (range 1-840 days). There were 22 females and 26 males transplanted. The mean age of adults transplanted was 56 years and that of children was 2 years. The majority of transplants in adults were done for viral hepatitis-related liver disease, non-alcoholic fatty liver disease or alcoholic liver disease and many of the adult recipients (35%) had small liver cancers (hepatocellular cancers) at the time of transplant. The children were mostly transplanted for biliary atresia. The mean surgical time was 6.7 hours (range 4.1 – 16.7 hours). The mean number of units of red blood cells was 1 unit (range 0 – 89 units). In 44% of cases, no red blood cell transfusion was needed. Outcomes remain excellent (see survival curves below).



We now have done over 850 liver transplants since the unit opened in 1998.

Liver Research Activity

The Liver Research Unit currently is conducting active studies in many different areas of hepatology. The most active area for growth has been in hepatocellular carcinoma – a huge unmet need with now more than 300 new cases presented at the HCC MDM each year. In addition to several studies of checkpoint inhibitors with or without oral TKIs as first line therapy for patients with advanced hepatocellular carcinoma, we are also conducting studies of checkpoint inhibitors as adjuvant therapy to prevent recurrence after resection, ablation or TACE. In addition, we have started new studies of novel therapies for Wilson's Disease (a new once daily chelator), Hepatitis Delta (lonafarnib, the first oral therapy), PSC (FXR agonist) and NASH (CCR2/CCR5 inhbitor), HBV (TAF in pregnancy). We have 3 studies of antiviral therapy in novel HCV populations including HIV coinfection and acute infection. To match the increasing workload, the staff at LRU has also grown over the last 12 months. Dr Andrew Knox has been appointed as a permanent full-time MOSS to coordinate the many HCC studies and supervise the clinical research registrar (MATCH). A separate non-MATCH advanced research fellowship has been funded for trainees wishing to complete an MD or PhD in Hepatology. Current Fellow is Dr Santhakumar (PhD in immunology of advanced HCC). The research coordinator/nurse pool has grown to 9 including a manager. Later this year, the LRU space is being expanded to include a large day-stay facility for infusions, intensive PK and monitoring.

Paedatric Gastroenterology Services Report

by Dr Helen Evans

Clinical observations

- Increasing presentations of very early onset IBD (VEO-IBD) in infants
- Eosinophilic oesophagitis increasingly common & a burden on endoscopy time
- Psychosocial & educational issues in paediatric liver transplant survivors impacting on adherence & graft loss in young adult life – requires more psychological FTE & intervention

National Clinical Network

- Working with other paediatric services to create fatty liver disease guidelines

New Zealand Paediatric Surveillance Unit studies

- Paracetamol overdose leading to admission completed – infants most commonly affected due to staggered dosing in viral illness. May provide evidence to lobby to decrease number of products available
- Alagille syndrome study possible to commence
- New cost of $5000 per annum per study may prohibit new future studies

Collaborative research studies

- Audit of adherence to IBD guidelines
- Vitamin D status in IBD
- Update of outcomes of 2015 IBD cohort
- Parental and child knowledge of IBD
- Role of ursodeoxycholic acid in prevention of cystic fibrosis liver disease
- International intestinal failure registry
- Hepatitis C in New Zealand children
- TAF for hepatitis B in children
- Alagille syndrome
- Graft injury following liver transplantation
- Ethnic disparity in biliary atresia
- Atopy & allergy following liver transplantation

New initiatives

- Biopsy-free diagnosis of coeliac disease at Starship Child Health very successful
- 2/3 patients referred for coeliac disease diagnosed without biopsy (females > males)

NZ Intestinal Failure Service Report

by Dr Helen Evans

The National Intestinal Failure Service (NIFS) is contracted by the Ministry of Health and delivered by Auckland District Health Board. It spans adult, paediatric and neonatal practice. There is a requirement that DHBs report patients with intestinal failure to the NIFS register. The register has now reached two years' worth of data.

Personnel

- Change of the Clinical Director for Paediatrics from Dr Helen Evans to Dr Amin Roberts

Clinical observations

- Increasing contribution of dysmotility as cause of IF across paediatrics and adults
- Ethnic disparity in newborns with IF (Māori > European)

National Clinical Network

- Paediatric IF guidelines almost ready
- For ratification by National Clinical Network in early 2020

Education and Network Day

- 2019 110 delegates, great feedback
- 202 April 2020 in Wellington

Collaborative research studies

- Participation in international intestinal failure registry for children
- Defining new criteria for intestinal transplant in children
- Ongoing burden of healthcare needs in paediatric survivors of IF

New initiatives

- Possible change of name to reflect importance of intestinal rehabilitation in management of IF

Congress of the Intestinal Rehabilitation and Transplant Association

- Auckland bid successful
- 30 June – 3 July 2020
- Save a date in your diaries

NZ ATS Report

by Dr Adrian Claydon

This year has been an interesting year on the committee. The RACP is undertaking a lot of work to update the advanced training curriculum across all the medical specialties, and the College and its committees are hoping to achieve a modern, evidence based training program fit for the next decade. There is a consultation process underway, and the gastroenterology ATS really urge all of you to express your views when given the opportunity in upcoming college correspondence.

I've had questions asked of me regarding getting courses approved by the college. The Royal College of physicians only endorses courses that it runs. If Hospital departments or other institutions put on courses to improve training in areas of gastroenterology, the college will not advertise these or support them. This does not mean that they are not good courses but that you are on your own to get people to attend. There seems to be a process by which courses can be added to the list of DHB approved courses and educational material. This appears to be a contractual process and not a college one. We are currently looking into this.

I have learnt much about what the college does and does not get involved in. I thought it might be useful to share some of my insights. It might seem strange that the college is not interested in endoscopy training, despite it being a key skill that our trainees learn over their 3 years of training. The reason for this is that in advance training committee in Australia has delegated this role to the conjoint committee. As there are surgical trainees and now nurse endoscopists (In NZ) learning this skill, it has been decided that delegating this part of training to a committee run by surgeons and gastroenterologist would be the best way of ensuring consistency across specialties. This does potentially mean that the Conjoint committee can have a lot more say in how trainees train, and potentially draw up a curriculum for this purpose. The ATS would like to be kept informed about any recommendations for change.

As many will be aware there were a few hiccups at the MATCH meeting this year. (We love you David) With the advice from Ministry health workforce New Zealand that more training posts were needed, a number of centres were keen to provide additional training posts. Unfortunately the college has processes it needs to go through, to ensure consistency of standards cross Australasia. This means that training posts need to be applied for, assessed and deemed to have enough facility, patient contact and supervision to provide high quality training. Our small committee

of 6 members have to find the time to visit units and report back to the college before post can be approved. This is not a quick process. We would urge centres thinking of increasing their training numbers, to let us know as soon as possible, and also filling all the paperwork to assist us making the decision. I have been assured that the college now recognises the importance of having the chair or delegate of the ATS attend Match day. The committee also asks that before the appointment letters go out, our education officers have an opportunity to check them against the list of approved training posts, to ensure that trainees will receive the preapproval that they need.

We have increased number of training posts by 2 this year up to 20. Including fellowship positions and are overseas trainees are currently 26 advance trainees on our books.

We have had yet another change to our education officer at the college. Michelle Sharpe is taken over from Jenny Lee. This has been the third change in the last 18 months, and I apologise to the college for being so hard to work with! It has been a bit more difficult with lack of institutional knowledge supporting me. I do thank Carolyn Lill, who is the education officer for general medicine, for her assistance over this time.

I thought I would put a paragraph together to provide insight into some RACP speak. We often get referred to as the gastroenterology SAC. We now he gastroenterology ATS. This is the advanced training subcommittee, the advanced training committee (ATC) being the Australian equivalent on which I am Deputy chair. You will also hear the terms core and non-core posts. The important thing to know is that non-core cannot precede core training. The reason for this is that non-core is considered to be training put together by the trainee to round off their training once they have completed the acquisition of core skills. Therefore to do non-core training before core misses the point of this.

This year we welcomed a new trainee representative to the committee. Anthony Whitfield replaced Sri Selvaratnam. We thank Sri for his excellent contribution to the committee over the last couple of years.

Finally I would like to thank my colleagues on the committee. Teresa Chalmers-Watson has just completed 6 yrs of membership. Proof reader extraordinaire. We will miss you. Derek Luo is Deputy, Maggie Ow NZSG rep, Stephen Mouat paediatric rep, and we are currently looking for a South Island representative. It is a team effort.

Bowel Screening Advisory Group

by Dr Jim Brooker

TERMS OF REFERENCE DEFINED:

Objectives:

- provide expert advice and make recommendations to the National Screening Unit (NSU) on implementation of the NBSP
- advise on equity, quality, safety, quality, issues for the National Screening Advisory Committee (NSAC)

Relationships

- Working with: National Bowel Screening Working Group, National Screening Advisory Group, EGGNZ, other groups as appropriate
- Reporting to NSU

Members:

- 2 year appointment (re-appointable)
- Maximum 10 core members: population health, public health, gastroenterologist, colorectal surgeon, GP, equity expertise, pathologist, consumer, independent Chair
- Ex officio members

Meetings

- Meant to be quarterly but unfortunately due to scheduling problems only two meeting in the last 12 months (Dec 2018 and July 2019).

Issues covered

- EGGNZ 2018 Workforce and training report reviewed
- Reviewed equity data, initiatives (Hui and Pacific Fono) and Maori age range extension proposal
- Discussed recommendations of the Independent Assurance Review of the NSBP
- NBSP Monitoring updates including participation rates, FIT positivity
- Updates from NBCWG
- National IT Screening Solution progress Feedback on FIT position statement subsequently published: https://www.nsu.govt.nz/health-professionals/national-bowel-screening-programme/reporting-test-results
- Colonoscopy wait time indicators

NZ Conjoint Committee Report

by Dr Marianne Lill

Committee Objectives

The New Zealand Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (NZCCRTGE) is a New Zealand body compromising representation from the Royal Australasian College of Physicians (RACP), the Royal Australasian College of Surgeons (RACS) and the New Zealand Society of Gastroenterology (NZSG). The Committee provides recognition of training undertaken in New Zealand in gastroscopy, colonoscopy and ERCP procedures within the confines of a set standard of guidelines. The Committee strives to keep these guidelines up to date and aligned with similar guidelines in Australia so that reciprocal recognition of training can occur.

Year	RACP	RACS	Total
2002	8	26	34
2003	1	4	5
2004	28	27	55
2005	5	4	9
2006	16	11	27
2007	9	10	19
2008	5	8	13
2009	5	4	9
2010	4	6	10
2011	8	6	14
2012	4	6	10
2013	12	3	15
2014	4	1	5
2015	7	12	19
2016	14	11	25
2017	19	15	34
2018	7	9	16
2019	12	3	15
Total	168	166	334

Assessment Outcomes

The previous table is an outline of the number and type of Fellows recognised by the Conjoint Committee since December 2002.

Conjoint Executive Committee Composition and Terms of Office

The Conjoint Executive Committee consists of two representatives from each of RACS, RACP and NZSG. The current Committee consists of the following members

Parent Body	Member	Current Term
Chair (RACS rep)	Dr Marianne Lill	June 2015 -
Secretary (RACP rep)	Dr Alasdair Patrick	June 2015-
RACP rep	Dr Richard Stein	June 2015-
NZSG rep	Mr Michael Booth	June 2015-
RACS rep	Mr Rowan French	June 2015-
NZSG rep	Dr Rees Cameron	March 2017-

The management of the Committee is under the control of the six (6) members of the Executive Committee who are comprised as such:

- Two members must be proposed by the RACP who must both be physicians, including one from a provincial centre.
- Two members must be proposed by the NZSG one of whom must be a physician and one of whom must be a surgeon.
- Two members must be proposed by the RACS who must both be surgeons, including one from a provincial centre.

Mr Michael Booth has offered his resignation after many years of service. The Committee offers thanks to Michael for his contribution. A replacement is being sought.

Application Assessment Process

Applications are assessed via the following process:

- Completed applications are forwarded to the Executive Officer no later than two weeks before the Committee meeting. Upon applying, applicants include a cover letter, CV, application form for each procedure required (gastroscopy, colonoscopy or ERCP), summary sheets of completed procedures, logbooks of completed procedures, a cleaning summary sheet, supervisors' reports and a minimum of two relevant written references from individuals who have preferably been recognised by the Committee in the past.
- An application fee of $200 per procedure applied for, is paid with the application. This is processed and a receipt provided to the applicant.
- Prior to the next meeting of the Committee, the applications are emailed to all members for consideration. These meetings occur twice to three times yearly, approximately April, July and November. Applications may be considered in

between meetings, by email.

- The applications are assessed by the Committee against the relevant criteria including logbook cases, supervisors' reports and written references.
- Applicants are advised of the outcome of their application shortly after the meeting with a letter endorsed by the Committee Chair and sent by the Executive Officer. If more information is required, a letter endorsed by the Committee Chair is sent by the Executive Officer outlining the necessary requirements. If submitted, the additional information will be assessed at the next meeting of outside of a meeting by email. Alternatively on a case by case basis, the Committee may give authority to the Chair to assess the additional information and approve the application once this is received.

Grandfathering Process

The Grandfathering Process was open to applicants from the inception of the Committee in 2001 and was closed to all applicants in 2008.

Financial Status

The Financial Report for the year ending 31 March 2019 records a total income of $3,800 and a total expenditure of $10,073, resulting in a deficit of $6,273. The fund overall as of 31 March 2019 has a balance of $11,994.

Comparison to previous two financial years:

Financial year	Total Income $	Total Expenditure $	Surplus/(Deficit)$	Overall fund balance at year end $
1 April 2013 – 31 March 2014	4,200	1,620	2,580	12,410
1 April 2014 – 31 March 2015	2,800	2,271	529	12,939
1 April 2015 – 31 March 2016	5,000	743	4,257	17,196
1 April 2016 - 31 March 2017	5,800	2,197	3,603	20,800
1 April 2017 – 31 March 2018	6,600	9,133	(2,533)	18,267
1 April 2018 – 31 March 2019	3,800	10,073	(6,273)	11,994

Current Activities

The following is a summary of current activities in progress, and issues that need to be addressed:

- Preparation and administration of applications to be considered at the November meeting.
- Continuation of discussions with RACS (Mr Richard Perry) and RACP regarding dissolution of the current Incorporated Society and reformation of the Conjoint Committee as a partnership to mirror the Australian model. This is an essential component of the National approach to endoscopy performance standards, in order to provide a mechanism for recognition of endoscopy training for all trainees, regardless of specialty or background.
    - Support from NZSG is requested to facilitate this transition
    - Alternative models may need to be explored, and would still require support of NZSG
- The funding model for secretarial support has been remedied and is now more sustainable. Secretarial support is being charged on an hours-worked basis rather than FTE. The Conjoint Committee is grateful to NZSG for assisting to correct this problem. The Conjoint Committee is likely to be financially stable in the short to medium term.
- Work to achieve consensus on the principles of a generic DOPS/PBA for endoscopy assessment has been undertaken with good support from interested parties.
- Contribution to activities of EGGNZ where input is requested
- Work towards adjustment of the standards for recognition of training to parallel the changes that have occurred in Australia and to incorporate DOPS/PBA and a shared online logbook is underway. The aim is to have a single system that allows an accurate and verifiable record of training for endoscopy trainees that can provide the basis of future Conjoint Committee applications. Collaboration between NZSG and NZAGS creates the opportunity to achieve a universal record of training that is simple and cost effective.

Compilation Report

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy
For the year ended 31 March 2019

Compilation Report to the Board of NZ Committee for Recognition of Training in Gastrointestinal Endoscopy.

Scope

On the basis of information provided and in accordance with Service Engagement Standard 2 Compilation of Financial Information, we have compiled the financial statements of NZ Committee for Recognition of Training in Gastrointestinal Endoscopy for the year ended 31 March 2019.

These statements have been prepared in accordance with the accounting policies described in the Notes to these financial statements.

Responsibilities

The Board are solely responsible for the information contained in the financial statements and have determined that the Special Purpose Reporting Framework used is appropriate to meet your needs and for the purpose that the financial statements were prepared.

The financial statements were prepared exclusively for your benefit. We do not accept responsibility to any other person for the contents of the financial statements.

No Audit or Review Engagement Undertaken

Our procedures use accounting expertise to undertake the compilation of the financial statements from information you provided. Our procedures do not include verification or validation procedures. No audit or review engagement has been performed and accordingly no assurance is expressed.

Independence

We have no involvement with NZ Committee for Recognition of Training in Gastrointestinal Endoscopy other than for the preparation of financial statements and management reports and offering advice based on the financial information provided.

Disclaimer

We have compiled these financial statements based on information provided which has not been subject to an audit or review engagement. Accordingly, we do not accept any responsibility for the reliability, accuracy or completeness of the compiled financial information contained in the financial statements. Nor do we accept any liability of any kind whatsoever, including liability by reason of negligence, to any person for losses incurred as a result of placing reliance on these financial statements.

MTM Accounting Limited

Level 1

100 Tory Street

Wellington

Dated: 2 October 2019

Statement of Profit or Loss

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy
For the year ended 31 March 2019

	NOTES	2019	2018
Trading Income			
Subscriptions		3,800	6,600
Total Trading Income		**3,800**	**6,600**
Gross Profit		**3,800**	**6,600**
Total Income		**3,800**	**6,600**
Expenses			
Accounting & Consulting		1,372	1,208
Bank Fees		48	52
Secretariat Support		8,653	7,874
Total Expenses		**10,073**	**9,133**
Profit (Loss) for the Year		**(6,273)**	**(2,533)**

Balance Sheet

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy
As at 31 March 2018

	NOTES	31 MAR 2018	31 MAR 2017
Assets			
Current Assets			
Cash and Bank			
BNZ Bank Account		18,267	20,800
Total Cash and Bank		**18,267**	**20,800**
Total Current Assets		**18,267**	**20,800**
Total Assets		**18,267**	**20,800**
Net Assets		**18,267**	**20,800**
Equity			
Retained Earnings		18,267	20,800
Total Equity		**18,267**	**20,800**

Balance Sheet

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy
As at 31 March 2019

	NOTES	31 MAR 2019	31 MAR 2018
Assets			
Current Assets			
Cash and Bank			
BNZ Bank Account		11,994	18,267
Total Cash and Bank		**11,994**	**18,267**
Total Current Assets		**11,994**	**18,267**
Total Assets		**11,994**	**18,267**
Net Assets		**11,994**	**18,267**
Equity			
Retained Earnings		11,994	18,267
Total Equity		**11,994**	**18,267**

These financial statements have been prepared without conducting an audit or review engagement, and should be read in conjunction with the attached Compilation Report.

Notes to the Financial Statements

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy
For the year ended 31 March 2019

1. Reporting Entity

The financial statements presented here are for NZ Committee for Recognition of Training in Gastrointestinal Endoscopy Incorporated, a separate legal entity.

NZ Committee for Recognition of Training in Gastrointestinal Endoscopy is an incorporated society registered under the Incorporated Societies Act 1908.

This special purpose financial report was authorised for issue in accordance with a resolution of members dated 9 August 2018.

2. Statement of Accounting Policies

Basis of Preparation

These special purpose financial statements have been prepared in accordance with the Tax Administration (Financial Statements) Order 2014.
The financials statements have been prepared on a historical cost basis, except as noted otherwise below.
The information is presented in New Zealand dollars.

Historical Cost

These financial statements have been prepared on a historical cost basis. The financial statements are presented in New Zealand dollars (NZ$) and all values are rounded to the nearest NZ$, except when otherwise indicated.

Changes in Accounting Policies

There have been no changes in accounting policies. Polices have been applied on a consistent basis with those of the previous reporting period.

Income Tax

Income tax is accounted for using the taxes payable method. The income tax expense in profit or loss represents the estimated current obligation payable to Inland Revenue in respect of each reporting period after adjusting for any variances between estimated and actual income tax payable in the prior reporting period.

Goods and Services Tax

The entity is not registered for GST. Therefore all amounts are stated inclusive of GST.

	2019	2018
3. Income Tax Expense		
Net Income for the Year per Financial Statements		
Current Year Earnings	(6,273)	(2,533)
Total Net Income for the Year per Financial Statements	**(6,273)**	**(2,533)**
Additions to Taxable Profit		
Non-Deductible Expenses	10,073	9,133
Total Additions to Taxable Profit	**10,073**	**9,133**

	2019	2018
Deductions from Taxable Profit		
Non-taxable income	3,800	6,600
Total Deductions from Taxable Profit	**3,800**	**6,600**
Taxable Profit	-	-
Tax Payable at 33%	-	-
Deductions from Tax Payable		
Dividend Imputation Credits	-	-
Resident Withholding Tax Paid	-	-
Provisional Tax Paid	-	-
Total Deductions from Tax Payable	**-**	**-**
Income Tax Payable (Refund Due)	-	-

4. Related Parties

The NZ Society of Gastroenterology Incorporated is a related party and pays expenses and receives income on behalf of NZ Committee for Recognition of Training in Gastrointestinal Incorporated.

5. Contingent Liabilities

There are no contingent liabilities at balance date. (2018: none).

6. Capital Commitments

There are no capital commitments at balance date. (2018: none).

National Bowel Cancer Working Group

by Dr Teresa Chalmers-Watson

BOWEL CANCER QUALITY IMPROVEMENT REPORT PUBLICATION

The first Bowel Cancer Quality Improvement Report published in March 2019 presented results using the Ministry's National Collections to calculate the six QPIs for bowel cancer. The report measured the quality of care and outcomes for people diagnosed and treated for bowel cancer in New Zealand and provided a baseline for ongoing quality improvement. The report identified opportunities to drive quality improvement in bowel cancer diagnosis and treatment services leading to better outcomes for people with bowel cancer. It was an important milestones as bowel cancer was the first tumour stream to have QPIs, which in turn informed the development of others.

BOWEL CANCER QUALITY IMPROVEMENT FORUM

A day one summit was held in Wellington Thursday 12 September. The NBCWG facilitated the event led by Professor Ian Bissett and supported by the Ministry of Health and the regional cancer networks. The summit intended to support DHBs to improve performance in bowel cancer treatment by sharing quality improvement initiatives. The forum celebrated the leadership provided by Prof Ian Bissett who has led this week.

The summit included a wide range of attendees such as surgeons, radiologists, pathologists, medical and radiation oncologists, nurses, service managers and representatives from each DHB. The attendees reviewed their performance. The findings of the forum are being collated to identify priorities for action.

REVIEW OF THE CRITERIA FOR DIRECT REFERRAL FOR COLONOSCOPY AND CTC

The Direct Referral Criteria have been reviewed and some of the criteria clarified. Waitemata have a pilot looking at redesigning the e-referral form to a combined single access point for colonoscopy and CTC. Work is underway to those with appropriate criteria direct towards CTC based on symptoms and other factors. Northern are also developed their e-referral colonoscopy form, pending sign-off.

ACCESS TO RADIOTHERAPY/LONG COURSE VS SHORT COURSE

An MDM survey was launched to gather data with regard to the differences between long/short courses. The results were presented at the September 2019 Bowel Cancer Summit with a view to generate conversation about the patients where results differed, with the long term goal being to reduce variation in treatment across the country.

SCREENING PROGRAMME

In preparing for screening Midland have made improvements that have increased the detection rates for CRC and are likely to lead to improved standards across the board. Screening continues to be rolled out by the DHBs with about half of the eligible national population now in the screening programme. Whanganui and Mid-Central are now starting their programmes.

PERITONECTOMY CLINICAL ENDORSEMENT

The NBCWG provided advice to the Ministry regarding endorsement of the current practice on the provision of peritonectomy and heated intra-peritoneal chemotherapy in New Zealand.

NZ Familial GI Cancer Service Report

by Dr Rachael Bergman

The highlight for the Familial GI cancer this year was hosting, with the NZSG, the Biannual meeting for the International Society for Gastrointestinal Hereditary Tumours (InSIGHT). As Chair of InSIGHT, Susan Parry was instrumental in gathering the world's experts in the field of Familial GI cancer and hosting a highly successful conference at Sky City, Auckland. Julie Arnold, Service Clinical Director supported Susan with this endeavour, in conjunction with the executive of the NZSG. Overall, this was well attended by Gastroenterologists and Colorectal surgeons throughout the country, and the feedback from the local and international attendees was overwhelmingly positive. A highlight was the evening Update meeting for those with familial bowel cancer – a range of international experts spoke and over 400 people attended from all over New Zealand.

There is on-going pressure on the service with increasing referral numbers nationwide. The service was referred 1840 patients over the last year. This is a 4.2% increase from 2018 and a 35% increase compared with referral numbers 5 years ago. Once again, in line with international trends, the most noticeable referral increase has been that of patients with oligopolyposis – referrals for these patients now account for 21% (>fifth) of referrals to our service compared with 13% in 2017. The New Zealand Registry monitors the care of 1257 registered families- double the number of registered families compared to 2014 (662). This steady increase in registered families and referral numbers is providing challenges for this service because like many areas of the health sector, the increased work has not been accompanied by increased funding and most of the efficiency gains have been made. The NZ Familial Cancer Service's future funding and strategic plan is under review this year with the Ministry of Health. This will be part of the improving cancer outcomes outlined as a priority in the NZ cancer action plan. If increased funding is not secured this will impact the range of services that the NZFGICS can deliver.

The Medical Advisors have been gradually updating, in response to new data and our local research, recommendations for surveillance and management of different hereditary conditions managed by our service. Patients with Lynch Syndrome caused by a mutation in PMS2 have been shown to have a much lower lifetime risk of colorectal cancer (and other cancers) compared with other people with Lynch syndrome. In accordance with this, we have changed screening recommendations for PMS2 carriers from annual colonoscopy from age 25 years to 2 yearly colonos-

copies to start at the age of 35 years. The Service is very conscious of the pressure colonoscopy and endoscopy services are under and if there is any question regarding colonoscopy surveillance in families this is discussed at the twice weekly National difficult case meetings. Over 42000 outpatient colonoscopies are performed in the public sector each year and the NZFGICS referrals account for approximately 1500 of these – however, these are carefully considered and are in line with recommendations and practice of countries with similar health systems eg the UK.

The NZFGICS continues to be involved in on going collaborative research projects including the Australasian Colorectal Cancer Family Study of cancers in Lynch Syndrome, and the Genetics of Serrated Neoplasia study which involves Genome sequencing in attempt to find additional genes in patients with polyposis and uninformative genetic testing (this has been expanded to include families). Two abstracts from the service were accepted for oral presentation at the InSiGHT meeting in March and the same held for the 2019 DDW meeting in San Diego. Gastroenterology Registrar Mehul Lamba was awarded a young investigator award for his presentation. Finally, funding has been secured from the Bowel Cancer Research Foundation to address the question "Can we defined the cancer risk (and therefore improve treatment strategies and outcomes) for patients from high risk families with oligoadenomatous polyposis in New Zealand?" We continue to strengthen ties with Surgical, Gastroenterology and Primary Care colleagues. Although John Keating leaves us as a Medical Advisor this year, Jamish Gandhi a Colorectal Surgeon at Auckland hospital joins us in a similar role. Although stretched, the NZFGICS staff continues to advocate for excellent care for patients with Familial GI Cancer and we are repeatedly encouraged by patient feedback.

Endoscopy Governance Group NZ Report

by Dr Russell Walmsley

Another busy year fighting the good fight for the Endoscopy Community of New Zealand.

Our main areas of focus have been:

WORKFORCE - NATIONAL ENDOSCOPY TRAINING

As part of the remit of the Bowel Screening Programme to look into the Capacity and Capability of Endoscopy services, we undertook a consultation with member organisations around barriers and opportunities to increase endoscopy capacity in New Zealand. A major concern was the lack of training opportunities, facilities and trainers. One proposal is to improve physical teaching facilities in units willing to then run courses and work towards a National Endoscopy Centre where larger numbers of trainees of all backgrounds could learn and National Endoscopy courses could run.

This detailed proposal which covers the types of courses to be run, numbers and background (nurse, physician, surgeon, GP) of trainees, size of programme, possible physical locations, equipment (simulators, audio-visual, teaching rooms), knock-on effects on endoscopy capacity and costs, was submitted to the Ministry in October.

NURSE ENDOSCOPY

Again, as part of the Capacity & Capability work, the Nurse Endoscopy Working group have held a series of meetings to discuss concerns and work through options and solutions to endure best outcomes for Nurse Endoscopists and DHBs. The final report was submitted to the Ministry in July 2019.

PROCEDURAL SEDATION

As a spin-off of the work with ANZCA (http://www.anzca.edu.au/resources/safe-procedural-sedation-competencies) and the Nurse Endoscopy Workstream, EGGNZ are starting tentative work on a model for Standing Orders for Nurse Endoscopist Procedural Sedation, as well as advising the Nursing Council of NZ on how to expand the list of relevant medications to allow Nurse Endoscopists to give sedation. EGGNZ have also been asked to join a consultative group on re-writing SP09 "Guidelines *on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures"*.

UNIT STANDARDS

The Unit Standards working group are currently undertaking a review of the EGG-NZ Unit Standards for Bowel Screening document. The development of a more comprehensive ' *Endoscopy Unit Service and Facilities Standards'* document is closely allied to the Quality Assurance work we are undertaking in conjunction with the National Screening Unit.

NATIONAL ENDOSCOPY DATA STANDARDISATION (NEDS) GROUP

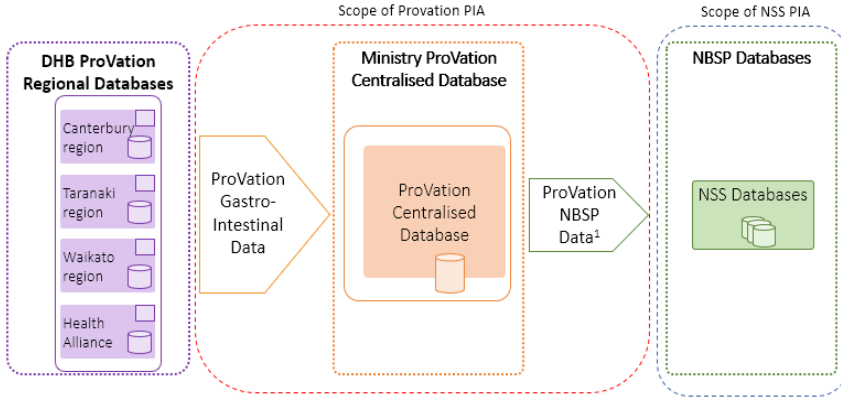
One of the actions from the ProVation User Group meeting in October 2018 was to develop a national process for change and decisions for the annual upgrades to Provation. A new group has been established (named National Endoscopy Data Standardisation (NEDS) group). EGGNZ have supported the establishment and running of the new NEDS group, chaired by Dr James Irwin.

If you have any changes to ProVation that you would like to put forward for consideration, please email eggnz@nra.health.nz and these will be submitted to the NEDS group for discussion.

PROVATION CENTRALISED DATA SYSTEM

The NSBP are to extract all endoscopy reporting data form the provincial Provation servers and, once de-identified, extract the relevant data of BSP-related colonoscopies for audit of the programme (see diagram below for how this works).

ProVation PIA Data Scope



1. Colonoscopies for Bowel Screening and Bowe Surveillance (for NBSP Participants only)

EGGNZ has been closely involved in development of the governance structure around this project and will be represented on the Data Governance Committee moving forward.

The current Guidelines on Local Credentialing, Unit and Individual Endoscopy Standards in BSP are available on our website, which is also a point of contact for any NZSG member who has questions about, or would like to contribute to Endoscopy Quality in New Zealand https://endoscopyquality.co.nz/.

Happy ‘scoping