BOARD MEETING

Date: Wednesday 27 February 2019

Time: 1:30pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Dan Druzianic
Barbara Arnott
Peter Dunkerley
Dr Helen Francis
Diana Kirton
Jacoby Poulain
Heather Skipworth
Ana Apatu
Hine Flood

Apologies:

In Attendance:
Kevin Snee, Chief Executive Officer
Executive Management Team members
John Gommans and Jules Arthur, Co-Chairs of Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Mintute Taker: Jacqui Sanders-Jones

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Kevin Snee	1	
8.	Financial Performance Report – Carriann Hall, ED Financial Services	2	
9.	Board Health & Safety Champion's Update – Board Safety Champion	3	

	Section 2: Governance / Committee Reports		
10.	Te Pitau Health Alliance HB Update – Helen Francis	4	2:05
11.	Māori Relationship Board – Chair, Heather Skipworth	5	2:10
12.	HB Health Consumer Council – Chair, Rachel Ritchie	6	2:15
13.	HB Clinical Council – Co-Chairs, John Gommans and Jules Arthur	7	2:20
	Section 3: For Information & Discussion		
14.	Ngātahi Briefing End of Year Two "Vulnerable Children's Workforce Development" Annual Update – Russell Wills and Bernice Gabrielle	8	2.30
15.	Bowel Screening – Chris Ash	9	2.45
16.	HBDHB Draft Disability Plan – Bernard TePaa, Shari Tidswell, Dr Diane Mara	10	3.00
17.	Strategic Planning Update – Chris Ash, Bernard TePaa and Kate Rawstron	11	3.10
18.	HBDHB Alcohol Harm Reduction Strategy 2017-22 (six month update) – Bernard TePaa, Rachel Eyre, Rebecca Peterson	12	3.25
	Section 4: Monitoring		
19.	People & Quality Dashboard Q2 (Oct-Dec 18) – Kate Coley	13	3.35
20.	20.0 HBDHB Performance Framework Exceptions Q2 (Oct-Dec 2018) 20.1 HBDHB Non-Financial Performance Framework Dashboard Q2	14	3.45
	Section 5: For Decision		
21.	21.0 Health Finance, Procurement and Information Management System Report 21.1 Business Case	20	3.50
22.	**Section 6: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Routine	Ref #	Time (pm)
23.	23.0 Minutes of Previous Meeting 19 December 2018 (public excluded) 23.1 Minutes of Previous Meeting held 30 January 2019 (public excluded)		4.00
24.	Matters Arising – Review of Actions		-
25.	Board Approval of Actions exceeding limits delegated by CEO	15	-
26.	Chair's Update (verbal)		
	Section 8: Presentation		
27.	He Ngākau Aotea – George Mackey	16	4.05
	Section 9: For Information		
28.	HB Clinical Council – Co-Chairs, John Gommans & Jules Arthur	17	4.20
29.	Finance Risk and Audit Committee – Chair, Dan Druzianic	18	4.25
30.	Whole of Board Appraisal Action Plan – Ken Foote	19	4.30
	Meeting concludes		

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 27 March 2019

Board "Interest Register" - 19 December 2018

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
	Active	Iwi Chairs involved with Treaty of Waitangi Health Claim #2575	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	19.12.18
Barbara Arnott	Active	Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
Dr Helen Francis	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
	Active	Independent Consultant	To a variety of health organisations.	Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions	The Chair	26.02.18

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Elected Board Member of the Federation of Primary Health Aotearoa New Zealand	Newly established sector wide multi-professional membership association, providing an inclusive platform for health and care integration with the people of New Zealand at the hear of the organisations objectives. No contracts held and have no financial interest in any of their work.	No conflict perceived	The Chair	10.11.18
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Whararíki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 19 DECEMBER 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.40 PM

PUBLIC

Present: Kevin Atkinson (Chair)
Ngahiwi Tomoana (Deputy Chair)
Dan Druzianic
Dr Helen Francis
Peter Dunkerley
Diana Kirton *joined the meeting 1.50pm*
Barbara Arnott
Heather Skipworth
Jacoby Poulain
Ana Apatu
Hine Flood

Apologies Kevin Snee (Chief Executive Officer)

In Attendance: Chris Ash (Acting Chief Executive Officer)
Members of the Executive Management Team
Drs Gommans and Phillips (as co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Brenda Crene

APOLOGY

Kevin Snee (Chief Executive Officer)

2. INTEREST REGISTER

Ngahiwi Tomoana advised that the Iwi Chairs are part of Health Claim around the Treaty of Waitangi. **Action**

No board member advised of any interest in the items on the Agenda.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 28 November 2018, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Peter Dunkerley
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **A Working Group / Workshop** with MRB will be held in the New Year with MRB (October Action advised by HBDHB Chair) - timing will be advised (K Snee / C Ash)

Item 2: **Training Front Line staff –** Kate Coley/Wayne Woolrich (HHB) covered this off in the People Plan Progress Presentation (agenda #15). This is being actioned remove item.

Item 3: **Funding of Capital Projects –** Carriann Hall to provide more detail (raised initially under the Chair's report). This would be discussed with the MoH on 18th January.

Item 4: **Consumer Experience Facilitators –** to attend May 2019 meeting – to remain as matters arising.

Item 5: **Wairoa Integrated Care Demonstrator Site –** An update will be received by the Board in March. This has been scheduled on the workplan. Item to remain as matter arising.

5. BOARD WORK PLAN

The Board Work Plan was noted.

A sub-committee of FRAC to meet on 18 January and this would be followed by a "Special Meeting" of FRAC on 30 January 2019.

6. CHAIR'S REPORT

- The Chair advised the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retired /Retires
Gloria Astridge	Receptionist - Inpatient	Operations Directorate	19	31-Oct-18
Ellen Apatu	Care Associate	Older Persons & Mental Health	15	30-Dec-18
Robyn Fox	Physiotherapist	Older Persons & Mental Health	10	2-Jan-19
Ann Wallace	Care Associate	Older Persons & Mental Health	16	2-Jan-19

- A letter had been received dated 17 December from the Minister advising approval of the 2018/19 Annual Plan for one year. He advised the Production Plan was still to be confirmed. In addition the Minister was aware HB were planning a number of service reviews in the 2018/19 year and advised that acceptance of the Annual Plan did not constitute acceptance of proposal for services changes that have not undergone review and agreement by the MoH. He also advised that approval of the Plan does not constitute approval of any capital business cases that have not been approved through the normal processes.

7. CHIEF EXECUTIVE OFFICER'S REPORT

The Acting CEO (Chris Ash) provided an overview of the report.

- Shorter stays in ED improved however was still below target. However there have been encouraging signs in ED's performance following changes within the department, resulting in several promising weeks.
- Improved access to Elective Surgery at 85%, however still remains short of target. There had been a presentation to FRAC on elective performance (earlier in the day) with plans being developed to ensure we can process as many through within required timing.
- Items being on the days agenda include the Health Equity Report and a People Plan Progress (presentation).
- A complimentary story had been received from the Area Commander of Police, thanking for services provided.
- December Cancer report: We have reached 100% against the 62 day target for the second month in a row which is encouraging.

8. FINANCIAL PERFORMANCE REPORT

Carriann Hall (ED of Financial Services) spoke to the Financial Report for November 2018, which showed a $1.1m variance unfavourable to plan for the month. The year to date result is $1.8m adverse.

It was noted that an extended discussion on the financial positon had been held during the FRAC meeting.

9. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Board Champion Hine Flood provided an update following her first safety visit to the Wairoa Health Centre with Christine Mildon.

The following safety points were raised:

- Signage around the helipad (to define where people should not be) was noted
- The Wairoa birthing unit's décor was complimented, however there were 2 separate rooms which could be made into one to enhance service provision. This is a fairly high usage area with 19 births in November.
- Contractors observed with no high viz gear or signage. Contractor monitoring and management was actioned immediately by Christine Mildon.
- H&S training for Wairoa

Suggested housekeeping – "noting a little can go a long way":

- The Mortuary could be painted and signed (looks unloved).
- Size of the Mortuary chillers was raised.
- No link from Mortuary to the Chapel
- The courtyard which was 50 steps from the Mortuary could be tidied up.
- An unused landing upstairs could be made into a special place.

REPORT FROM COMMITTEE CHAIRS

10. TE PĪTAU HEALTH ALLIANCE (HAWKE'S BAY) - Formerly the Primary Care Development Partnership Governance Group

Helen Francis, Deputy Chair provided an update from the meeting held on 12 December 2018.

The assistance of Kaumatua had been sought in developing the group's new name "Te Pītau Health Alliance (Hawke's Bay)" and had received unanimous support from governance group members. The Partnership Agreement had been changed to reflect the new name and this was signed between the parties following the board meeting.

Mental Health and Addictions is number one priority. Those leading the re-design were seeking feedback and input on both the issues raised in the paper and on the commissioning framework to be developed for the re-design.

Mauri Compass: the process used by the Wairoa Community Partnership Group was explained and the governance group felt this process could be utilised to assist further changes envisaged for primary care in the CSP.

11. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Chair of MRB spoke to the meeting held 5 December 2018.

- **Bowel Screening in HB:** The reasoning behind the recommendation raised was covered in the report to seek Board's approval to implement bowel screening from the age of 50 years for Māori within the Hawke's Bay region.

Action **The Chair advised the Board were not in a position to support MRB's Bowel Screening recommendation. He requested management (and MoH) bring a paper together (including <u>all</u> aspects) for further consideration. Timeline to be ascertained and advised.**

Chris Ash advised he was planning to hold a workshop with MRB in the New Year (February).

- **It's Hard to Ask** – MRB had supported a regional Hui being held at Easter to promote discussion about kidney donations for Māori. In Hawkes Bay 69% of the renal population identifies as Maori

Action: Rachel Ritchie asked that Consumer Council receive It's Hard to Ask presentation in February 2019

A Muscular Skeletal Service to Reduce Health Inequities in HB: MRB asked how we can move this forward as we do not want to drop this preventative programme (which was originally run with MoH Funding which was no longer available). The programme worked and that was proven. Following discussion it was suggested the PCDP (now Te Pītau Health Alliance) be approached for a view on this. This is about initiatives to direct patients into corrective actions which was being discussed further under agenda item 16.

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 6 December 2018:

- It had been suggested and agreed to have enhanced Consumer involvement on the judging panel of the HB Health Awards and in the shortlisting process (potentially in conjunction with Clinical Council).
- Received update on Disability Strategy Group.
- There had been some frustration regarding some aspects of the training from those who attended the HQSC Consumer Representatives Train the Trainer Workshops.
- Received DHB funding overview.
- Received the scoping report around Addictions which overwhelming showed that the general public do not know where to go to receive help for their loved ones with addictions to alcohol and meth. The pending redesign of HB Mental Health and Addiction Services will include meth addiction.

13. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Dr John Gommans spoke to the report from the Council's meeting held on 5 December 2018 and introduced Jules Arthur in her capacity as the new co-Chair of Clinical Council.

- Advanced Care Planning Advisory Group will report to the new clinical governance structure via the Clinical Experience Committee (with Consumer Council approval received).
- A joint workshop between Clinical and Consumer Council would be held in March on Person & Whanau Centred Care.
- The Muscular Skeletal Service detail provided to Reduce Health inequities in HB received received no discussion by Council, however Dr Gommans advised the meeting that it was a "no brainer" to roll this out.

FOR DECISION / DISCUSSION

14. HEALTH EQUITY REPORT (FINAL)

The published version of the document was released for the meeting. A word version had been provided the day prior via Diligent.

In attendance were Andy Phillips, Nick Jones, Jessica O'Sullivan, Patrick LeGeyt and Anna Kirk.

Additional comments from earlier reviews have been included in the published version provided, introducing a life course approach to health equity, noting there are many inconsistent health equity issues that have been there for a long time.

Patrick LeGeyt referred to the next steps on the last page of the document:

1. Listen to our communities most impacted by health inequities and act to change services
2. Partner with Māori and Pacific leaders to deliver on commitments made in our Clinical Services Plan that are focused on eliminating health inequities.
3. Invest in whānau ora approaches to community needs
4. Establish an equity promoting system and explicitly tackle structural ethnic bias.

A communications release had been prepared for issue. Presentations to a number of groups included Councils, Rotary and Lions (to name a few) were planned.

Comments summarised:

- Diana Kirton advised that the big change will only occur when individuals say "I want my life to be different." It is a personal decision to opt into change.
- It is hard to get whanau to think about this with so many other stresses going on in their lives but it starts with the person themselves.
- Only 20% can be achieved from health delivery with 80% coming from social determinants.
- Currently we do not have the right services in the right place at this time. We need to Unpick, unpack and cement.
- Rachel Ritchie found the report interesting reading – but her real interest is in the reallocation of resources and how fertile the ground is to implement the changes required. This is about doing things differently. Need to communicate with the community and hear what they have to say and then follow through. To not make the change would dilute trust and create barriers.
- We must start from the top and clearly accept there is institutional racism and unconscious bias alive and well in the HBDHB and HB Health sector. The Board need to own it and lead by example.
- Ngahiwi Tomoana advised that methamphetamine (P) is creating havoc and destroying lives in our community and the situation is worsening by the day. Chaos prevails as those deported from Australia are setting up shop in NZ and bringing their networks with them. A mind-set change and inspirational investment is required. HB can lead the country in this area but we must do so now!
- Going forward we need to ensure continuous improvement as a result of the Health Equity Report released today – we must do things differently.

15. PRESENTATION: PEOPLE PLAN – six month update

A presentation was provided by Kate Coley, Executive Director People and Quality

- Putting our values at the heart of everything we are doing.
- Agreed priorities for 2018-19 (EMT are leading pieces of work and all members have accountability). The work that we are doing is not costing us money as it is about valuing staff/our people as our biggest asset.
- HB are nationally recognised for building the Maori workforce.

Key Intentions were provided in the presentation noting the following:

- Frontline leaders programme developed
- Behaviours framework endorsed
- BUILD – train the trainer sessions completed

- BUILD training – rolling out to organisation
- Executive / Senior leaders coaching
- Values based recruitment developed (aligned to Kawa – recruitment framework & Tikanga – practice framework)
- Engaging effectively with Maori – refreshed
- Values based recruitment – train the trainer, new materials co-designed, ongoing training
- Health & Safety Strategy endorsed
- Board Health and Safety Champion role embedding and valued by staff
- Hazardous substances project nearing completion
- Health & Safety training rolling out to all leaders & managers
- Wellbeing activities – wellness hampers, Body Balance, boot camps, Self-Care in Health Care, September, flu vaccinations, Access to EAP
- IT – business intelligence, mobility, clinical portal, other key programmes
- Co-design sessions – individual team activities, bullying approach, performance appraisals, orientation/on-boarding
- Internal Communications strategy agreed and being implemented
- Maori & Pacific workforce development action plans endorsed
- Partnership approach with People & Quality team and Maori Health services
- Clinical and Consumer councils joint work on person & whanau centre care
- Team development and strength based conversation incorporated into leadership training
- Co-design training with consumers being developed
- CCDM significant investment in nursing resources
- Investigating similar approach for allied health professionals
- Appreciation – Hawkes Bay Health Awards, Allied Health values awards, wellness packages, Staff BBQ, InFocus

The Next six months will focus on:

- Launch BUILD e-learning module
- Launch new HB Core Concept & new orientation programme
- Annual wellbeing programme and framework for 2019
- Launch new approach to dealing with bullying and unacceptable behaviour
- Leadership/frontline managers training programme
- Coaching philosophy and training rolled out to all leaders
- Begin the development of a sector wide workforce development programme
- Review current performance appraisal process
- Development of organisational capability framework & mandatory training
- Domestic violence support programme for affected staff
- Workplace violence support programme, policy & support

Measures of Success include:

- Increasing representation of Maori & Pacific in workforce
- Increase completion rates for Engaging Effectively with Maori
- Increase completion rates for Relationship Centred Practice
- Increase completion rates for Health & Safety training for managers
- Reduction in Annual leave liability
- Pulse survey
  Improvement in results relating to behaviours, wellbeing, health & safety
- Feedback from staff & leaders

FOR INFORMATION

16. MOBILITY ACTION PLAN (A Musculoskeletal Service to address health inequities in HB)

Andy Phillips spoke to the programme which was designed to address muscular skeletal issues for Maori and Pasifika (quintile 5 deprivation). Following review by MRB a recommendation was initiated for PCDP to: Consider what role a Muscular Skeletal Service to reduce Health Inequities

in HB (which ran as a pilot funded by MoH), may have in primary care delivery as a preventative measure with an aim to reduce surgical procedures?

Those who worked in and/or assisted with the running of this pilot programme were introduced and included: Dr Tae Richardson, Lee Grace and Adam McDonald

Tae was clinical and project lead for most of the life of the programme. Pilot funding was made available to treat early and preventatively and prevent operations (a key target for MoH). Of the DHBs participating, Hawke's Bay (HB) and Waikato took an equity driven approach and actually ran a program instead of talking about what might be good to do in a report.

In HB 330 participated in the programme over one year. Even though the programme follow ups have now closed, people continue to have long functional improvements thereafter.

Utilised Māori owned, managed and delivered programs in the community and he reason it worked was because of shared values. Those participating were not taken from waiting lists but from services such as WINZ (for those in disability benefits) as an example. NGOs are good at what they do, they are segmented but within the providers they can show where the various age groups are to deliver focussed programs. Physio Adam McDonald treated 300 of the 330 through the program. They were defined from those with acute issues, (none were from ACC) and half were receiving disability support for more than 3 months. Fifty percent of participants were from Flaxmere. The success of the programme came through the removal of barriers to access (cost), with the key to success being the client got to choose their pathway. These people cannot afford $80 to $100 per visit. The model is easily transferred to a number of conditions and was designed as a "plug n play".

Tae advised we all pitched in and did what we needed to do to the best of our ability. NGOs are under resourced and managed on a shoe string – which is no surprise as the Māori in the room will understand they already have brilliant networks and able to manage on a shoe string anyway

- Note that MRB's recommendation in their report to the Board *under item 11* above, that PCDP (now Te Pītau Health Alliance) be approached for a view on continuing the programme.

Additional comments included:

- These people are who we need in the community despite politics and pressure. Need to keep this going into the future.
- The current system is equity deficient. Fully support this model.
- There is very real evidence around early physio and preventative programmes that is irrefutable. Need to keep our people as productive members of society. We need to think about what funding paths will make best use of all resource. There are life gains for those involved. The path to fund is not immediately clear but will take this to the commissioning leadership group for January. Must read report to understand.
- The choice of rehabilitation provided was key, and we simply navigated a system others find difficult.
- This is about relationship centred practice – we already have the people (within Māoridom) to do this and much more. It occurs easily because you don't have to train specifically as passion and compassion occurs naturally within the Māori culture and they also have extensive networks to plug in to.

Action:

a) The programme received an extensive MoH audit. Circulate the Mobility Action Plan Programme Audit.

b) Carriann Hall and Chris Ash to meet, review and discuss with some urgency the potential for HBDHB to fund continuation of the programme.

GENERAL BUSINESS

There being general business, the Chair accepted a motion to move into Public Excluded.

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board Exclude the public from the following items:

18. Confirmation of Minutes of Board Meeting - Public Excluded
19. Matters Arising from the Minutes of Board Meeting - Public Excluded
20. Board Approval of Actions exceeding limits delegated by CEO
21. Chair's Update
22. Māori Relationship Board
23. HB Health Consumer Council
24. HB Clinical Council
25. Finance Risk and Audit Committee

Moved: **Barbara Arnott**
Seconded: **Peter Dunkerley**
Carried

The public section of the Board Meeting closed 3.50pm.

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	29/9/18 10/10/18	The following process was agreed to move towards addressing the areas raised by MRB (in September's Board Report) around **Equity and Cultural Competency:** Kevin Atkinson Board Chair suggested the following process which was accepted at the MRB meeting: a) That a Working Group come together to study and focus on next year's planning. b) That a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.	Kevin Snee	Timing TBC	
2	28/11/18	**Funding of Capital Projects**: Carriann will come back to the Board with more detail. Raised under Chair's Report.	Carriann Hall		
3	28/11/18	Schedule **Consumer Experience Facilitator**s to attend the May 2019 Board meeting as members would like to hear about their work.	Kate Coley	May 19	Included on workplan – to remain as an action
4	28/11/18	**Wairoa Integrated Care Demonstrator Site:** The Board requested an update at the March 2019 Board meeting.	Chris Ash / Emma Foster	Mar 19	Included on Workplan for Feb 19 – to remain as an action.
5	19/12/18	**Bowel Screening in HB:** Recommendation from the MRB for the HBDHB Board to provide approval to implement bowel screening from the age of 50 years for Māori within the HB region. In response the Chair advised the Board were not in a position to support this recommendation. • He requested management (and MoH) bring a paper together (including all aspects) for further consideration. Timeline to be ascertained and advised.	Kevin Snee / Chris Ash	Feb 19	Agenda item 15.0

Action	Date Entered	Action to be Taken	By Whom	Month	Status
6	19/12/18	Chair of Consumer Council requested **"It's Hard to Ask**" presentation to be provided to Consumer Council in February around seeking kidney donors.	Admin	Feb	Actioned: Consumer Cncl received 14 Feb.
7	19/12/18	**Mobility Action Plan** (A musculoskeletal service to address health inequities in HB): a) MoH audit to be circulated to the Board b) Review and discuss with some urgency the potential for HBDHB to fund continuation of the programme. Note MRB recommended this be taken to a Te Pītau Health Alliance meeting for their view.	Admin Cariann Hall and Chris Ash	Jan 19	Actioned

Board Workplan as at 20 February 2019 (subject to change)	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Ngatahi Vulnerable Children's Workforce Development end of year two	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Alcohol Harm Reduction Strategy (6 monthly update)	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
HBDHB Draft Disability Plan	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
He Ngakau Aotea					27-Feb-19
People & Quality Dashboard Q2 (Oct-Dec 18)					27-Feb-19
Finance Report (Jan)				27-Feb-19	27-Feb-19
HBDHB Performance Framework Exceptions Q2 Nov 18					27-Feb-19
HBDHB Non-Financial Performance Framework Dashboard Q2					27-Feb-19
Strategic Planning Update post CSP	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly)	13-Mar-19	13-Mar-19	13-Mar-19		27-Mar-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator)	13-Mar-19	13-Mar-19	13-Mar-19		27-Mar-19
Wairoa Integrated Health Services and Community Led Commissioning (Update Board from Nov meeting)					27-Mar-19
Finance Report (Feb)				27-Mar-19	27-Mar-19
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	10-Apr-19	10-Apr-19	11-Apr-19		27-Mar-19
After Hours Urgent Care Service Update 6mthly	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19
Violence Intervention Programme Report	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19
Hawke's Bay Health Awards Event - REVIEW Alcohol at this event annually					24-Apr-19
Finance Report (Mar)				24-Apr-19	24-Apr-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator)	8-May-19	8-May-19	9-May-19		29-May-19
HBDHB Performance Framework Exceptions Q3	8-May-19				29-May-19
HBDHB Non-Financial Performance Framework Dashboard Q3					29-May-19
People & Quality Dashboard Q3					29-May-19
Finance Report (Apr)				29-May-19	29-May-19
Annual Plan 2019/20 SPEs to Board by end of June	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
People Plan Progress Update Report (6 monthly - Dec, **Jun 19**)	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Finance Report (May)				26-Jun-19	26-Jun-19
Finance Report (Jun)				31-Jul-19	31-Jul-19
HB Health Awards - preparation for judging **2019**-2020		14-Aug-19	15-Aug-19		28-Aug-19
Annual Plan 2019/20 draft to the Board	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Alcohol Harm Reduction Strategy (6 monthly update) Feb **- Aug**	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
People & Quality Dashboard Q4 (Apr-Jun 19) Feb-May-**Aug**-Nov (formerly HR KPI Rpt)					28-Aug-19
HBDHB Performance Framework Exceptions Q4 Feb19 /May/**Aug**/Nov (Just in time for MRB Mtg then to EMT)	14-Aug-19				28-Aug-19
HBDHB Non-Financial Performance Framework Dashboard Q4 - **EMT/Board**					28-Aug-19
Finance Report(July)				28-Aug-19	28-Aug-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
Finance Report (Aug)				25-Sep-19	25-Sep-19
Finance Report (Sept)				30-Oct-19	30-Oct-19
Shareholder representatives for Allied Laundry and TAS meetings each year					30-Oct-19
People & Quality Dashboard Q1 (Jul-Sep 19) Feb-May-Aug-**Nov**					27-Nov-19
HBDHB Performance Framework Exceptions Q1 Feb19 /May/Aug/**Nov** (Just in time for MRB Mtg then to EMT)	13-Nov-19				27-Nov-19
HBDHB Non-Financial Performance Framework Dashboard Q1 - **EMT/Board**					27-Nov-19

Board Workplan as at 20 February 2019 **(subject to change)**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**F R A C Meeting date**	**BOARD Meeting date**
Finance Report (Oct)				27-Nov-19	27-Nov-19
People Plan Progress Update Report (6 monthly - **Dec 19**, Jun)	11-Dec-19	11-Dec-19	12-Dec-19		18-Dec-19
Finance Report (Nov)				18-Dec-19	18-Dec-19

HAWKE'S BAY
District Health Board
Whakawāteatia

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 01
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 February 2019
Consideration:	For Information

RECOMMENDATION

That the Board

1. **Note** the contents of this report.

INTRODUCTION

The last few months have been challenging for Hawke's Bay District Health Board (HBDHB) with much of the organisation affected by industrial action. As this DHB has more localised contractual arrangements than other DHBs, we have been more affected by strike action than elsewhere.

In addition we have had the incomplete sterilisation of equipment incident, which is now subject to review which we are doing in partnership with the Ministry of Health.

This month's agenda covers a number of key issues and important pieces of work. Ngātahi is an excellent example of a workforce development partnership which offers a potential model for other workforces locally and nationally. We will also consider the equity implications of bowel screening. Our Disability Plan will enable the local implementation of the national plan. We will present progress on our emergent Strategic Plan, which we intend to complete by June. The harm caused by alcohol and the actions we are taking to reduce alcohol harm is also a key focus on today's agenda.

PERFORMANCE

The key performance exceptions of note for January 2018 are:

- Emergency Department (ED): Shorter stays in ED (ED6) has deteriorated to 87 percent in January. I have asked for a report to come to FRAC explaining how this will be improved throughout the remainder of the year.
- Elective performance: ESPI 2 (First Specialist Assessment) has continued to deteriorate. A plan has been presented to FRAC today which involves targeting some additional resources, increasing throughput and managing to our capacity. This will be closely monitored. For ESPI 5 (time taken to treat) this month's figure, whilst an increase, is below our plan which will get us back to under 4 months by December 2019.
- Financial performance. The result for the month of January is $356k favourable to plan, improving the year-to-date result to $2.1m adverse.

Measure / Indicator	Target	Month of January	Qtr to end January	Trend For Qtr
Shorter stays in ED	≥95%	87%	87%	▼
Improved access to Elective Surgery (2018/19YTD)	100%	88%	91.3%	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	3,142	709	1,016
Patients given commitment to treat, but not yet treated (ESPI-5)	795	187	539

Faster cancer treatment – 62 day indicator* *(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	100% January	88% 6m to January	▲
Faster cancer treatment - 31 day indicator	≥85%	90% January	85% 6m to January	▲
Increased immunisation at 8 months	≥95%	---	91% 3m to January	---
Better help for smokers to quit – Primary Care			81.4% 15m to December	▼
Raising healthy kids (New)			96% 6m to November	---
Financial – month (in thousands of dollars)	1,298	1,654	---	---
Financial – year to date (in thousands of dollars)	(4,200)	(6,338)	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.*

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*16/19 = 84%*	*107/114 = 94%*

NGĀTAHI PROJECT – PROGRESS REPORT, END OF YEAR TWO

Ngātahi is a workforce development project for 27 agencies and >450 practitioners in the vulnerable children's workforce in Hawke's Bay. In 2018 the Ngātahi team partnered with iwi, and local and national experts, to write and deliver online and face-to-face content for two work streams. Three one-day wānanga on mental health and addictions (MH&A) were delivered in 2018 and 24 wānanga will be delivered in 2019 to around 400 practitioners in MH&A, Self-Care and Engaging effectively with Māori. A research partnership with Eastern Institute of Technology is providing real-time feedback for improvement and will describe the impact of the programme.

BOWEL SCREENING

Following a request for a management recommendation at the December Board, a paper is included on this month's agenda that recommends against lowering the screening age for Māori to 50 years. This recommendation is consistent with national policy, although Hawke's Bay has signalled clearly its priority of being included early within any national pilot of extended screening for Māori. The DHB recognises the potential negative equity consequences of the National Bowel Screening Programme, and is focused on increasing participation amongst Māori communities as the principal strand within the plan to address this.

HBDHB DRAFT DISABILITY PLAN

People with disabilities make up 23 percent of our population and experience a range of impairments. This Draft Disability Plan has been designed to support staff and services to respond effectively to people with disabilities, including their whānau, ultimately reducing inequity.

The Plan outlines how our organisation will implement the National Disability Strategy, Whaia Te Marama and Favia Ora Disability Plans, as well as meet Government expectations. The Plan has been co-designed with a representative working group and input from community disability advisory groups. The planned actions will be delivered via the People Strategy, Clinical Services Plan and in line with HBDHB's core values.

STRATEGIC PLANNING UPDATE

The Board will receive an update on strategy development activity which has been underway since the signoff of the Clinical Services Plan (CSP) in November. The overarching strategy (which combines the three key documents of CSP, People Plan and the Equity Report) has been discussed at the Executive Management Team (EMT) meeting and will be further discussed at at the Hawke's Bay Health Leadership Forum in early March.

ALCOHOL HARM REDUCTION STRATEGY 2017-22 PROGRESS REPORT

The Alcohol Harm Reduction Strategy involves a range of activities to address:

- the drivers of alcohol use
- shift attitudes towards alcohol
- limit availability and exposure and
- provide appropriate and accessible health service response to alcohol harms.

The organisation has achieved a number of successes related to reducing alcohol harm, through focused population health engagement, both at a local level and in submissions to central and local Government on policy levers to reduce alcohol-related harm. An example of this is the Mental Health & Addictions Inquiry report, which recommended the Government take a bolder approach to the sale and supply of alcohol (i.e. implementing the recommendations of the Law Commission's report in 2010).

Discussions have occurred nationally and locally, raising concerns around the ability to successfully implement the current legislation, aimed at minimising alcohol-related harm. A more system-wide approach to addressing alcohol harms can best be addressed by our DHB. An integrated approach to screening in particular has received support from EMT and Clinical Council.

PEOPLE AND QUALITY DASHBOARD QUARTER TWO

The Maori representation target for staff for 2018/19 is set at 16.02 percent, the DHB has achieved 14.54 percent. To meet the target we would need to employ a further 44 people. In spite of this comparisons with all 20 DHBs, Māori representation figures in Hawke's Bay continue to be favourable. A significant amount of work has been undertaken in partnership between the People & Quality team and Maori Health services; an update will be provided in March. Staff turnover is 10.4 percent for the last year which is lower than the average for the Central Region. Annual leave balances two plus years are 149 employees (5.2 percent) compared to 143 (5.3 percent) at the same time last year.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS REPORT QUARTER TWO

Our quarterly performance exceptions report is included in this month's papers. The report looks at indicators that are not currently meeting target expectations or where unexpected variation has been noted in the last period. It also highlights key areas of performance achievement. The EMT is currently reviewing how performance is managed at a corporate level, and this is likely to result in improvements to the structure and content of this report over the coming year.

HE NGĀKAU AOTEA

He Ngākau Aotea – A New Way, A New Heart – is the Māori Relationship Board's (MRB) set of strategic priorities. He Ngākau Aotea suggests that in order to achieve equity for Māori in Hawke's Bay we must consider doing some things differently; for example, co-designing approaches with whānau, hapū, iwi and Māori communities, adopting kaupapa Māori models of care, and working with the health sector to develop a culture of performance and equity. These priorities are consistent with HBDHB's strategic priorities and Clinical Services Plan objectives. EMT looks forward to working with MRB and Ngāti Kahungunu Iwi Inc to achieve equity for Māori in Hawke's Bay.

CONCLUSION

In spite of the significant distractions of industrial action and the problem that emerged with sterile services in February, we continue to address some our critical underlying problems. There are signs that our actions are bringing the financial problems that have emerged over the last two years under greater control. In addition, considerable work is being undertaken to bring elective waiting times under control which I expect to have a significant impact over the next six months. Furthermore critical pieces of strategic work have continued to be prioritised.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report January 2019** 2
	For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	For Information

8

RECOMMENDATION:

That the HBDHB Board:

1. **Note** the contents of this report

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

As shown in the table below, the result for the month of January is $356k favourable to plan, improving the year-to-date (YTD) result to $2.1m adverse. The key drivers are summarised below the table.

Despite the overspend, we continue to forecast to achieve plan, although this is dependent on a number of factors. These , are being closely monitored by management with the support of the Finance, Risk and Audit Committee (FRAC) through the FRAC Finance Sub-Committee.An additional FRAC meeting was also held earlier this year to ensure continued monitoring of performance.

	January				*Year to Date*				*Year End*	Refer
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*	Appendix
Income	48,965	48,455	510	1.1%	338,513	336,452	2,060	0.6%	577,732	1
Less:										
Providing Health Services	27,708	27,958	250	0.9%	172,092	169,228	(2,863)	-1.7%	288,383	2
Funding Other Providers	20,992	20,431	(561)	-2.7%	145,439	141,840	(3,599)	-2.5%	245,435	3
Corporate Services	4,008	3,977	(31)	-0.8%	29,704	29,044	(659)	-2.3%	49,086	4
Reserves	(5,397)	(5,208)	188	3.6%	(2,383)	540	2,923	541.5%	(171)	5
	1,654	**1,298**	**356**	**27.4%**	**(6,338)**	**(4,200)**	**(2,138)**	**-50.9%**	**(5,000)**	

Key Drivers

The detail of the variances are covered in the appendices to the report. The key drivers are:

- Providing Health Services (Appendix 2)

A combination of factors in nursing staff driving overspends, demand in pharmaceuticals and shortfall on delivery of savings targets, partially offset by funding to deliver elective volumes and difficulties recruiting to Allied Health roles.

- Funding Other Providers (Appendix 3)
  Higher than budgeted levels of Inter District Flow (IDF) outflows, particularly earlier in the year, demand in pharmaceuticals and a combination of demand and funding issues in residential and home care. This is partly offset by lower demand in residential and home care for mental health.

- Savings Plans (Appendix 8)
  Shortfall on savings plans of $3.1m are included in the YTD position and discussed further below.

Forecast

Whilst we are adverse YTD, we remain committed to achieve our planned deficit of $5m. Actions to achieve this include:

- Structured leave management
- Ongoing focussed review of how we use our increased nursing resources cost efficiently and effectively;
- Improved visibility and control around temporary resources;
- Delivering identified savings plans;
- IDF analysis and management;
- Housekeeping activities, including review of ACC revenue processes, indepth analysis on areas of significant expenditure; and
- Progressing primary care prioritisation.

Additional issues not currently built into our forecast that may impact this year, including:

- MECA settlements above levels assumed in the budget and potential flow on effect to contracts, will impact on the deficit if not funded by MoH
- Annual impairment review of key assets
- Potential for increased provisioning for employee entitlements as a result of Holidays Act and other pay related provisions

Other Performance Measures

	January				*Year to Date*				*Year End Forecast*	Refer Appendix
	Actual	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*			
	$'000	*$'000*	*$'000*	*%*	*$'000*	*$'000*	*$'000*	*%*	*$'000*	
Savings plans	729	960	**(231)**	**-24.1%**	3,653	6,739	**(3,086)**	**-45.8%**	14,152	8
Capital spend	767	1,159	**(392)**	**-33.8%**	10,047	11,709	**(1,662)**	**-14.2%**	17,933	12
	FTE	*FTE*	*FTE*	*%*	*FTE*	*FTE*	*FTE*	*%*	*FTE*	
Employees	2,428	2,419	(10)	-0.4%	2,396	2,429	33	1.4%	2,438	2 & 4
	CWD	*CWD*	*CWD*	*%*	*CWD*	*CWD*	*CWD*	*%*	*CWD*	
Case weighted discharges	2,477	2,013	464	23.1%	17,497	16,934	563	3.3%	28,699	2

Note: Savings Plan budgets have been updated from an even spread across the year, to management budget figures to match the table in appendix 8.

- Savings Plans (Appendix 8)
    - Achievement of the $14.2m saving plan is a significant factor in financial performance. Savings plans have been identified for $11.7m (82%), down from $13.0m (92%) last month due to a reassessment of the likely annual leave savings to be delivered (down $1.4m). Identified savings removed from operational budgets, is down from $6.8m last month to $5.6m for the same reason.

    - On a straight line basis YTD savings of $8.3m should have been achieved by the end of January, and $3.7m has been made. To adjust for timing, a further $1.5m of the savings required has been accrued centrally. This is matched by assuming budgeted contingency of $583k and a further $933k relating to the new investments reserve, will not be spent.

- Capital spend (Appendix 12)
    - Capital spend has slipped slightly more behind budget with procurement lead times in the block allocations offsetting additional costs in 2018/19.

- Cash (Appendices 11 & 13)
    - January's low point was a $13.1m overdraft on 3 January with a forecast low of $12.8m overdrawn by the end of the year. These are within our current statutory limit of $27m. Interest is expected to come in $0.2m less than planned as a result.

- Employees (Appendices 2 & 4)
    - Employee numbers are marginally favourable reflecting challenges filling vacancies in medical and allied health positions, partly offset by high use of nursing resources and lower than expected savings from annual leave reductions.

- Activity (Appendix 2)
    - YTD CWD are ahead of plan, driven by acute general surgery, orthopaedic surgery and acute internal medicine.

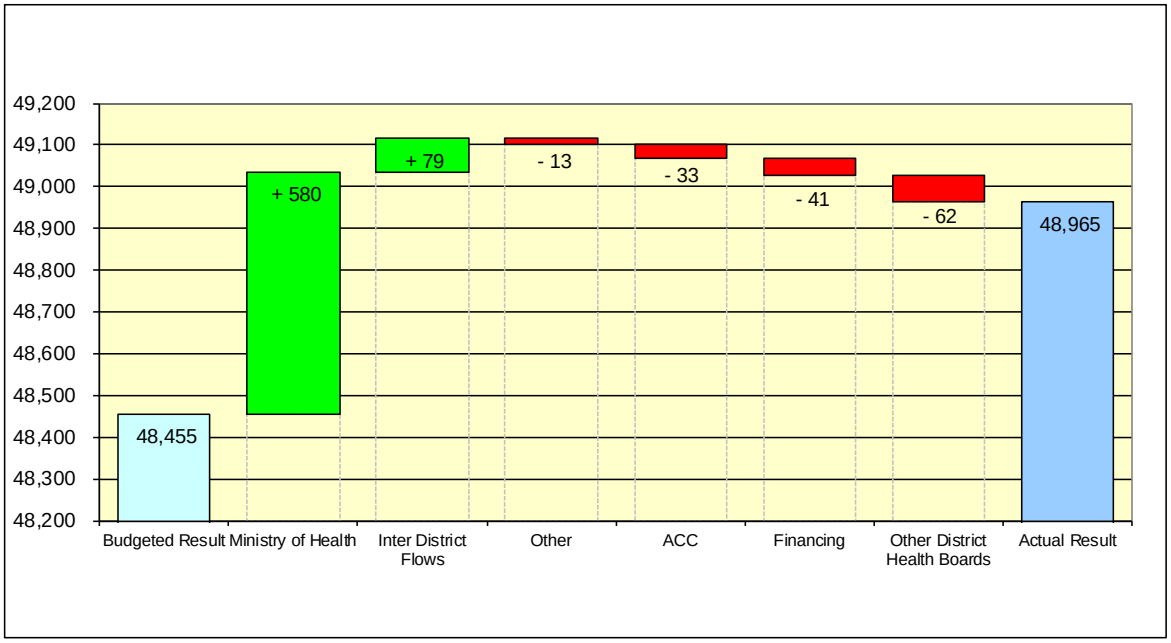
    - Elective discharges show a shortfall on achieving the Ministry of Health target, however the DHB is likely to meet the case weighted discharge (CWD) target, and receive all of the base elective surgery funding as a result.

APPENDICES

1. INCOME

$'000	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	46,817	46,237	580	1.3%	322,680	320,604	2,076	0.6%	550,597
Inter District Flows	841	762	79	10.4%	4,927	5,335	(408)	-7.6%	9,146
Other District Health Boards	292	354	(62)	-17.5%	2,558	2,456	102	4.1%	4,229
Financing	14	55	(41)	-75.1%	227	387	(159)	-41.2%	663
ACC	390	423	(33)	-7.8%	2,719	3,115	(396)	-12.7%	5,370
Other Government	50	43	6	14.5%	314	418	(104)	-24.9%	673
Patient and Consumer Sourced	98	106	(8)	-7.3%	663	731	(67)	-9.2%	1,261
Other Income	463	474	(12)	-2.5%	3,852	3,390	462	13.6%	5,776
Abnormals	-	-	-	0.0%	571	17	554	3261.4%	17
	48,965	**48,455**	510	1.1%	**338,513**	**336,452**	2,060	0.6%	**577,732**

Month of January



Note the scale does not begin at zero

Ministry of Health (favourable)
Recognised MoH funding relating to elective activity this month, as MoH usually funds up to the base target if the equivalent case weighted discharge (CWD) target is met, which is likely. Also includes In-Between-Travel (home support), and pay equity (residential care).

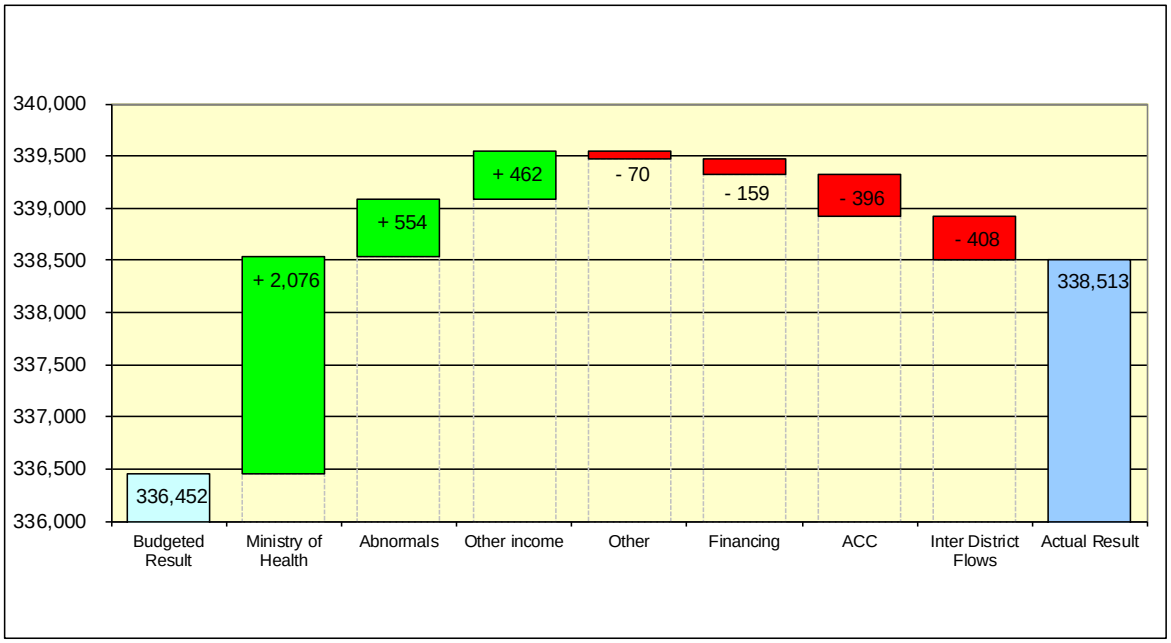
Inter District Inflows (favourable)
Reflects visitor numbers into Hawke's Bay.

ACC (unfavourable)
Lower elective surgery income reflecting capacity constraints, partly offset by rehabilitation income.

Financing (unfavourable)
Lower interest earnings due to lower cash balances.

Other District Health Boards (unfavourable)
Lower cancer drug sales to Tairawhiti DHB over the holiday season.

Year to Date



Note the scale does not begin at zero

Ministry of Health (favourable)
Pay equity and In-Between-Travel income offset in related expenditure (Appendix 4). Also immediate relief funding, Care Capacity Demand Management (CCDM) funding (nurses agreement), and capital charge funding.

Abnormals (favourable)
Prior year wash-ups and accruals no longer required. All recognised in September.

Other income (favourable)
Special fund and clinical trial income, and a wide variety of income sources.

Financing (unfavourable)
Lower interest earnings due to lower cash balances.

ACC (unfavourable)
Reduced elective surgery income due to capacity constraints, partly offset by increased rehabilitation income.

Inter District Flows (unfavourable)
Reducing as there is a steady catchup over the summer of the reduced income over the winter months.

2. PROVIDING HEALTH SERVICES

	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	8,247	8,529	282	3.3%	40,510	40,744	234	0.6%	67,334
Nursing personnel	8,690	7,987	(703)	-8.8%	51,125	48,909	(2,216)	-4.5%	84,029
Allied health personnel	2,964	3,195	231	7.2%	20,801	22,443	1,642	7.3%	38,973
Other personnel	2,340	2,190	(150)	-6.8%	14,660	14,534	(126)	-0.9%	24,941
Outsourced services	559	1,014	455	44.9%	5,575	7,086	1,511	21.3%	12,166
Clinical supplies	3,331	3,264	(67)	-2.0%	26,296	22,686	(3,610)	-15.9%	38,802
Infrastructure and non clinical	1,578	1,779	201	11.3%	13,125	12,826	(299)	-2.3%	22,137
	27,708	**27,958**	250	0.9%	**172,092**	**169,228**	(2,863)	-1.7%	**288,383**
Expenditure by directorate $'000									
Medical	8,624	7,899	(725)	-9.2%	48,995	45,892	(3,103)	-6.8%	77,786
Surgical	6,100	6,404	304	4.8%	37,210	37,690	480	1.3%	64,038
Community, Women and Children	4,419	4,587	168	3.7%	27,379	27,137	(243)	-0.9%	46,529
Older Persons, Options HB, Menta	3,268	3,652	384	10.5%	21,073	21,511	438	2.0%	37,166
Operations	3,781	3,648	(133)	-3.7%	24,990	24,091	(898)	-3.7%	41,176
Other	1,516	1,768	252	14.3%	12,445	12,907	462	3.6%	21,688
	27,708	**27,958**	250	0.9%	**172,092**	**169,228**	(2,863)	-1.7%	**288,383**
Full Time Equivalents									
Medical personnel	389.3	390.4	1	0.3%	355	369	15	4.0%	366.8
Nursing personnel	1,042.2	1,001.7	(41)	-4.0%	997	970	(27)	-2.8%	978.9
Allied health personnel	430.5	464.9	34	7.4%	461	493	32	6.5%	494.4
Support personnel	150.7	132.8	(18)	-13.5%	143	138	(5)	-3.6%	138.9
Management and administration	257.5	260.6	3	1.2%	270	276	7	2.4%	277.0
	2,270.3	**2,250.6**	(20)	-0.9%	**2,224**	**2,246**	22	1.0%	**2,256.0**
Case Weighted Discharges									
Acute	1,866	1,340	527	39.3%	12,866	11,563	1,303	11.3%	19,417
Elective	401	472	(72)	-15.2%	3,266	3,924	(657)	-16.8%	6,850
Maternity	178	171	6	3.7%	1,224	1,198	26	2.2%	2,000
IDF Inflows	33	30	3	10.0%	141	250	(108)	-43.4%	432
	2,477	**2,013**	464	23.1%	**17,497**	**16,934**	563	3.3%	**28,699**

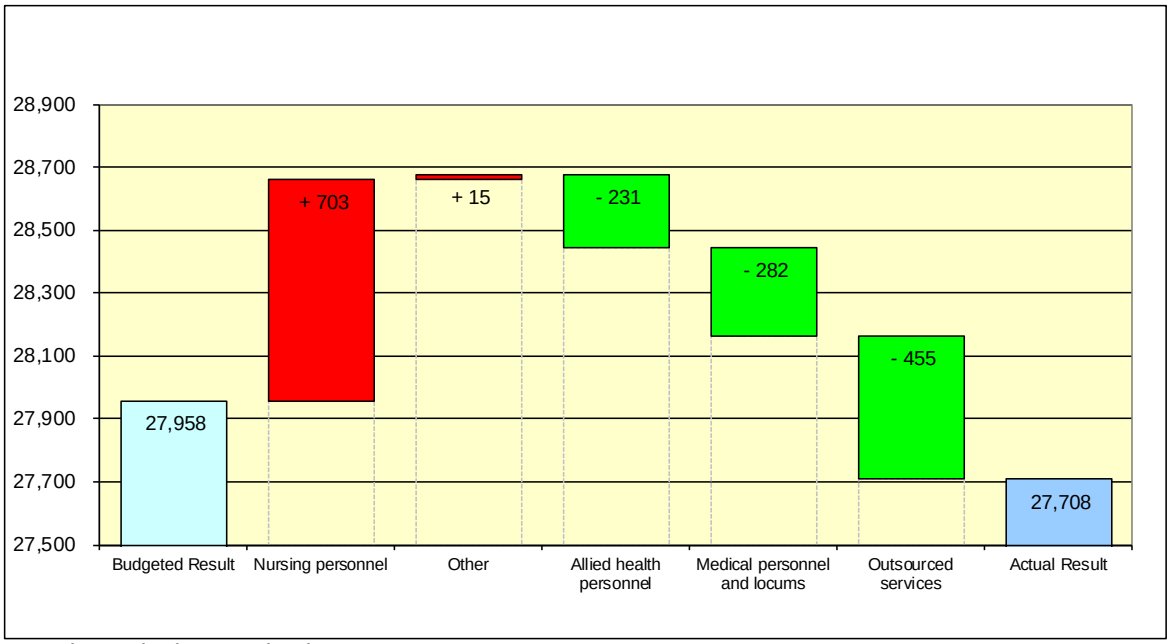
Directorates YTD

- Medical – lower than budgeted savings from nursing annual leave over the holiday period, including the additional savings included as an efficiency and higher nurse hours than budgeted;
- Older Persons, Options HB, Mental Health – continuing medical education and allied health vacancies;
- Surgical –benefited from a net underspend on elective capacity funding. We expect external expenditure on elective capacity to increase from February. This partly offset by lower than budgeted annual leave savings.

Case Weighted Discharges

Acute discharges were significantly above plan both month and YTD, including general medicine, orthopaedics and general surgery. Correspondingly, electives are below plan in January, and remain below plan YTD across all specialties, with elective activity on site, constrained by finite capacity and acute demand. IDF inflows are picking up as summer months bring increased visitors.

Month of January



Note the scale does not begin at zero

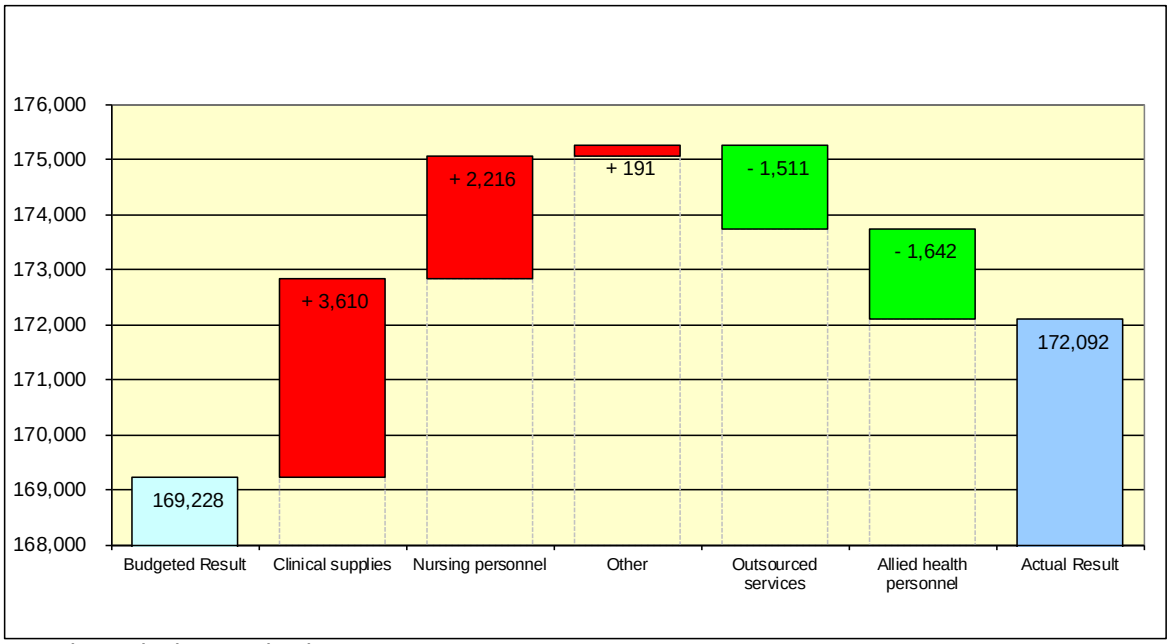
Nursing personnel (unfavourable)
Continues to be overspends on nursing due to a number of factors, higher than budgeted hours to match acuity and average rates higher than planned. Additional savings from reducing leave balances, did not occur.

Allied health personnel (favourable)
Vacancies including therapists, pharmacists, and psychologists.

Medical personnel and locums (favourable)
Favourable from the January update of continuing medical education balances, partly offset by vacancy and leave cover.

Outsourced services (favourable)
Budget for elective capacity activity, which partially offsets costs on other expense lines, including nursing. Additional costs expected from February as capacity actions are implemented.

Year to Date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Challenges achieving planned efficiencies, pharmaceuticals including biologics, treatment disposables including blood and blood intragam, and patient transport. Biologic overspend appears to be a national trend.

Nursing personnel (unfavourable)
Overspend on nursing cost due to a number of factors, including hours to match acuity and average rates higher than planned. Additional savings from reducing leave balances, did not occur.

Outsourced services (favourable)
Expected to be less favourable in future months as actions underway to manage elective surgery volumes start to impact.

Allied health personnel (favourable)
Continuing national issue with recruitment and retention.

Full Time Equivalents (FTE)

FTEs are 22 (1.0%) favourable YTD including:

Medical personnel (15 FTE / 4.0% favourable)
- Vacancies in radiology, Wairoa GPs, and psychiatrists.

Nursing personnel (-27 FTE / -2.8% unfavourable)
- Impact of high patient volumes in acute areas, and difficulties flexing down staffing levels.

Allied health personnel (32 FTE / 6.5% favourable)
- Vacancies in therapies, medical radiation technologists (MRTs), social workers, pharmacists, health promotion workers, psychologists, community support workers, and laboratory technicians.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To January 2019

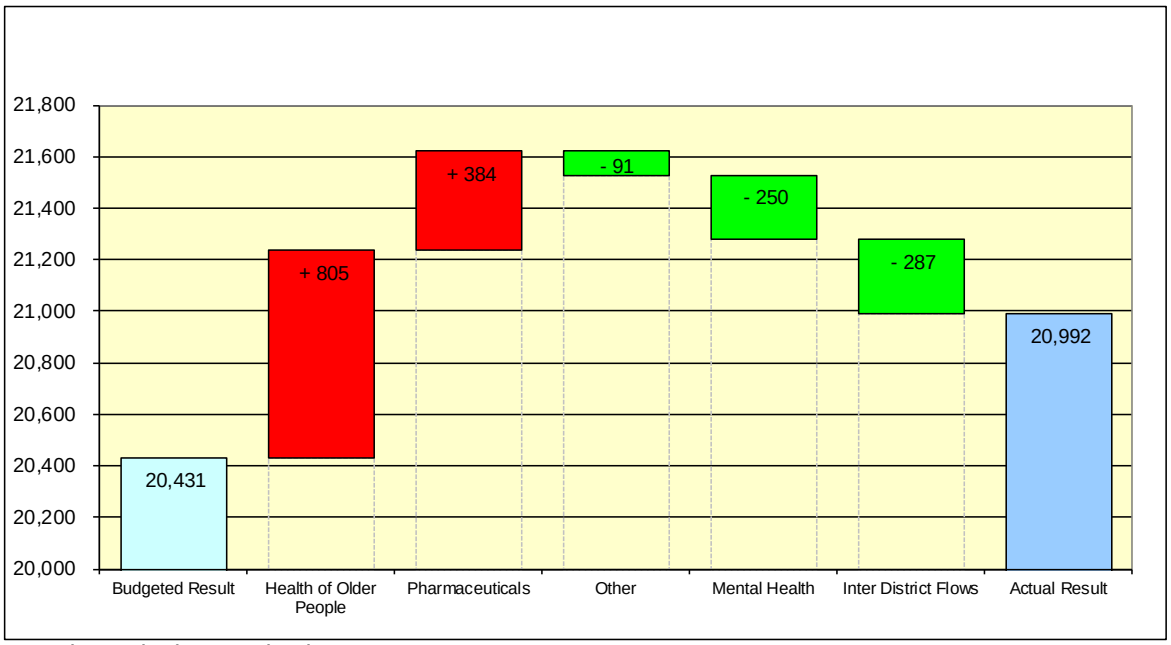
	January 2019				YTD January 2018				Full Year Plan
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	
Anaesthetics	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**	**4**
Cardiothoracic	1	9	-8	0.0%	**59**	**67**	**-8**	**0.0%**	**119**
Avastins	20	15	5	33.3%	**125**	**110**	**15**	**13.6%**	**201**
ENT	70	55	15	27.3%	**321**	**407**	**-86**	**-21.1%**	**740**
General Surgery	75	98	-23	-23.5%	**696**	**728**	**-32**	**-4.4%**	**1324**
Gynaecology	45	53	-8	-15.1%	**369**	**390**	**-21**	**-5.4%**	**708**
Maxillo-Facial	19	38	-19	-50.0%	**187**	**278**	**-91**	**-32.7%**	**507**
Neurosurgery	1	7	-6	0.0%	**48**	**52**	**-4**	**0.0%**	**95**
Ophthalmology	99	99	0	0.0%	**707**	**731**	**-24**	**-3.3%**	**1328**
Orthopaedics	61	85	-24	-28.2%	**679**	**628**	**51**	**8.1%**	**1145**
Paediatric Surgery	2	6	-4	0.0%	**31**	**46**	**-15**	**0.0%**	**85**
Skin Lesions	16	18	-2	-11.1%	**105**	**138**	**-33**	**-23.9%**	**254**
Urology	60	45	15	33.3%	**277**	**337**	**-60**	**-17.8%**	**618**
Vascular	15	25	-10	-40.0%	**125**	**183**	**-58**	**-31.7%**	**333**
Non Surgical - Arranged	11	11	0	0.0%	**76**	**80**	**-4**	**-5.0%**	**144**
Non Surgical - Elective	11	11	0	0.0%	**80**	**82**	**-2**	**-2.4%**	**148**
TOTAL	**506**	**575**	**-69**	**-12.0%**	**3885**	**4257**	**-372**	**-8.7%**	**7753**

Please Note:This report was run on 11 February 2019
The volumes by specialty now include both Elecitve and Arranged discharges rolled into one.
Data is subject to change.

3. FUNDING OTHER PROVIDERS

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,967	3,583	(384)	-10.7%	23,521	25,073	1,552	6.2%	43,008
Primary Health Organisations	3,406	3,368	(37)	-1.1%	22,548	22,312	(237)	-1.1%	39,481
Inter District Flows	4,510	4,797	287	6.0%	34,193	33,579	(614)	-1.8%	57,564
Other Personal Health	1,615	1,720	105	6.1%	13,352	12,141	(1,211)	-10.0%	21,803
Mental Health	808	1,058	250	23.6%	7,152	7,405	253	3.4%	12,699
Health of Older People	6,371	5,566	(805)	-14.5%	42,003	38,969	(3,034)	-7.8%	66,826
Other Funding Payments	315	338	23	6.7%	2,669	2,361	(308)	-13.0%	4,053
	20,992	20,431	(561)	-2.7%	**145,439**	**141,840**	(3,599)	-2.5%	245,435
Payments by Portfolio									
Strategic Services									
Secondary Care	3,978	4,236	257	6.1%	31,071	29,650	(1,421)	-4.8%	50,827
Primary Care	8,540	8,218	(322)	-3.9%	55,967	56,407	440	0.8%	98,917
Mental Health	1,117	1,343	226	16.8%	8,931	9,404	474	5.0%	16,127
Health of Older People	6,630	5,871	(760)	-12.9%	44,224	40,991	(3,233)	-7.9%	70,357
Other Health Funding	133	133	(0)	0.0%	933	933	(0)	0.0%	1,600
Maori Health	491	495	5	0.9%	3,436	3,545	109	3.1%	6,024
Population Health	102	134	33	24.3%	877	910	33	3.6%	1,582
	20,992	20,431	(561)	-2.7%	**145,439**	**141,840**	(3,599)	-2.5%	245,435

Month of January



Note the scale does not begin at zero

Health of Older People (unfavourable)
Higher residential care and home support costs related to pay equity costs and In-Between-Travel are partly offset in income. The increases in both residential and home care that are being analysed.

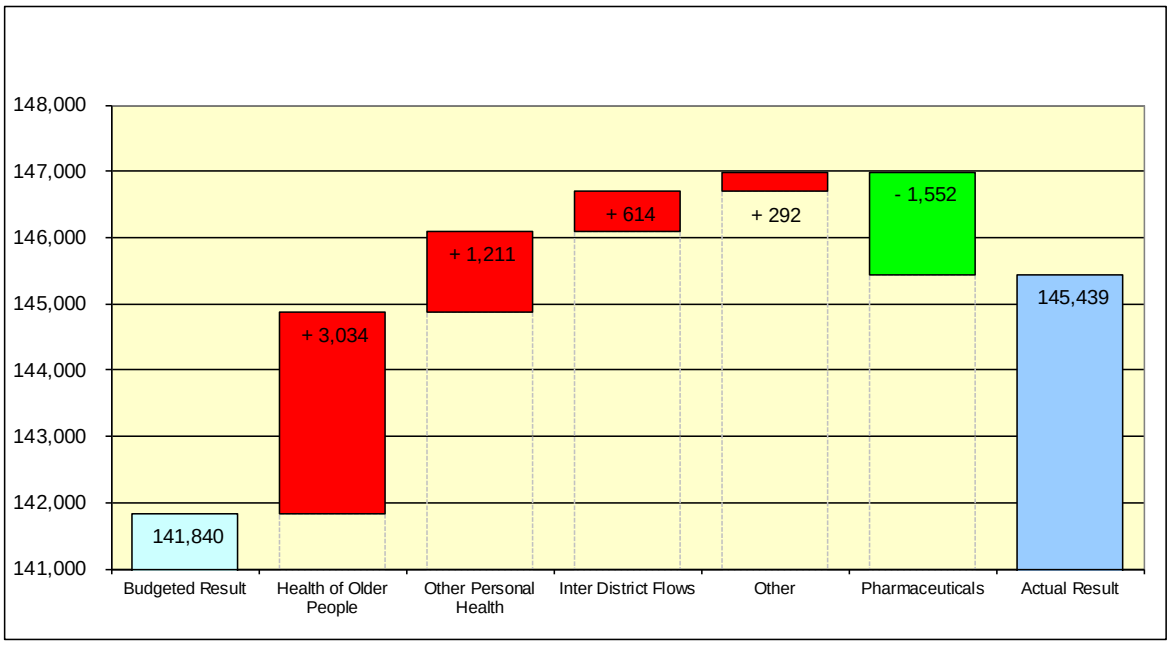
Pharmaceuticals (unfavourable)

Pharmaceutical expenditure was higher than budgeted in-month to reflect actual performance and alignment to the PHARMAC forecast.

Mental Health (favourable)
Lower residential and home based care.

Inter District Flows (favourable)
Lower than budgeted outflows.

Year to Date



Health of Older People (unfavourable)
Pay equity (residential care) and In-Between-Travel (home support) partly offset in income.There are complexities around these arrangements and our treatment is being reviewed.

Other Personal Health (unfavourable)
Efficiencies not yet achieved.

Inter District Flows (unfavourable)
Higher volumes earlier in the year.

Pharmaceuticals (favourable)
Pharmaceutical rebates in line with PHARMAC forecasts.

4. CORPORATE SERVICES

$'000	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Operating Expenditure									
Personnel	1,504	1,431	(73)	-5.1%	10,315	10,463	147	1.4%	17,589
Outsourced services	67	71	4	6.0%	503	504	1	0.2%	860
Clinical supplies	10	(0)	(11)	-2804.1%	65	(90)	(155)	-171.6%	(146)
Infrastructure and non clinical	636	662	26	4.0%	6,184	5,843	(341)	-5.8%	9,270
	2,216	2,164	(53)	-2.4%	17,066	16,719	(347)	-2.1%	27,573
Capital servicing									
Depreciation and amortisation	1,137	1,158	22	1.9%	7,592	7,740	147	1.9%	13,652
Financing	-	-	-	0.0%	-	-	-	0.0%	-
Capital charge	655	655	0	0.0%	5,045	4,586	(459)	-10.0%	7,861
	1,792	1,813	22	1.2%	12,637	12,325	(312)	-2.5%	21,513
	4,008	**3,977**	(31)	-0.8%	**29,704**	**29,044**	(659)	-2.3%	**49,086**
Full Time Equivalents									
Medical personnel	0.2	0.4	0	37.1%	0	0	(0)	-0.4%	0.3
Nursing personnel	8.3	14.5	6	42.9%	12	16	4	22.8%	15.8
Allied health personnel	0.1	0.4	0	69.6%	0	0	0	49.5%	0.4
Support personnel	9.0	7.3	(2)	-22.7%	9	8	(1)	-16.7%	8.0
Management and administration	140.5	145.5	5	3.5%	149	159	9	5.7%	157.9
	158.0	**168.0**	10	6.0%	**172**	**183**	12	6.3%	**182.4**

High infrastructure and non clinical costs mainly relate to the new Microsoft Agreement and other software licences. The additional capital charges relate to the June 2018 land and buildings revaluation, and is offset by the accrual of additional MOH income in appendix 1. YTD clinical supplies variance is mainly planned efficiencies yet to be achieved.

5. RESERVES

$'000	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure									
Contingency	20	20	0	0.0%	489	489	(0)	0.0%	700
Efficiencies	(5,476)	(5,260)	217	4.1%	(1,517)	0	1,517	0.0%	0
Other	59	31	(28)	-91.9%	(1,355)	51	1,406	2750.3%	(871)
	(5,397)	**(5,208)**	188	-3.6%	**(2,383)**	**540**	**2,923**	541.5%	**(171)**

The contingency budget reduces when EMT approves expenditure where no source of funding has been identified. Contingency can still be released for unusual or unexpected events up to the remaining balance of the contingency, currently $700k.

Transfers out of the original $4m contingency YTD include:

- New nursing initiatives $1m;
- Executive Director Provider Services contingency $300k; and
- Cost pressure adjustments to budgets $2m.

The accrual for unachieved savings (recognising savings are more likely to increase incrementally rather than being achieved evenly over the year), appears as a negative expense amount in the efficiency line. Similar accruals to budget have been made (CEO contingency $408k, Executive Director Provider Services contingency $175k and new investments reserve $933) that offset the unachieved savings accrual.

The “Other” category comprises the net impact of an ongoing review of accruals relating to the prior year. If the variance remains favourable it will be a one-off benefit.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	January			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	46,192	45,547	645	319,272	317,346	1,926	545,336	537,477	7,859
Less:									
Payments to Internal Providers	24,030	24,030	-	181,913	181,453	(459)	309,784	309,025	(759)
Payments to Other Providers	20,240	19,809	(431)	139,936	137,489	(2,447)	237,972	233,452	(4,521)
Contribution	**1,922**	**1,708**	**214**	**(2,576)**	**(1,596)**	**(980)**	**(2,420)**	**(5,000)**	**2,580**
Governance and Funding Admin.									
Funding	281	281	-	2,028	2,028	-	3,424	3,383	40
Other Income	3	3	-	18	18	-	30	30	-
Less:									
Expenditure	235	306	71	1,847	2,122	275	3,564	3,413	(150)
Contribution	**49**	**(22)**	**71**	**198**	**(76)**	**275**	**(110)**	**-**	**(110)**
Health Provision									
Funding	23,749	23,749	-	179,885	179,425	459	306,361	305,542	819
Other Income	2,669	2,809	(140)	18,560	18,416	144	31,212	30,594	618
Less:									
Expenditure	26,735	26,946	211	202,405	200,371	(2,035)	340,043	336,136	(3,907)
Contribution	**(317)**	**(388)**	**71**	**(3,961)**	**(2,530)**	**(1,431)**	**(2,469)**	**-**	**(2,469)**
Net Result	**1,654**	**1,298**	**356**	**(6,338)**	**(4,202)**	**(2,136)**	**(5,000)**	**(5,000)**	**(0)**

The table above reports the result in the classifications used by the Ministry of Health and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

7. MANAGEMENT BUDGET MOVEMENTS

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management Budget is used for internal reporting and the annual plan is used for MoH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes, or unbudgeted new funding received during the year and the associated expenditure.

	January			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	45,547	44,721	827	317,346	313,575	3,772	545,336	537,477	7,859
Less:									
Payments to Internal Providers	24,030	23,966	(64)	181,453	181,001	(452)	309,784	309,025	(759)
Payments to Other Providers	19,809	19,247	(562)	137,489	135,766	(1,723)	237,972	233,452	(4,521)
Contribution	**1,708**	**1,508**	**200**	**(1,596)**	**(3,193)**	**1,597**	**(2,420)**	**(5,000)**	**2,580**
Governance and Funding Admin.									
Funding	281	276	5	2,028	2,002	26	3,424	3,383	40
Other Income	3	3	-	18	18	-	30	30	-
Less:									
Expenditure	306	295	(11)	2,122	2,007	(115)	3,564	3,413	(150)
Contribution	**(22)**	**(17)**	**(6)**	**(76)**	**12**	**(89)**	**(110)**	**-**	**(110)**
Health Provision									
Funding	23,749	23,682	67	179,425	178,940	485	306,361	305,542	819
Other Income	2,809	2,573	236	18,416	18,004	412	31,212	30,594	618
Less:									
Expenditure	26,946	26,422	(524)	200,371	197,940	(2,430)	340,043	336,136	(3,907)
Contribution	**(388)**	**(167)**	**(221)**	**(2,530)**	**(996)**	**(1,534)**	**(2,469)**	**-**	**(2,469)**
Net Result	**1,298**	**1,324**	**(26)**	**(4,202)**	**(4,176)**	**(26)**	**(5,000)**	**(5,000)**	**(0)**

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Savings plans are transferred to operational budgets as they are agreed. Living within budget will indicate that directorates are achieving their savings targets.

The table below shows $11.7m of savings have been identified. This is $1.3m less than last month and recognises the reassessment of the likely annual leave savings to be delivered. $5.6m of identified savings has been removed from operational budgets.

Savings targets have been budgeted evenly through the year at directorate level. However, the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued at a consolidated level to overcome this. The amount accrued Year To Date (YTD) is $1.5m, matched by reserves and contingency. A further $642k has been accrued YTD which recognises that Primary Care expect to deliver the bulk of their savings in the second half of the year.

	Target	Current Year Identification					Savings Delivered / Forecast				Recurrency	
Division	2018/19 Savings Target $'000	2018/19 Identified Saving $'000	%	2018/19 Budget Adjusted	2018/19 Savings WIP	2018/19 Un-identified Savings	YTD Actual	YTD Plan	Var	2018/19 Forecast	2019/20 Identified Saving $'000	%
Strategic	-	-	- %	-	-	-	-	-	-	-	-	- %
Primary Care	4,673	4,735	101 %	716	4,019	(62)	1,374	2,726	(1,351)	2,542	4,634	99 %
Provider Services												
Medical	1,820	1,866	103 %	1,634	232	(46)	339	1,062	(723)	881	554	30 %
Surgical	1,450	807	56 %	766	41	643	133	846	(713)	260	812	56 %
CWC	1,049	772	74 %	772	-	277	282	612	(330)	489	45	4 %
OPMH	865	1,100	127 %	1,100	-	(235)	536	505	32	1,027	865	100 %
Operations	893	564	63 %	298	267	329	118	521	(403)	312	192	21 %
Facilities	232	246	106 %	246	-	(14)	111	135	(25)	188	232	100 %
COO	235	(1,170)	(498)%	(1,370)	200	1,405	13	137	(124)	120	200	85 %
Total Provider Services	*6,544*	*4,184*	*64 %*	*3,445*	*740*	*2,360*	*1,532*	*3,817*	*(2,285)*	*3,277*	*2,900*	*44 %*
HI&E	402	435	108 %	435	-	(33)	223	235	(12)	335	184	46 %
People & Quality	105	126	120 %	124	3	(21)	40	61	(21)	101	105	100 %
Information Services	254	272	107 %	18	254	(18)	8	148	(140)	124	254	100 %
Financial Services	1,430	1,238	87 %	158	1,080	192	100	834	(734)	238	1,116	78 %
Executive	112	28	25 %	28	-	84	6	65	(59)	22	-	- %
Capital Servicing	632	632	100 %	632	-	-	369	369	-	632	632	100 %
Timing Adjustments	-	-	- %	-	-	-	-	(1,517)	1,517	-	-	- %
Totals	**14,152**	**11,651**	**82 %**	**5,556**	**6,096**	**2,501**	**3,653**	**6,739**	**(3,086)**	**7,271**	**9,825**	**69 %**
Annual Leave Savings Total		*1,499*		*1,499*	*-*	*-*	*293*	*664*	*(371)*	*1,119*	*-*	

NB: these are included in the above Division & Directorate figures.

9. FINANCIAL POSITION

30 June 2018	$'000	January Actual	January Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
	Equity					
164,706	Crown equity and reserves	164,706	175,069	(10,363)	-	174,711
(15,982)	Accumulated deficit	(22,321)	(15,175)	(7,146)	(6,338)	(15,973)
148,723		142,385	159,894	(17,509)	(6,338)	158,738
	Represented by:					
	Current Assets					
7,444	Bank	875	5,363	(4,487)	(6,569)	2,313
1,885	Bank deposits > 90 days	1,855	1,901	(46)	(30)	1,901
25,474	Prepayments and receivables	24,929	24,865	65	(544)	25,045
3,907	Inventory	3,732	4,486	(753)	(175)	4,520
2,293	Investment in NZHP	2,638	-	2,638	345	-
-	Non current assets held for sale	-	625	(625)	-	625
41,003		34,030	37,239	(3,210)	(6,974)	34,404
	Non Current Assets					
175,460	Property, plant and equipment	177,899	182,387	(4,487)	2,440	185,018
1,479	Intangible assets	1,421	3,454	(2,033)	(58)	4,147
9,280	Investments	10,303	11,813	(1,510)	1,023	11,798
186,220		189,624	197,654	(8,030)	3,404	200,963
227,223	**Total Assets**	**223,653**	**234,893**	**(11,240)**	**(3,569)**	**235,368**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	8,539	-	(8,539)	(8,539)	-
35,817	Payables	31,198	35,871	4,673	4,618	36,249
40,064	Employee entitlements	38,913	36,417	(2,496)	1,151	37,579
75,881		78,650	72,288	(6,361)	(2,769)	73,828
	Non Current Liabilities					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	**Total Liabilities**	**81,269**	**75,000**	**(6,269)**	**(2,769)**	**76,629**
148,723	**Net Assets**	**142,385**	**159,894**	**(17,509)**	**(6,338)**	**158,738**

Crown equity and reserves includes changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. It also includes the $4m reduction to the 30 June 2018 revaluation reserve due to the seismic upgrades required in the theatre block. Bank and bank deposits > 90 days reflects special funds and clinical trials, and the bank overdraft reflects the operating cash position at the end of the month. The investment in New Zealand Health Partnerships (NZHP) relates to a classification change separating the investment from property, plant and equipment.

10. EMPLOYEE ENTITLEMENTS

30 June 2018	$'000	January Actual	January Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
10,004	Salaries & wages accrued	6,884	5,960	(924)	3,120	7,756
1,157	ACC levy provisions	1,596	734	(862)	(439)	532
5,945	Continuing medical education	6,678	7,667	989	(734)	6,456
21,348	Accrued leave	21,872	20,441	(1,431)	(524)	21,199
4,230	Long service leave & retirement grat.	4,502	4,327	(176)	(272)	4,438
42,683	**Total Employee Entitlements**	41,532	39,128	(2,403)	1,151	40,380

Accrued leave reduced further in January as the usual decline over the summer months continued, helped by management activities to reduce leave balances.

11. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZHP under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

The cash low point for each month is generally incurred immediately prior to receipt of MOH funding on the 4th of the month. January's low point was a $13.1m overdraft incurred on 3 January, and next month's low point is likely to be the $9.7m overdraft that occurred on 1 February. The forecast low for the end of the financial year is $13.0m overdraft, which is within our statutory limit of $27m.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

12. CAPITAL EXPENDITURE

Capital spend for the month is under budget, mainly in the block allocations for facilities, information services and clinical plant and equipment. The budget approved by the Board in June assumed even phasing across the year, whereas expenditure is likely to be more randomly spread reflecting immediate needs and procurement lead times.

See table on the next page.

2019 Updated Plan (Sep 18)		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,652	Depreciation	7,592	7,740	147
(5,000)	Surplus/(Deficit)	(10,823)	(4,202)	6,621
11,688	Working Capital	14,145	8,301	(5,844)
20,340		10,914	11,838	925
	Other Sources			
-	Special Funds and Clinical Trials	38	-	(38)
-	Funded Programmes	4	-	(4)
-		42	-	(42)
20,340	**Total funds sourced**	**10,956**	**11,838**	**882**
	Application of Funds:			
	Block Allocations			
3,347	Facilities	1,207	1,990	783
3,400	Information Services	982	1,989	1,007
3,225	Clinical Plant & Equipment	1,243	1,808	565
9,972		3,432	5,788	2,355
	Local Strategic			
100	Replacement Generators	-	17	17
26	Renal Centralised Development	24	26	2
2,872	Endoscopy Building	3,078	2,778	(300)
350	Travel Plan	144	204	60
1,263	Histology and Education Centre Upgrade	1,310	1,263	(47)
150	Radiology Extension	-	-	-
50	Fit out Corporate Building	-	-	-
500	High Voltage Electrical Supply	-	200	200
700	Seismic Upgrades	-	50	50
1,950	Surgical Expansion	1,803	1,384	(419)
7,961		6,358	5,922	(437)
	Other			
-	Special Funds and Clinical Trials	38	-	(38)
-	Funded Programmes	4	-	(4)
-	Other	214	-	(214)
-		257	-	(257)
17,933	***Capital Spend***	***10,047***	***11,709***	***1,662***
	Regional Strategic			
1,945	RHIP (formerly CRISP)	564	129	(434)
1,945		564	129	(434)
	National Strategic			
462	NOS (Class B shares in NZHPL)	345	-	(345)
462		345	-	(345)
20,340	**Total funds applied**	**10,956**	**11,838**	**882**

13. ROLLING CASH FLOW

	Actual	January Forecast	Variance	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	50,392	47,291	3,100	47,061	47,315	47,392	47,060	47,413	46,875	46,174	53,627	46,947	47,270	47,174	47,451
Cash receipts from donations, bequests and clinical trials	38	-	38	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	1,290	2,992	(1,702)	499	493	493	499	493	495	501	502	529	495	489	492
Cash paid to suppliers	(30,063)	(26,365)	(3,698)	(25,450)	(28,127)	(28,110)	(26,470)	(28,805)	(28,715)	(26,504)	(28,613)	(27,131)	(28,218)	(29,546)	(19,774)
Cash paid to employees	(20,167)	(23,042)	2,875	(18,443)	(17,413)	(18,015)	(20,898)	(17,783)	(16,802)	(22,611)	(17,546)	(20,516)	(17,374)	(16,848)	(23,137)
Cash generated from operations	**1,490**	**877**	**614**	**3,667**	**2,269**	**1,760**	**190**	**1,318**	**1,853**	**(2,440)**	**7,969**	**(172)**	**2,173**	**1,269**	**5,032**
Interest received	14	15	(1)	10	5	0	0	0	(0)	(0)	0	0	0	0	0
Interest paid	-	(24)	24	(15)	(15)	(13)	(15)	(26)	(26)	(34)	(14)	(16)	(15)	(15)	(15)
Capital charge paid	(0)	(0)	0	(0)	(0)	(0)	(0)	(4,670)	(0)	(0)	0	(0)	(0)	(4,970)	(0)
Net cash inflow/(outflow) from operating activities	**1,504**	**868**	**636**	**3,662**	**2,259**	**1,747**	**176**	**(3,378)**	**1,826**	**(2,474)**	**7,955**	**(187)**	**2,158**	**(3,716)**	**5,017**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	1	(0)	1	-	-	0	0	0	0	-	-	(0)	0	0	(0)
Acquisition of property, plant and equipment	(758)	(1,570)	813	(1,478)	(1,909)	(1,504)	(1,766)	(1,170)	(1,372)	(1,372)	(1,372)	(1,372)	(1,372)	(1,372)	(1,372)
Acquisition of intangible assets	(9)	(115)	105	(115)	(115)	(115)	(115)	(115)	(156)	(156)	(156)	(156)	(156)	(156)	(156)
Acquisition of investments	(33)	(0)	(33)	-	-	-	-	-	-	-	-	-	-	-	(0)
Net cash inflow/(outflow) from investing activities	**(799)**	**(1,686)**	**887**	**(1,593)**	**(2,024)**	**(1,619)**	**(1,881)**	**(1,285)**	**(1,528)**	**(1,528)**	**(1,528)**	**(1,528)**	**(1,528)**	**(1,528)**	**(1,529)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	-	-	-	(357)	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	705	(818)	1,523	2,069	234	128	(1,706)	(5,020)	298	(4,003)	6,427	(1,716)	630	(5,245)	3,488
Add:Opening cash	(6,506)	(6,506)	-	(5,801)	(3,732)	(3,498)	(3,370)	(5,076)	(10,096)	(9,798)	(13,801)	(7,374)	(9,090)	(8,460)	(13,704)
Cash and cash equivalents at end of period	**(5,801)**	**(7,323)**	**1,523**	**(3,732)**	**(3,498)**	**(3,370)**	**(5,076)**	**(10,096)**	**(9,798)**	**(13,801)**	**(7,374)**	**(9,090)**	**(8,460)**	**(13,704)**	**(10,216)**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(8,562)	(10,205)	1,643	(6,614)	(6,379)	(6,251)	(7,957)	(12,977)	(12,679)	(16,682)	(10,255)	(11,971)	(11,341)	(16,586)	(13,097)
Short term investments (special funds/clinical trials)	2,726	2,877	(151)	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877
Bank overdraft	23	-	23	-	-	-	-	-	-	-	-	-	-	-	-
	(5,808)	**(7,324)**	**1,515**	**(3,733)**	**(3,498)**	**(3,370)**	**(5,076)**	**(10,096)**	**(9,798)**	**(13,801)**	**(7,374)**	**(9,090)**	**(8,460)**	**(13,705)**	**(10,216)**

Note the cash-flow assumes achievement of the forecast result.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Te Pītau Health Alliance Governance Group** 3
	For the attention of: **HBDHB and Health Hawke's Bay Ltd Boards**
Document Owner:	Bayden Barber, Chair
Author:	Ken Foote, HBDHB Company Secretary
Month:	February, 2019
Consideration:	For Information

RECOMMENDATION

That the Boards:

1. **Note** the contents of this report

The Health Alliance Governance Group met on Wednesday 13 February 2019.

Significant issues discussed and agreed included:

MENTAL HEALTH AND ADDICTIONS REDESIGN

An update report was received and noted. The report noted progress on:

- Finalising the design framework
- Engagement with local service providers
- A notice on GETS informing the market of our intentions
- A procurement timeline
- A communications plan and branding
- Internal conversations around methodology for stakeholder meetings

MAURI COMPASS

Following a presentations and discussion on the background to the use of the Mauri Compass and how it was being used by the Wairoa Community Partnership Group (CPG), the five recommended domains for the Te Pītau Compass (with some amendments to detail) were adopted for wider application across Hawke's Bay, i.e.

- Evidence of gap or need identified *(have we got a case?)*
- Whānau voice consistently strong throughout process *(do we have evidence of a strong community whānau voice?). Barriers/Māori non-engagement noted*.
- Health equity dimensions clearly understood and accounted for
- Funding and commissioning path options identified *(to enable realisation of initiative).*
- SMART plan to deliver proposed activity.

INFORMATION SERVICES STRATEGY UPDATE

The Governance Group were provided with a presentation which covered:

- Digital Health: strategy (including objectives and outcomes)
- Trends (old and new)
- Vision
- Capabilities - to digitally enable our health system, and consolidated data
- Enablement Road (work in progress).

It was generally agreed that to date, the focus has been primarily on the provision of IS support for hospital services. This needs to shift to primary care.

HEALTH CARE HOME PROJECT

Noting submission of a final paper to HHB PHO Board, members agreed that a presentation regarding the national patient-centred model Health Care Home should be received by the Te Pītau Governance Group in April 2019.

The Governance Group is particularly interested to look at the overall value of HCH to consumers and the system, and to assess the potential of this proposed work area using the Mauri Compass framework.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board**	5
	For the attention of: **HBDHB Board**	
Document Owner:	Heather Skipworth (Chair)	
Document Author:	Brenda Crene	
Month:	February 2019	
Consideration:	For Information	

RECOMMENDATION

That the HBDHB Board

Note the contents of this report.

The Māori Relationship Boad met on 13 February 2019. An overview of matters discussed is provided below:

HE NGĀKAU AOTEA

He Ngakau Aotea (HNA), the paper had been issued by Patrick prior to the meeting. It was noted by several members as having the potential to be the Vision.

It was realised the HNA had not yet been presented or discussed with the HBDHB Board.

Bernard advised that He Ngakau Aotea will be seen as one of the documents that informs the foundations to build upon. The challenge for the DHB is to balance the Maori side against the population we serve here in HB. This needs to be whole of community. It was noted that the Leadership Forum Agenda (for 6 March 2019) will include He Ngakau Aotea on the mornings agenda and Strategic Planning in the afternoon. Venue TToH, Orchard Road.

STRATEGIC PLANNING UPDATE POST CSP AND PRE-LEADERSHIP FORUM

Supported by Chris Ash Kate Rawstron; Bernard Te Paa (Executive Director Health Improvement & Equity) provided an overview of the process undertaken to develop the detail with the first draft to be provided to the HB Health Sector Leadership Forum on 6 March 2019

It was understood that the strategic planning overview shared with those present would be discussed and challenged. This was to prompt discussion and ensure we did not go out with a blank canvas.

LEPTOSPIROSIS SUPPORT

Ngaira Harker (Nurse Director) conveyed that a number of the Population Health team had been involved and that Leptospirosis remains an unacceptable burden on New Zealanders particularly those living in rural communities and on Māori. Research, across a diverse network of New Zealand stakeholders, highlights changes in leptospirosis epidemiology that suggest alternative and emerging pathways to infection are becoming important. In Hawke's Bay leptospirosis notification data from 2007 to 2017, young Māori males predominated and they were largely infected with vaccine preventable strains.

ACC have been challenging those with Leptospirosis who have sought support (as they cannot function and have lost jobs as a result). Having Lepto feels like having a bad flu 24/7/365 and can easily be mis-diagnosed by GPs. It is becoming increasingly difficult and very costly for those affected, to prove to ACC where the virus was picked up from (including work places like Freezing works).

With no financial implications for the HBDHB, MRB supported the following recommendations:

1. **Provide** support for current study within the rohe in relation to Leptospirosis
2. **Provide** guidance around long term engagement with Māori health and communities who are connecting with whānau to inform the importance and benefits of participating in the study;
3. **Identify** people and groups within the Māori community to support dissemination of information.
4. **Identify** speaker options for the Lepto Forum at Massey University in mid 2019

HBDHB DRAFT DISABILITY PLAN

Shari Tidswell and Diane Mara (from Consumer Council) supported the paper presented.

Shari Tidswell acknowledged Diane for keeping the work on the Disability Strategy on track. This has been a large piece of work which was driven at the outset by Consumer Council. Diane commended Shari for her consultation throughout the process and acknowledged the considerable amount of community and consumer input. This strategy aligns with the CSP and is all encompassing (from the young to old).

The Working Group included consumer representatives. The draft Plan was presented to the disability reference groups in Napier, Hastings, Central Hawke's Bay Wellbeing reference group and Wairoa IDEAL Services (based in Gisborne).

MRB were delighted with the work undertaken and congratulated those involved and were happy to support the recommendation.

HBDHB ALCOHOL HARM REDUCTION STRATEGY 2017-2022 (6 MONTHLY UPDATE)

In Rachel Eyre's absence, Rebecca Peterson was in attendance to speak to this paper and the work undertaken around the alcohol harm reduction strategy.

This was the first progress update and a number of successes had been achieved, including the fact that schools are writing their own alcohol free policies. The HBRC have been challenged to remove alcohol advertising and a number of relicensing applications within Hawke's Bay are being challenged. There has also been discussions at an intersector level to work together to implement local legislation and includes Joint Alcohol strategies. A future activity includes discussions with Maori wardens who do have influenced in specific areas during the course of their work. There have been whanau events, Rangatahi, mental emotional wellbeing for addictions.

Alcohol affects every area of health and it is a choice people make as to whether they drink alcohol or not. MRB noted the Treaty of Waitangi WAI 2575 Health Services Outcomes Kaupapa Inquiry claim is currently progressing through the Waitangi Tribunal.

MRB were pleased with progress and supported the recommendations put forward.

NGĀTAHI PROJECT PROGRESS REPORT END OF YEAR TWO – ANNUAL UPDATE

Russell Wills, Medical Director and Paediatrician, supported by Bernice Gabrielle, Programme Manager and Phycologist provided an extensive overview of progress today.

The report provided background and progress since year one (2017)

Very impressive progress with this valuable and transferable piece of work. Noted the assistance, in particular provided by Lauri Te Nahu and Kaumatua, Tiwana Aranui and others.

Tiwana Aranui advised that a values driven system is now being embedded into the DHB and into the Ngātahi program. We are striving for balance and quality of life, no matter where we live. Ngātahi project is one of many.

MRB were very pleased with the update and congratulated Russell and Bernice for their dedication.

BOWEL SCREENING

An MRB recommendation to the HBDHB Board to lower th**e** Bowel Screening age for Maori to 50 Years in HB resulted in the Board responding that they were not in a position to support the recommendation and requested management in conjunction with assistance from MoH bring together a paper for consideration. Chris Ash (ED Primary Care) brought MRB members, population health and primary care members together to openly discuss bowel screening on 23 January 2019

The MRB members who attended found the Seminar very informative and valuable. A report on the observations from the Seminar is contained in the Bowel Screening Report included within the February Board papers item 15.0 section 6.

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 6
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month:	February 2019
Consideration:	For Information

12

RECOMMENDATION

That the Board

Note the contents of this report.

Council met on Thursday 14 February 2019. An overview of matters discussed is provided below:

CHAIR'S REPORT

Significant issues noted in the Chair's verbal report to Council included:

- Acknowledged that the sterile services issue reported in the media was a disappointing situation that had been handled very well by the DHB
- Report on meeting with the CEO of the PHO to encourage a closer working relationship with Consumer Council
- Progress on getting greater Consumer Council involvement with the Health Awards

COMMITTEE REPRESENTATIVE FEEDBACK

Particular feedback was received from the Partnership Advisory Group expressing general concern about limited actions arising from ongoing engagement. General belief that if the DHB is going to keep asking for feedback, it needs to make sure it has the appetite and resources to follow through with improvements.

STRATEGIC PLANNING UPDATE

Council received and noted a progress update on the development of the Strategic Plan and Implementation plan. Members emphasised the importance of ensuring the plans identified specifically how things will look and feel different for consumers and that improved outcomes for consumers remains the goal. It was noted that many internal things will need to change, including structures, funding, KPIs and incentives.

ITS HARD TO ASK

Merry Jones, Clinical Nurse Specialist / Transplant Co-ordinator, provided a presentation about examining decision making among end stage renal disease patients considering asking friends and family for a kidney, noting how difficult many patients find it 'hard to ask'. Council supported the intent to address this issue, having noted the significant benefits to such patients having access to live donors.

DRAFT DISABILITY STRATEGY

Consumer Council were particularly pleased to receive this Draft Strategy, having initiated and supported its development over the past 12 months. A number of Council members (led by Diane Mara) have worked very closely with DHB sfaff to ensure this strategy met all the national obligations, linked directly to the CSP and People Plan and most particularly, met the needs of local people with disabilities. The Chair commended everyone involved in this process.

A number of valuable comments were noted during discussion:

- Need to decide 2-3 actions to prioritise
- Need the ability to measure and report. EMT and Clinical Council acknowledge there is IS work required. Data needs to be collected and used to drive improvements.
- Disability type should be captured on ECA, clinicians have recommended a coding report with four categories.
- Resource will be required for coding.
- Feedback – need to capture disability to be able to identify trends in regards to disability.
- Active feedback process suggested (not waiting for complaints)
- Better DHB linkages with community groups with a disability focus
- Mechanisms for reporting back to community groups

The Draft Disability Strategy was then endorsed by Council.

JOINT WORKSHOP DISCUSSION – "PERSON & WHANAU CENTRED CARE IN PRIMARY CARE"

Council briefly discussed the format and content of the combined workshop with Clinical Council to be held in March.

CONSUMER ENGAGEMENT

At Council's December meeting, members were asked "What will consumer engagement look like in the future". Due to time constraints, feedback was requested to the Consumer Experience Facilitators via email over the Christmas/ New Year period

The significant amount of feedback provided was reviewed and will now be summarised for further consideration and Council endorsement. It will then be submitted into the HBDHB planning processes.

INFORMATION PAPERS

Papers received and noted without any significant comment included:

- Ngatahi Annual Update
- HBDHB Alcohol Harm Reduction Strategy – Six Month Update

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 7
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair)
Month:	February 2019
Consideration:	For Information

13

RECOMMENDATION

That the HBDHB Board

1. **Note** the contents of this report.

HB Clinical Council met on 13 February 2019. A summary of matters discussed is provided below:

STRATEGIC PLANNING UPDATE

Council received and noted a progress update on the development of the Strategic Plan and Implementation plan. Areas were identified where specific clinical input will be required, all of which had been previously identified and included in Council's own Annual Plan.

It was noted again that Clinical and Consumer Councils will be holding a combined workshop in March, to further develop the concept of 'Person and Whānau Centred Care' in primary and community care. The workshop invitation will be expanded to include key Primary Care and Mental Health clinicians and leaders.

PEOPLE PLAN PROGRESS

A copy of the People Plan had been distributed and feedback invited.

Whilst acknowledging that it is a comprehensive, high level plan for the development of all staff in the sector, Council noted that it is equally important to note that HBDHB is a clinical training organisation, which has obligations to train and develop our clinical workforce: doctors, nurses, midwives and allied health professionals. HBDHB needs a clinical training hub to bring resources together, rather than the current fragmented approach across the disciplines. Council agreed that it needs to champion the training requirements of the clinical workforce

HBDHB DRAFT DISABILITY STRATEGY

Council received the report and presentation on the draft strategy, and sincerely congratulated the team involved in its development. During discussion, it was noted that:

- This has been a Consumer Council driven initiative
- There has been significant community and consumer involvement with local and national disability groups
- The Strategy has key links to the CSP and People Plan

- There is a clear need for a mechanism to alert all clinicians to any consumer's impairment/disability, to ensure needs can be met and an equitable outcome
- The Plan focusses on Hawkes Bay, but aligns with the national, Māori and Pacific disability guidelines.
- The actions in the strategy are practical and support the achievement of the HBDHB vision and work towards equity.

Council then formally endorsed the Draft Disability Plan and recommended Board approval.

NGATAHI ANNUAL UPDATE

An annual update at the end of year two of the 'Vulnerable Childrens Workforce Development' was received and the positive outcomes noted.

HBDHB ALCOHOL HARM REDUCTION STRATEGY – SIX MONTH UPDATE

General discussion on this report led to a very clear conclusion that alcohol is one of many factors causing 'social harm'. It was generally agreed that an integrated approach is preferred that could:

- Consolidate the current range of questionnaires and screening tools for 'social harm'
  - But still important to ask specific questions around violence, drugs, alcohol etc
- Enable a conversation with people on 'what is bothering them?'
- Pursue an integrated delivery of service, but also continue to focus on the individual
- Acknowledge that there are a wide range of underlying drivers, including access, poverty, housing etc that still need to be addressed
- Integrate social harms at governance level
  - If we are going to integrate the governance of programmes to reduce social harm, it needs to be explored in more detail to be clear what we are trading off to achieve integration.

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Project – Progress Report, End Of Year Two** 8 For the attention of: **HBDHB Board**
Document Owner	Kate Coley, Executive Director People and Quality
Document Author	Dr Russell Wills, Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor
Reviewed by	Bernice Gabriel, Project Manager; Executive Management Team; Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month/Year	January/ February 2019
Purpose	For information/ noting only
Previous Consideration Discussions	Previously discussed at EMT, MRB, Clinical and Consumer Councils and Board, who supported the project.
Summary	The Ngātahi Project has met nearly all milestones for year two and we are on track to deliver all remaining requirements by May. <u>How we will change practice</u> The three work streams (Mental Health and Addictions (MH&A), Trauma-Informed Practice (TIP) and Engaging Effectively with Maori (EEWM)), have agreed on the same approach to upskilling practitioners, namely: • Online learning for core knowledge, followed by • One-day wānanga to model and practice new skills, followed by • Wānanga Ita – peer coaching groups meeting regularly to embed the new skills into practice. <u>Mental Health and Addictions</u> • Partnered with Werry Whāraurau to develop online learning for MH&A and TIP. • Finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners. • Evaluation demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching. • Formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice <u>Trauma-informed practice (self-care)</u> • TIP (self-care) online module is written and will be reviewed by local leaders in January.

14

	• Russell and Bernice will write the one-day wānanga for leaders and for practitioners. <u>Engaging Effectively with Māori</u> • Agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content • Agreed to contract out writing/ co-constructing the one-day wānanga. One tender received, met contractor Thursday 17th January. Due diligence in progress at time of writing. <u>CAFS</u> • Continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services in 2018. • Agreed to not begin new training until current competencies are embedded. • Mechanisms are in place to ensure newly appointed staff obtain core skills through the Auckland University postgrad paper and in-house training. o Turnover has affected many vulnerable children's services in the past two years, of which CAFS is one. Most staff move within HB to other services, in particular to private practice and other community mental health teams (CAFS) and to Oranga Tamariki (NGOs), so their skills are not lost to the sector. This reinforces the value of skills that are transportable between services, which is a Ngātahi goal. <u>Evaluation</u> • EIT (Professors Kay Morris-Matthews and David Tipene-Leach) appointed as evaluators. First report received. The evaluators recommend the evaluation focuses on the immediate outcomes of the programme (staff wellbeing and practice change). We will not report on population-level outcomes as it will not be possible to demonstrate cause-and-effect relationship between the programme and outcomes, because population-level outcomes (referrals to Oranga Tamariki, substantiations, children in care, % receiving NCEA L2, etc) vary from year to year due to multiple, constantly changing, inter-related influences on outcomes and we do not have a comparison group. Report available on request. • First paper for publication accepted by *Policy Quarterly*, for publication February 2019. <u>Funding</u> • Project costs secured until completion end of 2019. <u>Objectives for 2019</u> • Write, deliver and evaluate 24 more one-day wānanga o Trauma-Informed Practice (self-care) ▪ 4 to leaders ▪ 7 to practitioners

	o Engaging Effectively with Maori – 8 o Mental Health and Addictions 4 more • Launch website and online registration system • Assess likely ongoing running costs for Ngātahi to become business as usual • Final report assessing impact of programme due early 2020. • Further papers, publications and presentations.
Contribution to Goals and Strategic Implications	Contributes to HBDHB Statement of Intent 2015-19 (p8, Fig 3): Working with Others; People better protected from harm; Health issues and risks detected early; Longer, healthier and independent lives; High quality, timely and accessible services; Sustainability. Contributes to NZ Health Strategy 2016 goals: Closer to Home; Value and High Performance; One Team; Smart System.
Impact on Reducing Inequities/Disparities	70% of vulnerable children are Māori so this project has been created with tamariki and whānau Māori at the fore: early and regular consultation with Māori providers and leaders, specific domain on Working Effectively with Māori (WEWM), co-constructed with Māori service leaders; cultural *and* clinical competency in teaching and learning; EEWM work stream to have oversight of other work streams.
Consumer Engagement	Early consultation with caregivers of children and young people in care and with care-experienced young people, facilitated by MVCOT. Strong support for the competencies and process, no additional competencies identified.
Other Consultation /Involvement	MRB, Māori providers, facilitated by HBDHB Māori Health Unit. Support for project, helpful advice regarding tikanga, added several additional competencies to the EEWM domain, EEWM work stream has oversight of other domains to ensure cultural competency.
Financial/Budget Impact	Y1 $250,000 Y2 $232,500 Y3 $212,500
Timing Issues	Wānanga: • TIP (self-care) will be written in time for first wānanga April 11th. • EEWM will be co-constructed by contractor, Ngāti Kahungunu iwi representatives and Ngātahi team. Due date dependent on negotiations. Final evaluation report due early 2020
Announcements/ Communications	Outcomes from evaluation will be shared: Internally — Project Sponsor Dr Wills Key Stakeholders — Meetings, conferences, papers Community — Through HBDHB communications team
RECOMMENDATION: That the HBDHB Board: 1. **Note** the progress of the Ngātahi Project in the second year.	

14

HAWKE'S BAY
District Health Board
Whakawāteatia

Ngātahi Project
Progress report - end of year two

Author:	**Dr Russell Wills**
Designation:	**Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor**
Date:	**26 January 2019**

SUMMARY
The Ngātahi Project is about Hawke’s Bay health, education and social services (the “vulnerable children’s workforce”) working together as one to deliver excellent care and interventions to vulnerable children and their families.

In the first year of the project (2017) we:
- partnered with iwi and kaupapa Māori providers, and established the tikanga for the programme
- engaged with, and mapped the skills and learning needs of 441 professionals from the vulnerable children’s workforce
- agreed the three priority training areas for 2018 and 2019
- established three work streams to develop, implement and monitor training and development programmes in these three priority areas to improve the confidence and competence of the vulnerable children’s workforce, and improve collaboration
- completed an independent research programme of interviews with a representative group of managers and practitioners, which provides assurance on the current direction, lessons learnt and important pointers for the following two years of the programme.

In the second year of the project (2018):
- The three work streams (Mental Health and Addictions (MH&A), Trauma-Informed Practice (TIP) and Engaging Effectively with Maori (EEWM)), have agreed on the same approach to upskilling practitioners, namely:
  - Online learning for core knowledge
  - One-day wānanga to model and practice new skills
  - Wānanga Ita/ Learning Circles – peer coaching groups meeting regularly to embed the new skills into practice.
- We finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners.
- We formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice.

- We partnered with Werry Whāraurau to develop online learning form MH&A and TIP.
    - MH&A reviewed by local leaders, is appropriate for use and completed by most practitioners who attended the M&A wānanga
    - TIP (self-care) module written and will be reviewed by local leaders in January
- The EEWM work stream agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content
- We agreed to contract out writing the EEWM wānanga, ran an EOI process and met a prospective provider. At the time of writing due diligence is underway before appointing the provider.
- Our evaluation of the three wānanga demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching.
- We have scheduled 24 wānanga across all three work streams for 2019
- We continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services this year
- EIT (Professors Kay Morris-Matthews and David Tipene-Leach) were appointed as evaluators for the second phase and their first report was received in January.
- Project costs secured for years 2-3
- Our first paper for publication accepted by *Policy Quarterly*, for publication February 2019.

Our Objectives for 2019 are:

- Complete and deliver a further 24 one-day wānanga
    - Trauma-Informed Practice (self-care) wānanga
        - 4 to leaders
        - 7 to practitioners
    - Engaging Effectively with Maori – 8
    - Mental Health and Addictions 4 more
- Form 48 more wānanga ita – we believe these will become the “engine room” for practice change
- Launch the Ngātahi website and online registration system
- Assess likely ongoing running costs for Ngātahi to become business as usual and formulate a business case to funders for that
- Final report assessing impact of programme is due early 2020.

We are a step nearer to our vision of better collaboration between disciplines and sectors, sharing of effective practices, development of a common language and improved workforce capacity.

This briefing paper describes the context and progress to date.

BACKGROUND

In 2015 an expert panel reviewed Child, Youth and Family. There were a number of reasons that the care and protection system failed vulnerable children and their families[1] and recommendations were made to address these issues. Children of parents with mental illness, addictions and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/ whānau and both the previous and current Governments accepted all of the Panel's recommendations.

A new programme was created to reform the way these families are supported, including:

- changes to legislation and accountabilities of Ministry Chief Executives
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children Oranga Tamariki
- implementation of multi-agency Children's Teams in ten sites
- additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families. See Appendix Two for a roadmap of these changes.

There are now many reports[2],[3],[4],[5] that recommend a focus on additional knowledge and skills ("competencies") for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved.

The Ministry of Social Development Children's Action Plan Directorate therefore began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. Hawkes Bay is piloting the Ngātahi Project, leveraging the draft Vulnerable Children's Core Competency Framework.

PURPOSE

The Ngātahi Project aims to assess the skills and development needs of health, education and social service professionals in Hawke's Bay who are working predominantly or exclusively with vulnerable children and families. Over a three year period Ngātahi and its partners will design, implement and evaluate a workforce development plan to support practitioners. By improving practitioners' competencies, including their ability to practice collaboratively and share information, in conjunction with the structural changes above, outcomes for vulnerable children and their families should improve.

PROGRESS in 2017 (year one)

Funding was obtained in 2016 from the Hawke's Bay District Health Board (HBDHB), Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Dr Bernice Gabriel, a senior psychologist at the HBDHB Child, Adolescent and Family Service (CAFS) was appointed as project manager in March 2017. Additional funding was secured from the Royston Health Trust in 2017. The funding is sufficient to see the project through to completion at the end of 2019, when, depending on the findings of the current evaluation, a business case will be prepared to take the project to a business-as-usual programme.

HBDHB CAFS

CAFS' staff completed their competency assessment against the Ngātahi framework and the Real Skills Plus CAMHS competency framework early in 2017[6]. Five training sessions have been completed to date:

- Assessment & Formulation
- Attachment & Trauma
- Emotional Regulation/Dialectical Behaviour Therapy*
- Acceptance & Commitment Therapy†
- Family Therapy supervision.

Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau and advise on subsequent activities to support CAFS' staff to integrate the new competencies into everyday practice.

Peer review groups continue to meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice.

At this point we have agreed to defer further training until we are confident that the new competencies are embedded into practice. CAFS is also working through how to provide the previous training to several new staff before progressing to further training.

Wider vulnerable children's workforce

In 2017 leaders from health, education and social services, kaupapa Māori, mainstream, Government and NGO services met and agreed the competencies each sector required of its staff. Four hundred and forty one staff from 27 agencies were surveyed and asked to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N).

Three priorities for development were agreed:

- Engaging effectively with Māori (EEWM)
- Mental health and addictions (MH&A)
- Trauma-informed care (TIP) – initially focusing on developing resilience skills in the workforce (see research findings below).

Professors Kay Morris-Matthews and David Tipene-Leach (Eastern Institute of Technology) are contracted to provide the evaluation. Key themes from staff interviews included:

- High levels of engagement of managers and staff:
- The value of clinical leadership
- High levels of practitioner stress: High levels of stress, burnout and fatigue were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

A detailed research report was completed in January 2018 and is available on request.

PROGRESS IN 2018 (year two)

Sector leaders joined or nominated staff to join one or more of the three work streams (EEWM, MH&S and TIP). Work streams were empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice and how each competency should be assessed. The EEWM work stream has supported the other two work streams to advise on the cultural competency aspects of the training.

* Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, DBT is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, and borderline personality.

† ACT is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.

We estimate 800 registrations (40 one-day wānanga) to meet the current demand for these three areas of competency. We delivered three pilot wānanga in 2018 and have scheduled 24 more for 2019. This is 50% of the target.

Mental Health and Addictions

- Partnered with Werry Whāraurau to develop online learning for MH&A and TIP.
- Finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners.
- Evaluation demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching.
- Formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice.

Trauma-informed practice (self-care)

- TIP (self-care) module written and will be reviewed by local leaders in January
- Russell and Bernice will write the one-day wānanga for leaders and for practitioners
- First wānanga scheduled for April.

Engaging Effectively with Māori

- Agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content
- Agreed to contract out writing/ co-constructing the one-day wānanga. One tender received, met contractor Thursday 17th January. Due diligence is underway.

CAFS

- Continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services this year
- Agreed to not begin new training until current competencies are embedded
- Working through how to ensure newly-appointed staff also receive the above core training.

Evaluation

- EIT (Professors Kay Morris-Matthews and David Tipene-Leach) appointed as evaluators. First report received.
- Project costs secured for years 2-3
- First paper for publication accepted by *Policy Quarterly*, for publication February 2019.

Objectives for 2019

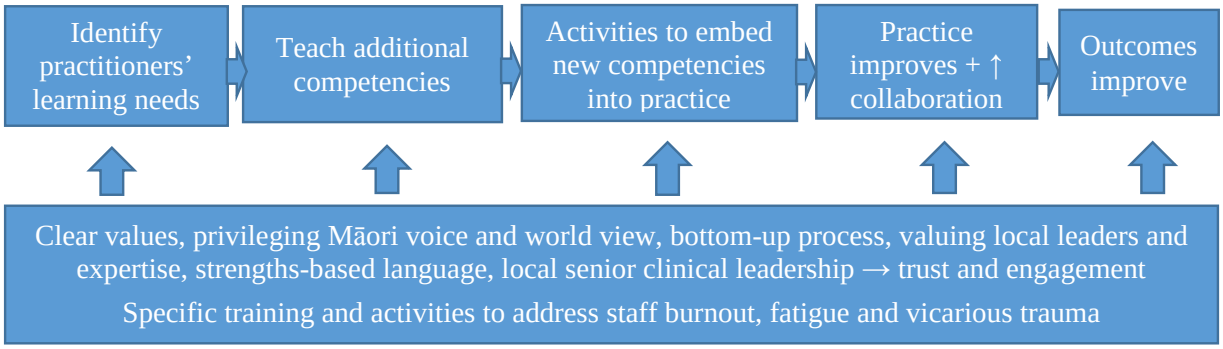
- Complete and deliver 24 more one-day wānanga
    - Trauma-Informed Practice (self-care) wānanga
        - 4 to leaders
        - 7 to practitioners
    - Engaging Effectively with Maori – 8
    - Mental Health and Addictions 4 more
- Launch website and online registration system
- Assess likely ongoing running costs for Ngātahi to become business as usual
- Final report assessing impact of programme due early 2020.
- Further papers, publications and presentations.

Why does this matter?

Hawke's Bay is the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership

with the Ministry for Children Oranga Tamariki and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MCOT, MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Our theory of change is essentially:



14

Measures and indicators

Outcome sought	**Demonstrated by**
Engagement	Research interviews year one with practitioners and managers
Practitioners' learning needs identified	Survey Monkey results Research interviews year one with practitioners and managers
Competencies taught	Number of attendees at training, number of trainings provided Evidence of programme delivery with fidelity Pre-post self-report of competence and confidence
New competencies embedded into practice	Description of activities and attendance at these Manager report of initial practice change with examples
Practice improved	Manager report of practice change with examples Practitioner self-report of competence and confidence New evidence-based programmes delivered, description, attendance Direct observation by evaluators
Collaboration improved	Manager report of improved collaboration with examples Practitioner self-report of improved collaboration with examples Direct observation by evaluators Reports from collaborative bodies (e.g., FVIARS, Strengthening Families, High and Complex Needs Interagency Management Group, Maternal Wellbeing Programme, Intensive Wraparound Service)
Reduced staff burnout, fatigue & vicarious trauma	Practitioner self-report HR indicators, e.g. recruitment, retention, turnover Direct observation by and feedback to evaluators
Improved outcomes for children and families	Client direct feedback within services Direct observation by and client feedback to evaluators

All outcomes to be assessed by independent researchers contracted to Ngātahi Programme.
All outcomes dis-aggregated by ethnicity.

ASSUMPTIONS

- Children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for children.
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whānau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies.

RISKS and MITIGATIONS

Risk	Mitigation
If agency leaders do not contribute their agency's time and skills to work streams this risks losing the mandate for that training.	At the hui on 6th November a clear message was given that it is important to engage or will not be able to influence the training. It was also made clear that all contributions are welcome
If work stream members do not agree on the content and implementation approach by the deadline this will impact negatively on the project timeline.	The work stream chairs will be supported to facilitate work stream well, value all contributions and look at best practice evidence. If no agreement in work stream this will be escalated to the governance group.
If non-Maori organisations and practitioners use kaupapa Maori approaches or methodology inappropriately, this could mean culturally inappropriate engagement with Maori whanau	Raise the issues with one, more or all of the following as required: HBDHB Maori Health and kaumatua; iwi mandated representatives on the work streams and steering group; kaupapa Maori evaluators. Co-construct workshops with tuakana from kaupapa Maori agencies.
If we do not manage, train and support the facilitator pool, the fidelity and continuity of the training programmes may be compromised	Facilitators to attend training programme prior to facilitating, new facilitators are paired with expert facilitators, project manager spends time with facilitators to discuss the training if needed, facilitators have handbook they can refer to, and facilitators debrief after each training. It is planned that facilitators will meet at least twice a year to discuss the training and any revisions.
If we do not implement processes around practitioner turnover in participating agencies, the competency mapping and training aspects of the project are not sustainable	Develop excel-based competency framework mapping for new staff to complete and managers to identify their learning needs, ensure new staff are given the opportunity to attend training programmes that are available to meet their learning needs.
If we do not implement processes around manager turnover in participating agencies, the continuity of the project is compromised.	Liaise with new managers to socialise them to the project as soon as possible.

BUDGET HBDHB Ngātahi Project Financials				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Senior clinical leadership	0.5 FTE	$55,000	$55,000	Clinical leadership is required to engage managers and staff in the learning programme, identify, recruit and brief the trainer, support managers and staff to arrange peer review groups, and support the evaluation.
Event management	0.5 FTE	$27,500 ($55k pro rata)	$27,500 ($55k pro rata)	Experience in the first year suggested that we needed event management capacity for the following: website design; online registration, tracking and reporting attendance and feedback; venue hire, IT, catering and certificates. The HBDHB EDC team is a multidisciplinary team with considerable experience in the above tasks.
External trainers		$50,000	$50,000	We would take a train-the-trainers approach with external trainers but a small budget will be required to bring in external trainers initially and for follow-up peer review.
Evaluation To be sought from HBDHB Transform and Sustain Fund		$80,000	$80,000	Ngātahi is a pilot project that, if successful, is likely to be taken up nationally. There is therefore a strong obligation to ensure the programme is evaluated independently and thoroughly, so clear documentation of lessons learnt and areas to improve are essential. Measures and indicators for 2018 and 2019 are noted above. The budget for 2017 was $80,000. We estimate that a credible evaluation could be expected for $80,000/year in 2018 and 2019.
Training costs		$20,000	$0	See table below re training costs
TOTAL COST		**$232,500**	**$212,500**	

Costs to participating services				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Training costs		$0	Contribution per agency to be determined	There will be costs for venue hire, IT, photocopying, catering and certificates. We will ask services, whenever possible, to donate venues for training and staff to bring their own lunch. Work streams will be asked, wherever possible, to identify local leaders to deliver training and support ongoing activities such as peer review. While this a cost to services (time spent training is time not spent in practice), reciprocity occurs because these services also gain from their staff attending training provided by others, and improving their practice.

RECOMMENDATION

That the HBDHB Board:

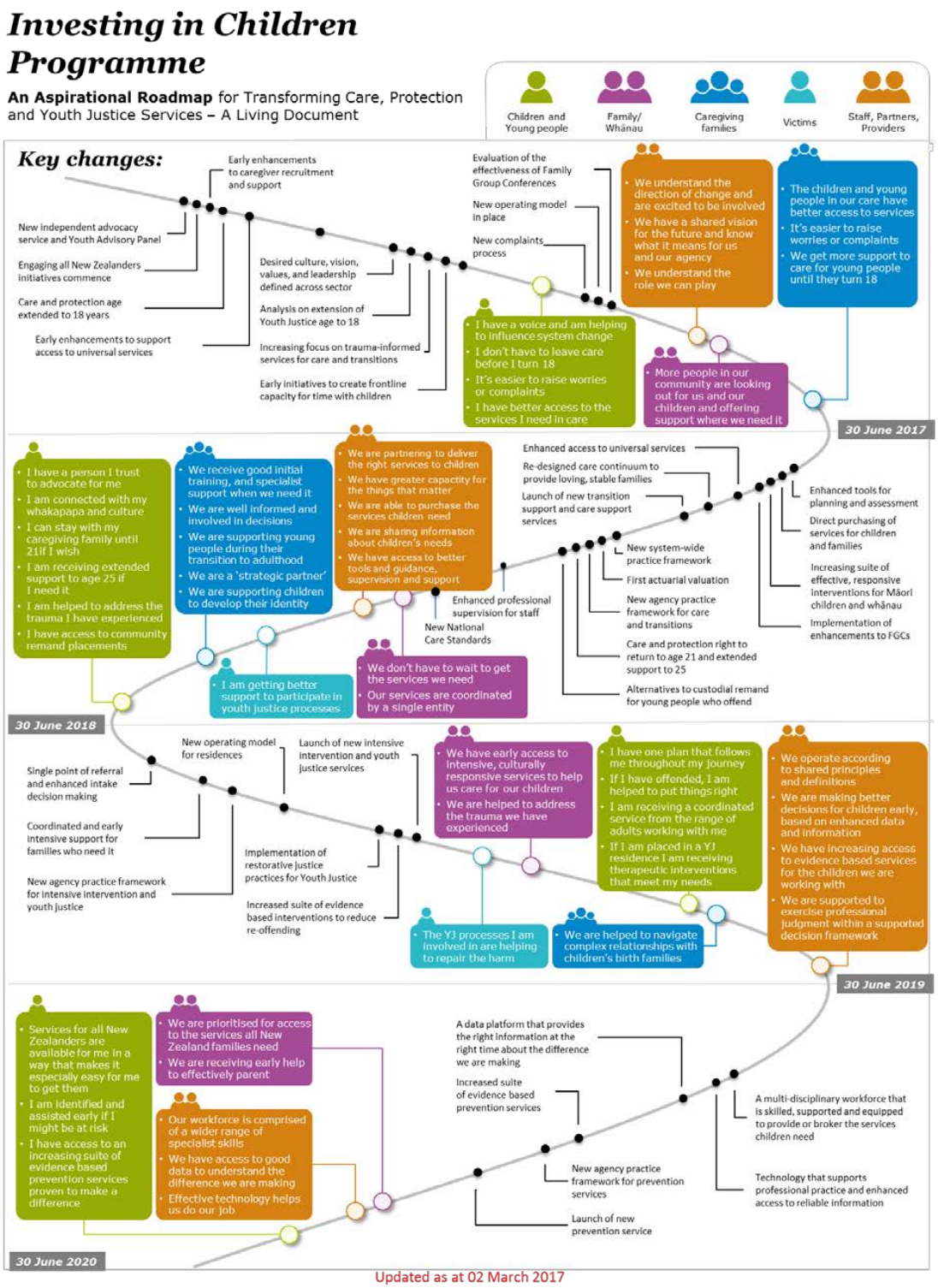
- **Note** the progress of the Ngātahi Project in the second year.

Appendix 1: Agencies/Services Participating in the Ngātahi Project

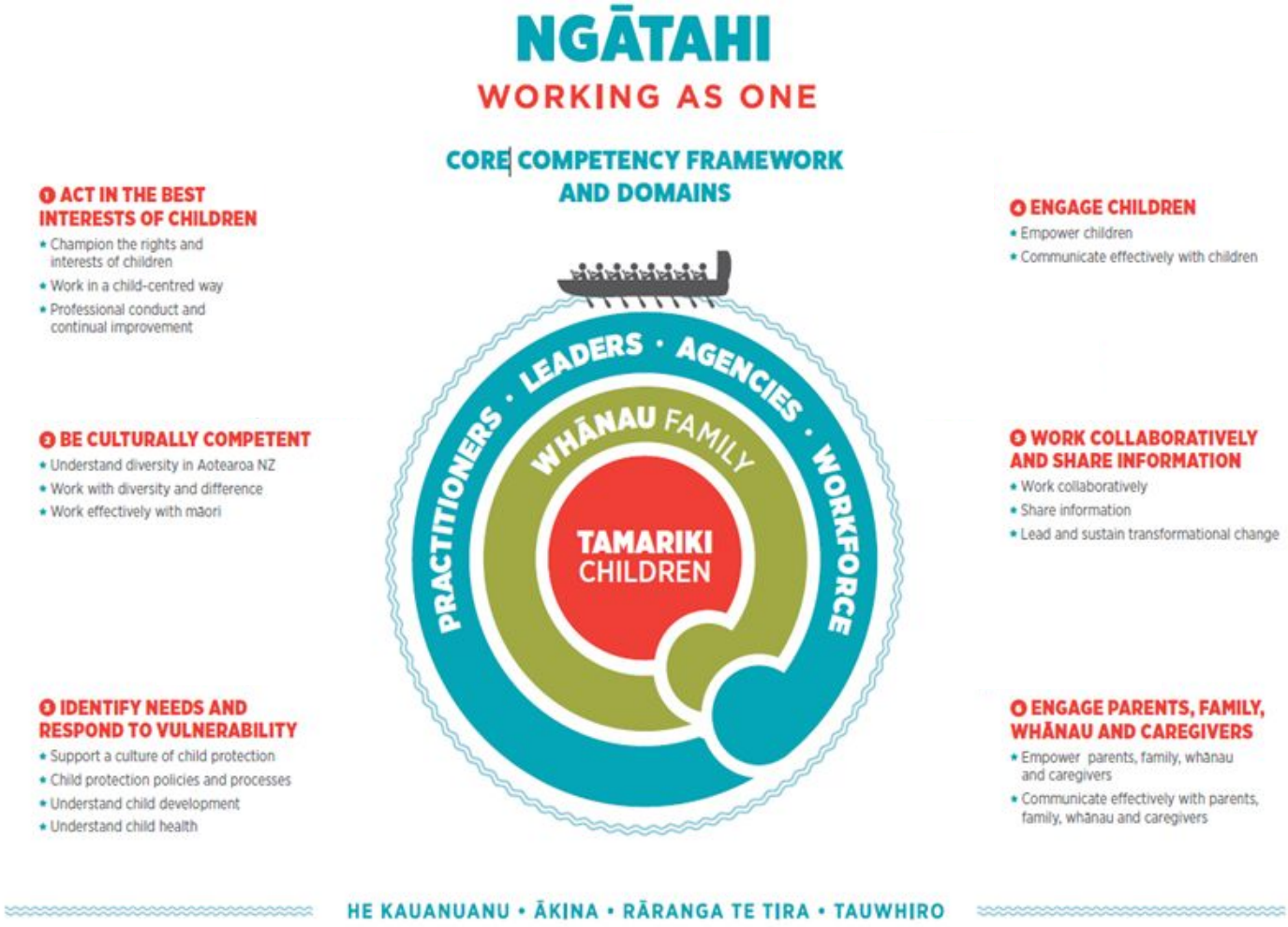
1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket
25 Wellstop
26 Explore
27 Women’s Refuge

Appendix 2: Investing in Children Aspirational Roadmap

http://www.msd.govt.nz/about-msd-and-our-work/



Appendix 3: Core Competency Framework Summary



[1] https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf
[2] Office of the Children’s Commissioner. Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru. Wellington, Office of the Children’s Commissioner, 2000
[3] Office of the Children’s Commissioner. Report of the Investigation Into the Deaths of Saliel Jalessa Aplin and Olympia Maria Aplin. Wellington, Office of the Children’s Commissioner, 2003
[4] Laming Lord. The Victoria Climbie Enquiry. London, HMSO, 2003. http://vcf-uk.org/wp-content/uploads/2010/07/laming-report.pdf
[5] Smith Mel. Report to the Hon. Paula Bennett Minister for Social Development and Employment. Following an Enquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to Welfare, Safety and Protection of Children in New Zealand. Wellington, Ministry of Social Development, 2011.
http://www.beehive.govt.nz/sites/all/files/Smith_report.pdf
[6] http://www.werryworkforce.org/real-skills-plus-camhs

HAWKE'S BAY District Health Board Whakawāteatia	**Management Recommendation: Reducing the Screening Age for Bowel Screening to 50 for Māori** 9 For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Document Author(s):	Chris Ash, ED Primary Care
Reviewed by:	Chris Ash, ED Primary Care Bernard Te Paa, ED Health Improvement & Equity Dr Bridget Wilson, Public Health Registrar
Month:	February 2019
Purpose	Decision
Previous Consideration Discussions	**Māori Relationship Board (Seminar)** A seminar for members of the MRB was held on 23 January 2019. Considerations from those discussions are set out within the report. **Executive Management Team** EMT considered and endorsed the management recommendation. Increased participation was acknowledged as the most amenable factor to drive equity.
Summary	• The National Bowel Screening Programme (NBSP) launched in Hawke's Bay in October 2018, aiming to reduce the impact of bowel cancer. The NBSP is for men and women aged 60-74 years. • The NBSP 'has the potential to increase inequities'. • On the recommendation of MRB, HBDHB Board has asked management to return with a recommendation as to whether extending the screening age for Māori to people aged 50-74 years would be an appropriate step to address the potentially adverse equity impact. • Management recommendations have been formulated on the basis of available clinical evidence and guidance (specifically around the balance of harms vs benefits), financial and operational feasibility, and relative value for money (as opposed to other equity positive interventions). These expert opinions were shared and explored during an MRB seminar in January 2019. • On the balance of these considerations, the management recommendation is that HBDHB should not consider extending bowel screening for Māori to people aged 50-74 years.

15

Contribution to Goals and Strategic Implications	• Transforming our engagement with Māori • Transforming health promotion and health literacy • Transforming patient experience through better clinical pathways • Transforming primary health care
Impact on Reducing Inequities/Disparities	The report sets out a number of considerations directly related to equity. It concludes that the inequity offsetting impact of an extension to the screening age would be minimal, and most likely outweighed by the harms associated with screening an asymptomatic population with lower disease prevalence. The report also reflects the DHB's need to account to its local population around implementation of a national programme that is acknowledged to have a negative impact on equity. The evidence shows the leading causes of avoidable mortality for our Māori populations significantly outweigh the impact of bowel cancer, and present more cost effective opportunities to make a bigger impact for a wider cohort.
Consumer Engagement	• No direct consumer engagement has been undertaken on this recommendation • Maximising the screening participation rate for Māori remains the most effective method of ensuring equity. HBDHB Population Health teams continue to promote awareness through regular stands at community events • The MRB Seminar focused on both evidence and the voice of the consumer in its considerations
Other Consultation /Involvement	• The Ministry of Health supports a position of not extending bowel screening until the initial rollout has been completed in 2021.
Financial/Budget Impact	The estimated cost of extending screening as described would be $320k. The cost of surgeries linked to confirmed cases of bowel cancer was removed from this calculation.
Timing Issues	• Any funding requirements associated with Board consideration of the management recommendation would need to be incorporated as a budget bid for 2019/20 • An operational lead time will be associated with any proposal to change demand and capacity for bowel screening within Hawke's Bay
Announcements/ Communications	The Bowel Screening Project Manager will advise Ministry of Health of HBDHB's decision in respect of this paper

RECOMMENDATION

It is recommended that the Board:

1. **Ratify** the management recommendation, that HBDHB should <u>not</u> consider extending bowel screening for Māori to people aged 50-74 years at this juncture, for the following reasons set out in clauses 6.1 - 6.5 and that:

- The DHB's internal public health advice is that insufficient evidence currently exists to definitively conclude that the benefits of extending the screening age would outweigh the harms (section 3)
- The extension of bowel screening is operationally unfeasible, with extended waiting time pressures generating risks to quality of care (section 4)
- Population health information indicates that the inequity offsetting effect of an extension to the age for bowel screening would not represent value for money, when compared against interventions for the leading causes of premature mortality amongst Māori (section 5)

2. **Consider** the observations agreed at the Māori Relationship Board Seminar (6.1 - 6.5) and clarify what further assurance is required from management on these issues.

HAWKE'S BAY
District Health Board
Whakawāteatia

Management Recommendation:

Reducing the Screening Age for Bowel Screening to 50 for Māori

Author:	**Chris Ash**
Designation:	**Executive Director, Primary Care**
Date:	**February 2019**

1 BACKGROUND

The National Bowel Screening Programme (NBSP) was implemented in Hawke's Bay in October 2018, with an aim to reduce the impact of bowel cancer, and covering men and women aged 60-74 years.

Bowel cancer prevalence is lower for Māori than for non-Māori, although rates are increasing for Māori. However, survival rates are lower for Māori than for non-Māori.

The NBSP 'has the potential to increase inequities', mainly on account of:

- Lower bowel cancer prevalence in Māori
- Māori having lower rates of new cases of bowel cancer registrations per year
- Screening programs being less successful in engaging with Māori
- Māori having a lower life expectancy than non-Māori

A screening participation rate of 73% for Māori would offset the increase in inequity, assuming that the non-Māori participation remains at 58%.

National 'consideration of the potential equity impacts for Māori of the age range for screening' was published in July 2018. This concluded that, 'given the balance of available evidence on harms and benefits [they] did not recommend lowering the age range for Māori currently'. The Ministry of Health has accepted this recommendation and will not at this stage support an extension to the NBSP. They will, however, review the issue once again in 2021, once the NBSP has been fully rolled out.

In December 2018, the Māori Relationship Board made a recommendation to HBDHB Board that consideration should be given to extending bowel screening for Māori to people aged 50-74 years. HBDHB Board requested a management recommendation.

2 IN NUMBERS: SCREENING THE MAORI POPULATION AGED 50-59 YEARS

The Māori population aged 50-59 is estimated to be around 4,260 people.

Assuming 60% take-up, this would result in an additional 2,556 non-invasive Faecal Immunochemical Tests (FITs).

From this group, it is estimates that 90 people (3.5%) would receive a colonoscopy.

This would be expected to detect between 2 and 3 additional bowel cancer cases each year.

3 CLINICAL CONSIDERATIONS

Screening programs are designed to detect potential presence of disease amongst populations without symptoms. The vast majority of people participating in a screening programme will be healthy. This requires active consideration of the harms entailed with the process of screening, set against the potential benefits arising from the detection of disease.

Because bowel screening FIT tests identify the presence of microscopic quantities of blood within faecal matter, the screening process is not 100% accurate. This will mean that some people will screen 'false negative', providing them with false assurance that they are disease free.

Colonoscopy is a safe but highly invasive procedure. While overall risk is low, procedures may result in a degree of bleeding for a small number of patients, and for a very small number of patients may entail more serious complications.

Very importantly, many people who screen positive will 'assume the worst' and believe that they therefore have bowel cancer. In reality, the overwhelming majority will not. The impact of the stress and anxiety that will be caused by a positive screen makes the process of timely colonoscopy, focused on the populations most likely to benefit, a priority.

Public health advice supports the view set out in the Ministry of Health report, which is that - at this stage - there is insufficient evidence to definitively conclude that the benefits of extending the screening age would outweigh the harms.

4 FINANCIAL AND LOGISTICAL CONSIDERATIONS

An extension of bowel screening for Māori to people aged 50-74 years would not, at this juncture, be included within the NBSP. HBDHB would therefore be liable for the total cost of the screening programme.

The total cost of the screening extension is estimated to be $320,000, comprised as follows:

	Unit Cost	Volume	Cost
FIT Test	$60	2,556	$153,360
Colonoscopies	$1,850	90	$166,500
			$319,860

Within this costing, outpatient and surgical procedures have been excluded.

An extension to bowel screening in Hawke's Bay would place significant pressure on colonoscopy capacity. With Ruakopito now open, HBDHB is not as pressured as many DHBs in terms of physical capacity to undertake colonoscopies, however the workforce required to do this is difficult to recruit. This includes doctors (gastroenterologists and anaesthetists), nurses, sterile services staff and anaesthetic technicians.

An additional 90 procedures per annum would equate to around 4% additional total colonoscopy demand, but 22.5% additional bowel screening colonoscopy demand. This would most likely build a waiting list backlog. Colonoscopy waiting times are a key performance indicator within the NBSP contract, and breach of these could result in the DHB being financially penalised for failing to meet the terms, or indeed having its contract suspended.

5 VALUE FOR MONEY CONSIDERATIONS

The Hawke's Bay DHB Health Equity Report 2018 shows that the leading causes of premature death for Māori are coronary heart disease, lung cancer and suicide. Further, several conditions linked to the cardiovascular health (such as diabetes and stroke) feature within the list.

In committing expenditure to reduce the health equity gap between Māori and non- Māori, consideration must be given to the relative cost effectiveness of interventions.

6 MĀORI RELATIONSHIP BOARD SEMINAR

These conclusions were presented to members of the Māori Relationship Board at a seminar on 23rd January 2019. Those present at the seminar made the following observations:

6.1 The public health opinion, that there is currently insufficient evidence to definitively conclude that the benefits of extending the screening age would outweigh the harms, was understood and accepted.

6.2 While less prevalent, bowel cancer is an issue that affects Maori. The DHB's response therefore has to clearly demonstrate that the issue of achieving equity has been prioritised.

6.3 More work is required to give confidence that differential screening rates between Maori and non-Maori will be effectively addressed in Hawke's Bay. This must include a stronger focus on cultural issues around the FIT test process, more proactive public information and awareness campaigns, and learning from early successes in the local Pasifika approach.

6.4 Evidence around lower survival rates for Maori diagnosed with bowel cancer are not acceptable, and will at least in part be driven by institutional racism within health services.

6.5 The result of the implementation of the National Bowel Screening Programme will be to widen the health equity gap between Maori and non-Maori, and the financial cost to offset this through extended screening would be at least $320k per annum. Management should work in liaison with the MRB to develop alternative approaches to address the leading causes of inequity in premature mortality.

RECOMMENDATION

It is recommended that the Board:

1. **Ratify** the management recommendation, that HBDHB should not consider extending bowel screening for Māori to people aged 50-74 years at this juncture, for the following reasons set out in clauses 6.1 - 6.5 and that:
   - The DHB's internal public health advice is that insufficient evidence currently exists to definitively conclude that the benefits of extending the screening age would outweigh the harms (section 3)
   - The extension of bowel screening is operationally unfeasible, with extended waiting time pressures generating risks to quality of care (section 4)
   - Population health information indicates that the inequity offsetting effect of an extension to the age for bowel screening would not represent value for money, when compared against interventions for the leading causes of premature mortality amongst Māori (section 5)
2. **Consider** the observations agreed at the Māori Relationship Board Seminar (6.1 - 6.5) and clarify what further assurance is required from management on these issues.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Draft Disability Plan** 10 For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director Primary Care Bernard Te Paa, Executive Director, Health Improvement & Equity
Document Author(s)	Shari Tidswell
Reviewed by	Executive Management Team; Working Group members; Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month/Year	February 2019
Purpose	Presenting the co-designed Disability Plan to HBDHB governance groups.
Previous Consideration Discussions	Responds to a paper presented by Consumer Council requesting a disability response for the Hawke's Bay DHB
Summary	The HBDHB Draft Disability Plan supports the HBDHB to implement the National Strategy. All government agencies are required to do this. It also supports the achievement of the HBDHB vision and work toward equity. People with disabilities experience barriers when accessing health services in a range of ways. Having a systematic approach to addressing and reducing these barriers is vital to achieving equity and improving health outcomes. The Plan provides a systematic approach through the delivery of actions. This Plan's actions are delivered via a key piece of HBDHB developing and existing work. This includes the; Clinical Services Plan, Person and Whānau Centered Care and the People Strategy. For this reason the Plan is aligned and integrated with the National Strategy and other plans, and HBDHB strategies and plans.
Contribution to Goals and Strategic Implications	Improving health and equity for all populations National Disability Strategy
Impact on Reducing Inequities/Disparities	People with disabilities experience considerable inequity. Disabled Pasifika people have low utilisation rates of disability services and Māori (Tangata Whaikahu) also experience a double set of barriers to accessing services. There is a need to ensure we are monitoring equity for people with a disability. This Plan will guide our investment to ensure equitable outcomes for people with disabilities.
Consumer Engagement	The Working Group included consumer representatives. The draft Plan was presented to the disability reference groups in Napier, Hastings, Central Hawke's Bay Wellbeing reference group and Wairoa IDEAL Services (based in Gisborne).

16

Other Consultation /Involvement	Representatives from Clinical and Consumer Councils have been involved in the Working Group. The Working Group also sought input from Taranaki Disability Resource Centre.
Financial/Budget Impact	Potential cost for training and establishing a monitoring system. This should be business as usual work and will reduce cost associated with consumer complaints and late access to services.
Timing Issues	None
Announcements/ Communications	The Plan will be made available on the HBDHB website and shared with stakeholders.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the contents of the Plan and Paper.
2. **Endorse** the Key Recommendations.

Hawke's Bay District Health Board
Draft Disability Plan

Author(s):	Shari Tidswell
Designations:	Intersector Development Manager
Date:	February 2019

BACKGROUND

To deliver effective services and achieve our Vision it is vital to ensure people with disabilities and their whānau are able to access and engage with services and do not experience inequities in health outcomes. The HBDHB is a lead provider and contractor of disability services in Hawke's Bay and has a vision of "Excellent health services working in partnership to improve the health and wellbeing of our people and the reduction of health inequities within our community".

Consumer Council championed the development of a Disability Plan in 2018. They identified a need:

- To have people with disabilities taken into account in our health system
- To have a Person and Whānau-Centred Care approach inclusive of people with disabilities
- For integration in the Clinical Services Plan implementation
- To be integral in achieving equity in health outcomes

For these reasons, this Plan does not sit in isolation and is linked to the National Disability Strategy, is aligned to key HBDHB Strategies and Plans (People and Capability Strategy and Clinical Services Plan) and is informed by Whaia Te Mārama and Faiva Ora Disability Plans.

The Plan's actions will support HBDHB in delivering effective services and our vision for people with disabilities and their whānau. According to census data, 23% of the population have a disability with the highest rates in older populations – making people with disabilities a significant population engaging with health services. National data identifies that people with a disability experience significant unmet need, much of which is the result of access and attitude issues experienced in health services. People with disabilities also experience inequity in education, employment and justice outcomes.

Like other marginalised populations, people with disabilities and their whānau benefit from increased awareness of issues and a focused response to achieving equity. A plan increases awareness and provides the actions to be responsive and ultimately reduce inequity.

Plan Development Process

The following process was followed to develop this Plan:

- A paper was presented by Consumer Council requesting the development of a Disability Plan, endorsed by HBDHB Board
- A Working Group established with the first workshop held in March 2018
- A series of workshops and meetings to design and draft a plan held between April–November 2018
- A draft Plan was presented to community stakeholders (including people with disabilities) and feedback from HBDHB managers November–December 2018
- Response to feedback and re-drafting of the Plan – December 2018
- A Final Draft Plan was written and reviewed by the Working Group - January 2019

Co-design

The Working Group included people with disabilities, whānau of people with disabilities, local Council leads for disability plans and HBDHB staff (Planning and Commissioning Manager – Integration, NASC Manager, Consumer Experience Facilitators and Intersector Relationship Manager). This group processed the responses,, information and feedback to draft the Plan's content.

Disability consumer groups were engaged across the region via the Central Hawke's Bay Disability Reference Group, Hastings Disability Reference Group, Napier Disability Advisory Group and Ideal Services – Wairoa to provide feedback on the drafts of the Plan. Through feedback processes and representation, consumers and key stakeholders developed the Plan.

Plan Structure and Content (see Appendix One for the full Plan)
This Plan covers services and the work of HBDHB. The Working Group discussed a regional disability plan approach, however each local authority has its own plan and the Working Group determined that developing a HBDHB plan would place us in a better position to develop a regional plan in the future. The Working Group chose to use the definition for 'disability' provided by the Office for Disability Issues, as it informs the National Strategy and provides consistency with other disability plans. Whānau and caregivers have been included in the Plan due to the critical role they undertake in supporting people with a disability. This also aligns with the Person and Whānau Centered Model of Care.

Disability is defined as "something that happens when people with impairments face barriers in society; it is society that disables us not our impairments…" The Plan's vision was developed by the Working Group and aligns to the HBDHB's visions and the National Strategy's vision.

"People with a disability and their whānau engaging with HBDHB, experience no barriers, are involved in the decision making, and engaged in services design and development." The Plan's principles link to HBDHB Values and include:

People with disabilities in Hawke's Bay:
- Experience respectful, mana enhancing engagement with HBDHB services
- Have a clear voice for people with disabilities in planning, service development and the care they receive. "No decision about me without me"
- Clear process for feedback and responding to feedback

HBDHB has a commitment to:
- Addressing barriers; to be inclusive and responsive to people with disabilities, including Tanagata Whaikaha and disabled Pasifika people
- Changing attitudes by being consistently inclusive and responsive to people with disabilities and their whānau, including Tangata Whaikaha and disabled Pasifika people

The Plan's coverage includes; services and work of the HBDHB, people with disabilities and their whānau engaging with HBDHB services and whānau and caregivers supporting people with a disability.
The Plan describes key outcomes directly linked to the National Strategy and detailed actions. These actions support the delivery of the outcomes and includes monitoring steps. To commence monitoring, the HBDHB will be required to record 'impairment' in consumer/patient records. It is currently not possible to identify how many of our patients have a disability, nor do we systematically identify their needs to support effective access to HBDHB services.

Linkages to Other Strategies and Plan *(see diagram on page 3 of the Plan)*
As outlined above, this Plan is developed to align, deliver and link with a range of national and local documents that relate to supporting people with disabilities to access health services and achieve equity.

Monitoring and ongoing delivery
Critical to this Plan's effectiveness in achieving equity is monitoring engagement of people with disabilities. This will require recording impairment on a patient's record and where applicable, notes to support access. This can then be used to measure access, refine training and support HBDHB staff to ensure needs can be met and to measure equity in health outcomes.

Priority Actions for 2019/2020 Annual Plan
To commence the implementation, the Working Group have identified 10 actions from the Plan (noted below) to be delivered over the 2019/20 financial year. The remaining actions will be roll-out over the following five years. Reference the "Outcomes and Actions" section of the Plan.

Education and Employment and Economic Security – implemented under Matariki actions

Health and Wellbeing
1) Establish practice that ensures the rights of people with disabilities to have whānau/support people when engaging with HBDHB services.

Accessibility
1) Service design and improvement will include people with disability and their whānau.
2) Services will have feedback mechanisms that enable people with disabilities to provide feedback and this is responded to.
4) Ensure barriers that could result in people with disabilities not being able to engage, participate or utilise HBDHB services are removed or addressed.

Attitudes
1) HBDHB Core Values are evident in all interactions with people with disabilities and their whānau.
3) Develop a training programme in partnership with the disability community and HBDHB.

Choice and Control
2) Connect with a wide range of disability communities.

Leadership
1) Include actions in annual planning
2) Implement actions from this Plan
3) Report to disability communities and their whānau on the Plan's progress, health outcomes and engagement.

RECOMMENDATIONS

Key Recommendations	Description	Responsible	Timeframe
Appoint a lead from EMT	An EMT lead is identified who is able to champion the Plan's actions, provide reporting on implementation and equity	EMT	April 2019
Priority actions included in the 2019/20 annual planning	Key actions are incorporated into HBDHB Annual Plan at the HBDHB level and service level	HBDHB Planner	May 2019
Establish formal links with consumer representative groups	Ensure HBDHB membership on existing disability groups and develop a feedback loop	Consumer Experience Facilities	March 2019
Establish a reporting framework	Framework to measure plan delivery and impact for people with disabilities	HIED	June 2019
HBDHB Disability Plan endorsed by HBDHB governance groups	Plan endorsed by all HBDHB governance groups	HIED	March 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the contents of the Plan and Paper.
2. **Endorse** the key recommendations.

HAWKE'S BAY DISTRICT HEALTH BOARD – DRAFT DISABILITY PLAN

BACKGROUND

Consumer Council have championed this Disability Plan and the development was endorsed by the HBDHB Board in 2018. The HBDHB are a lead provider and funder of disability services and deliver health services for the whole population – including those with a disability. Supporting equitable outcomes for people with disabilities will contribute to the HBDHB's overall vision "Excellent health services working in partnership to improve the health and wellbeing of our people and the reduce health inequities within our community".

The development process was led by a working group made up of HBDHB Consumer Council representatives, HBDHB staff, local authority staff and community stakeholders to develop a disability plan for Hawkes' Bay DHB consumers, staff and services. To gain further input from the community, particularly people with disabilities and their whānau, a draft document was presented to community groups, HBDHB service managers and consumers to seek further input and feedback. This feedback has been incorporated into this Plan.

This Plan sits within the context of a national strategy and plans, local plans delivered by local authorities and HBDHB strategic documents. The Plan ensures actions are complementary, aligned or deliver the visions and outcomes of these documents. There is a focus on equity including by ethnicity and people with a disability - it is noted that people can experience inequity via both. To inform this plan, the working group used:

- National Disability Strategy
- HBDHB Core Values
- Draft Clinical Services Plan
- Whaia Te Mārama and Faiva Ora disability plans

The Plan aims to reduce the barriers experienced by people with disabilities when engaging with HBDHB services and staff. The Plan will focus the HBDHB on meeting the needs of people with disabilities by providing tangible actions and measures to monitor progress. The Plan uses principles informed by the HBDHB values, outcomes from the National Strategy and actions to enable the HBDHB to respond to the needs, reduce barriers for and engage effectively with people with a disability. The actions are also informed by the Clinical Services Plan, Health Equity Report (2018) Whaia Te Mārama and Faiva Ora Disability Plan – ensuring an equity approach and alignment with HBDHB's service delivery direction.

INTRODUCTION

The Plan is set out as follows:

- Background information including definitions, population and supporting documents
- Vision, principles and coverage. The principles align with the HBDHB Core Values and other key documents which will support equity. This provides a clear process to integrate the actions into HBDHB practice.
- Outcomes to deliver each action.

As a key service provider and employer in the Hawke's Bay, HBDHB supports social inclusion, equity in health outcomes, access to services and wellbeing of the Hawke's Bay community. HBDHB has a role in reducing the barriers and attitudes that contribute to those with an impairment being disabled. Having a planned systematic approach is vital in delivering these aspirations. To know what we are doing is making a difference for people with disabilities, we need to measure health outcomes for people with disabilities and monitor feedback.

We acknowledge the role whānau and caregivers have in supporting the wellbeing of people with disabilities and the Plan seeks to ensure their engagement by reducing barriers they may encounter, whilst maintaining the person with a disabilities right to privacy and safety.

BACKGROUND INFORMATION

Defining Disability

The National Strategy defines "disability" as "something that happens when people with impairments faces barriers in society; it is society that disables us not our impairments…" This has a similar meaning to "disability" as the International Convention – "…those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others…" (Article one)

Disability is defined by the Office for Disability Issues as:

> *"Disability is the outcome of the interaction between a person with impairment and the environment and attitudinal barrier he/she may face. Individuals have impairment; they may be physical, sensory, neurological, psychiatric, intellectual or other impairments." (Minister for Disability Issues, 2001).*

These definitions are consistent and are applied to this Plan. People with physical, mental, intellectual and sensory impairments make up the population target of the Plan. Their whānau and caregivers supporting them to achieve "normal lives" and their potential are also covered in the actions.

Population with Disabilities

Nationally 24 percent of the population identify as having a disability, a total of 1.1 million people (2013 data).

- The increase from the 2001 rate (20 percent) is partly explained by our ageing population.
- People aged 65 or over were much more likely to be disabled (59 percent) than adults under 65 years (21 percent) or children under 15 years (11 percent).
- Māori and Pacific people have higher-than-average disability rates, after adjusting for differences in ethnic population age profiles.
- For adults, physical limitations were the most common type of impairment. Eighteen percent of people aged 15 or over, 64 percent of disabled adults, were physically impaired.
- For children, learning difficulties were the most common impairment type. Six percent of all children, 52 percent of disabled children had difficulty learning.
- Just over half of all disabled people (53 percent) had more than one type of impairment.
- The most common cause of disability for adults was disease or illness (42 percent). For children, the most common cause was a condition that existed at birth (49 percent).[1]

Hawke's Bay data

Data was collated for Gisborne/ Hawke's Bay – people identifying with a disability is 23 percent of the population. The 23 percent breaksdown into the following types of impairment. The highest is mobility (13 percent), followed by hearing (9 percent), agility (7 percent) and psychological and learning (6 and 5 percent respectively).

[1] 2013 Disability Survey, June 2014, produced by the Government Statistician

Fifty-eight percent of people with a disability have multiple impairments. Disease and illness (42 percent) and then accidents (37 percent) are the highest causes. Using the 23 percent, the estimate for people with a disability in Hawke's Bay would mean approximately 34,770 people with disabilities (based on 151,179 total Hawke's Bay population 2013).

DOCUMENTS THAT INFORM THIS PLAN

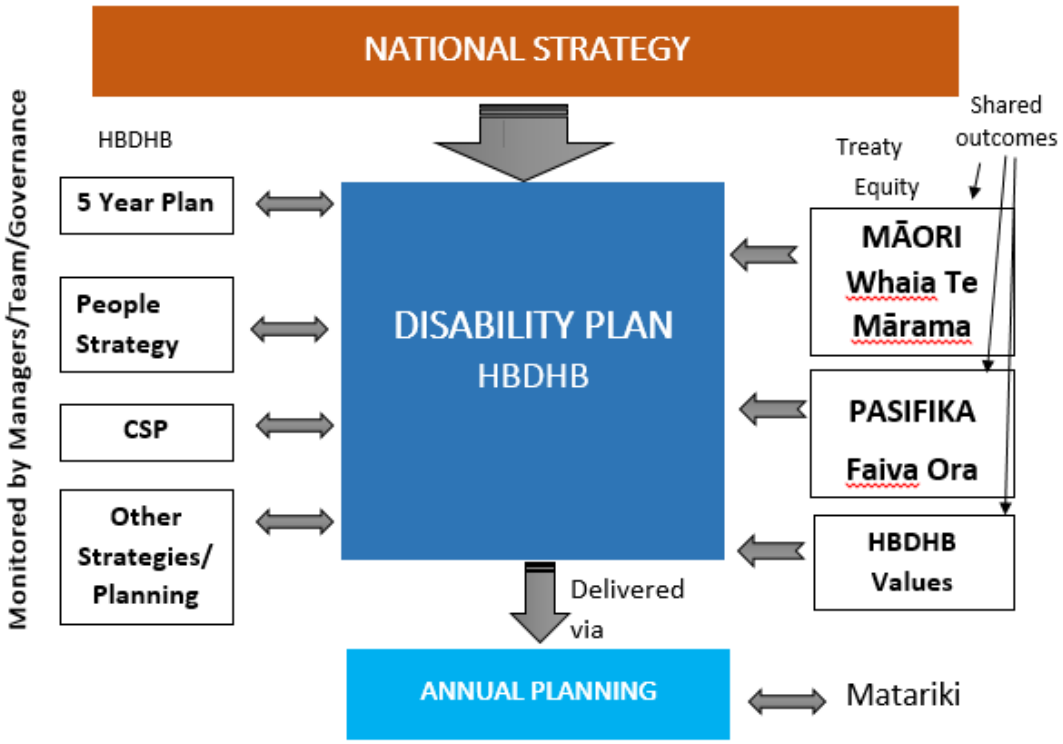
The Clinical Services Plan (CSP)[i] themes, Core Values and National Strategy are based on similar principles -Te Tiriti o Waitangi, ensuring whānau are involved in decision making, social investment and addressing unmet need. The Health Equity report illustrates the inherent differences in health outcomes for specific groups within our Hawkes Bay population.

This Plan uses the outcomes from National Strategy[ii]:

- Education
- Employment and economic security
- Health and wellbeing
- Right protection and justice
- Accessibility
- Attitudes
- Choice and control
- Leadership

Each of these actions have been developed to deliver an outcome. These actions have clear links to the CSP and HBDHB core values[iii]. In the table below the Actions are colour-coded to note the 'HBDHB value' being delivered via each action. Actions are also aligned to the Māori Disability Plan (Whaia Te Māraama)[iv] and Pasifika Disability Plan (Faiva Ora)[v] (Ministry of Health). This alignment supports an equity approach for the actions.

The diagram below illustrates how the informing documents, Plan and delivery of mechanisms relate to each other.



HAWKE'S BAY DISTRICT HEALTH BOARD – DISABILITY PLAN

VISION

People with a disability and their whānau engaging with Hawke's Bay District Health Board, experience no barriers, are involved in decision-making, and engaged in service design and development

PRINCIPALS

People with disabilities in Hawke's Bay:

- Experience respectful, mana enhancing engagement with HBDHB services
- Have a clear voice in planning, service development and the care they receive.
- Have a clear process for feedback and their feedback is responded to

Hawke's Bay District Health Board:

- Has a commitment to address barriers; being inclusive and responsive, including Tangata Whaikaha and disabled Pasifika people and their whānau
- Is committed to changing attitudes by being consistently inclusive and responsive to people with disabilities and their whānau, including Tangata Whaikaha and disabled Pasifika people
- Involves people with disability and their whānau in decision –making, development and design of services. "No decision about me without me".

COVERAGE

- Services and work of the Hawke's Bay District Health Board. This is wider than clinical services and includes, contracted services, service design, planning and governance functions.
- People with disabilities engaging with these services and work of the HBDHB and staff employed by HBDHB.
- Whānau and caregivers, where their engagement supports and maintains the safety of the person with a disability.

OUTCOMES:

EDUCATION

HBDHB supports education outcomes that ensure people with a disability are engaged in education, achieving and transitioning to further education and employment equitably with non-disabled people.
Linked to Matariki

EMPLOYMENT & ECONOMIC

HBDHB leads by example as a socially responsible employer and supports people with disabilities to engage in employment leading to financial security for all people with disabilities including Tangata. Whaikaha and Pasifika
Linked to People Plan and Matariki

HEALTH & WELLBEING

Delivering person and whānau-centered care that is responsive to the diversities of people with disabilities including Tangata Whaikaha and Pasifika.
Linked to Clinical Services Plan

RIGHTS PROTECTION & JUSTICE

Deliver equitable outcomes for all people with disabilities engaging with HBDHB services. Establish monitoring

ACCESSIBILITY

Services design and continuous improvement will meet the diverse needs of disabled people.

ATTITUDES

We have a workforce that demonstrates our core values in every encounter they have with a person with a disability and their whānau.

CHOICE & CONTROL

Support people with disabilities to make choices and have control over their health care and outcomes.
Linked to Clinical Services Plan

LEADERSHIP

Ensure that people with disabilities experience equitable health outcomes and are consistently engaged in decision-making.

OUTCOMES AND ACTIONS

Outcomes	Actions	Measures	Linked Documents	Reporting
EDUCATION HBDHB supports education outcomes that ensure people with a disability are engaged in education, achieving and transitioning to further education and employment equitably with non-disabled people.	1. Work with education providers including Kahui Ako (Communities of Learning) to review and co-create career development and career pathways that are localised, responsive and future-facing for all learners in Hawke's Bay including those requiring additional support to achieve sustainable employment	Measured via the Matariki outcomes and project tool	Matariki- Social Inclusion Strategy HBDHB Annual Plan	Board 6 monthly
EMPLOYMENT & ECONOMIC SECURITY HBDHB leads by example as a socially responsible employer and supports people with disabilities to engage in employment leading to financial security for all people with disabilities including Tangata. Whaikaha and Pasifika	1. Support the employment of people with challenges that may impact on their capacity to obtain or retain employment. (Social Inclusion) 2. Project 1,000: link local people on benefits to 1,000 new jobs (Regional Economic Development) 3. Ensure major infrastructure development projects consult with and optimize employment. (Regional Economic Development)	Measured via the Matariki outcomes and project tool	Matariki - Social Inclusion Strategy HBDHB Annual Plan	Board 6 monthly
HEALTH & WELLBEING Delivering person and whānau-centered care that is responsive to the diversities of people with disabilities	1. Establish practice that ensures the rights of all people with disabilities to bring whānau or support person when engaging with services. 2. Ensure the disability sector is provided with opportunities to participate in service and policy development.	Establish a baseline for the quality of service delivered to people with disabilities. Measure services on the level of delivery (using baseline measure), with Board monitoring via annual reporting.	Clinical Services Plan People and Capability Strategy HBDHB Annual Plan	

Outcomes	Actions	Measures	Linked Documents	Reporting
including Tangata Whaikaha and Pasifika. Additional activity will be delivered under the Clinical Services Plan and subsequent operational plans. There is also a link to the workforce training under the "Attitudes" outcome in this Plan	3. Increasing control for tangata whaikaha to choose the support they need and when, where and how this support occurs (self-determined). 4. Ensuring whānau are supported so that they are in the best position to support their whānau member with a disability. Including having their expectations met and achieving and maintaining mana and wellness. 5. In any service, the person is not only defined by their disability but also their other cultural, familial, linguistic and gender identities. 6. Transitions between services and to the community are easy and understood by people with a disability and their whānau.			
 RIGHTS PROTECTION & JUSTICE Deliver equitable outcomes for all people with disabilities engaging with HBDHB services. Establish monitoring	1. Develop monitoring and measurement approaches that include outcomes for people with disabilities by ethnicity. 2. Implement "Accessibility" outcome and actions. 3. Contracted providers are supported to develop policy and practice that delivers equity outcomes for people with disabilities. 4. Monitor the implementation of the plan through management KPIs and reporting to governance	Measurement frameworks include measures for people with disabilities Manager performance plans have KPIs to improve or maintain equitable outcomes for people with disabilities. Contract review process includes support for providers i.e. to develop disability plans, policy and audits All reporting frameworks including outcomes for people with disabilities	HBDHB Annual Plan, including the IS work plan and	

Outcomes	Actions	Measures	Linked Documents	Reporting
 **ACCESSIBILITY** Services design and continuous improvement will meet the diverse needs of disabled people.	1. Service design and improvement will engage people with disabilities and their whānau from the beginning. 2. Services will have feedback mechanisms that enable disabled people to provide feedback and this is responded to. 3. Services ensure that disabled people and their whānau get a fair deal. 4. Ensure barriers that could result in disabled people not being able to engage, participate or utilise HBDHB services are removed or addressed. This could include; environment audits being part of standard practice, and/or national guidelines.	People with disabilities and their whānau are involved in service design and improvement. Feedback processes reviewed to ensure people with disabilities and their whānau are able to and are providing feedback. Audits are completed to monitor compliance.	Policies – Building/Facilities, Consumer Feedback, Disability Audit (to be developed)	
 **ATTITUDES** We have a workforce that demonstrates our core values in every encounter they have with a person with a disability and their whānau.	1. HBDHB Core Values are evident in all interactions with disabled people and their whānau. 2. Establish mandatory disability training – linked to Values and Behaviour in context of disability. 3. Develop and deliver training programme in partnership with disability community. 4. Measures how embedded Values and Behaviours are via DHB systems (e.g. PDR, peer review). 5. Deliver feedback loops at every level using multiple systems (e.g. surveys, real time feedback) to inform training and staff practice.	Training agreed and set up in PAL$ annual performance plan. Training programme developed and feedback collated. Number and percentage of staff have completed training. Demonstrates evidence at application of training in PDR.	People and Capability Strategy	
 **CHOICE & CONTROL** Support people with disabilities to make choices and have control over their health care and outcomes.	1. Support accessible services by: • Developing peer support for people with a disability and their whānau to navigate services • Make information available and accessible – health literacy for every person with a disability.	Design and deliver a peer support navigation programme, in partnership with people with disabilities. Measure impact and effect of the programme.	Clinical Services Plan HBDHB Annual Plan	

Outcomes	Actions	Measures	Linked Documents	Reporting
	2. Connect with a wide range of disabled communities: • Via existing disability representative groups Hawke's Bay-wide • Clarifying and establish representative roles and their link with people with disabilities 3. All services actively seek feedback from people with a disability engaging with services. 4. People with a disability are consulted and actively involved in policy, planning, governance, service development and implementation via Intentional represented on forums.	Document connections made and the outcome of these connection with disabled community based groups. Audit feedback process to evaluate effect. Audit consultation and engagement with people with disabilities. Set targets for improvement		
 LEADERSHIP Ensure that people with disabilities experience equitable health outcomes and are consistently engaged in decision-making.	1. Include actions in the annual plan. 2. Implement the actions for this Plan. 3. Report to disabled communities and their whānau on the Plan progress, health outcomes and engagement.	1. Reporting to communities and their whānau 2. Reporting to governance groups	Board work programme Annual Planning	

Key for Hawke's Bay District Health Board – core values (actions are coded by the Core Values colour below to indicate how this Plan delivers Core Values).

Tauwhiro (Care) Rāranga te tira (Partnership) He kauanuanu (Respect) Ākina (Improvement)

[i]

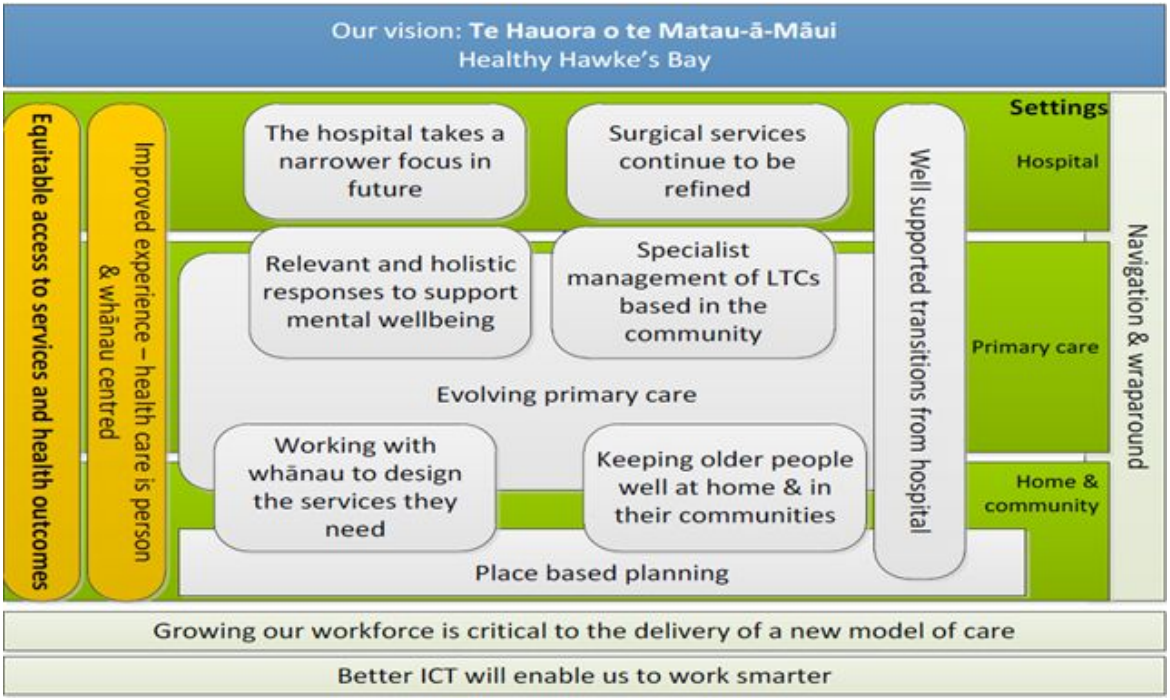
HBDHB Clinical Services Plan (Draft)
This Plan provides the direction for clinical services delivered by HBDHB for the next 10 years.

The key themes from the Clinical Services Plan are designed to address the overarching commitment to achieving equity. This included addressing the inequities and unmet need experienced by Māori, Pasifika peoples, **people with disabilities**, experiencing mental illness and those living in socio-economic deprivation. A new approach including "person and whānau centered system and building on pockets of excellence.

The CSP establishes a firm commitment to **prioritising and designing services to meet the needs of populations with the poorest health and social outcomes.** This means:

- Up-skilling of health professionals, with particular regard to cultural competence, mental health and addictions, wellness focus, family violence and poverty. The workforce reflects the population it serves
- Commissioning for equitable outcomes
- Multi-disciplinary and team-based approaches which more holistically consider and address health and social needs and aspirations for whānau
- Re-framing our approach to focus on wellness, preserving mana and building on existing strengths of whānau, communities, and population groups
- Whānau wellness models in addition to an expectation that core services will meet the needs of those with poorer outcomes
- A rights-based approach to health meeting our responsibilities under Te Tiriti o Waitangi
- Incorporating the guiding principles of the Nuka System of Carewhilst giving primacy to Māori indigenous thinking, values and solutions.

http://www.ourhealthhb.nz/news-and-events/clinical-services-plan-transforming-our-health-services/



[ii] **National Disability Strategy 2016 - 2026[ii]**

The Strategy includes principles used to guide this Plan – Te Tiriti o Waitangi, Convention on Rights of the Person with Disabilities, and ensures disabled people are involved in decision-making that impacts them. With the following approaches - whole of life (long term approach) to social investment and specific and mainstream supports and services (twin-track approach).

The National Strategy is designed to guide the work of government agencies on disability issues. The Working Group were clear that this document provides the strategic direction for the HBDHB. This Plan is designed to implement this Strategy.

[iii]

HBDHB Values

The HBDHB has a commitment to living our values in the workplace and in the community. The best outcomes for patients and staff can be achieved if we all work together with the same values. These valueswe show commitment to and demonstrate the behaviours of the health sector are:

- Tauwhiro (delivering high quality care to patients and consumers)
- Raranga te tira (working together in partnership across the community)
- He kauanuanu (showing respect for each other, our staff, patients, and consumers)
- Ākina (continuously improving everything we do)

These values are at the core of ensuring people with disabilities are experiencing effective engagement with our health services. Including having equitable health outcomes, experience no barriers to accessing services and are participating in the development and design of our health services.
https://ourhub.hawkesbay.health.nz/our-place/our-values/

[iv]

Whāia Te Ao Mārama (Māori Disability Action Plan)[iv]

Introduces the term tangata whaikaha to describe a Māori person with a disability – whaikaha meaning to have ability and be enabled. This Plan also aligns with the vision and outcomes from the New Zealand Disability Strategy. There are six goals:

1) Participate in the development of health and disability services
2) Have control over their disability support
3) Participate in Te Ao Māori
4) Participate in their community
5) Receive disability support services that are responsive to Te Ao Māori
6) Have informed and responsive communities.

These also align with our HBDHB Values. Our Plan acknowledges the need to have equity outcomes and that currently tangata whaikaha experience barriers in health services in HB both as a person with disability and as Māori. Finally this Plan acknowledges our commitment as a DHB to the Treaty of Waitangi.

[v]

Faiva Ora, National Pasifika Disability Plan[v]

This notes a clear under representation of Pasifika disabled people engaging with disability services and the plan is focused on the services delivered by the healthy sector for people with disabilities. The vision is "Pasifika disabled people and their families are supported to live the lives they choose." This plan is informed by New Zealand Disability Strategy, New Zealand Health Strategy and Pacific Health Strategy and the United Nations Convention on the Rights of Persons with Disabilities.

Faiva Ora has the following principals which guide the planned actions:

- Self-determination
- Beginning early
- Person and family centred
- Ordinary life outcomes
- Equity
- Enhancing Pasifika cultural identity
- Easy to use
- Building relationships

Faiva Ora focuses on services delivered in the health sector, for this Pland that is further refined to services delivered by HBDHB. Both Plans share outcomes relating to equity, access (easy use) and person and family centered.

STRATEGIC PLANNING UPDATE

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Alcohol Harm Reduction Strategy 2017-22 Progress Report** 12 For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Health Improvement & Equity
Document Author(s)	Rachel Eyre, Medical Officer of Health Rebecca Peterson, Acting Team Leader/Population Health Advisor
Reviewed by	Chris Ash, Chair Alcohol Harm Reduction Steering Group; Alcohol Harm Reduction Steering Group; Laurie Te Nahu, Health Gains Advisor ; Rowan Manhire-Heath, Population Health Advisor; Executive Management Team; Māori Relationship Board; HB Clinical Council and HB Health Consumer Council.
Month/Year	February 2019
Purpose	The Board requested six monthly progress reports to Clinical Council. This report provides an overview of progress and changes impacting on the HBDHB Alcohol Harm Reduction Strategy.
Previous Consideration Discussions	Alcohol harm reduction position statement (Nov 2016), steering group establishment and strategic framework and priorities were endorsed in September 2017.
Summary	*Work delivered under the Alcohol Harm Reduction Strategy involves a range of activities (Refer to Appendix One) :* • *addressing the drivers of alcohol use* • *shifting attitudes towards alcohol* • *limiting availability and exposure* • *providing appropriate and accessible health service response to alcohol harms* *Whilst health services response to alcohol harm, particularly alcohol screening and brief intervention (SBI) was identified as a priority, progress has been slow. Population Health have achieved a number of successes in relation to intersectoral action and community engagement detailed in this report.*
Contribution to Goals and Strategic Implications	This work contributes to the following: Hawke's Bay DHB Alcohol Harm Reduction Strategy 2017-2022 Joint Alcohol Strategy (2017) across Napier City and Hastings District Councils – HBDHB is a key stakeholder Improving health equity – note: Māori experience more harm from alcohol overall than non-Māori. Evidenced by higher hospitalisations wholly attributable to alcohol. System Level Measure/HBDHB Annual Plan (2018-19) - Youth are healthy, safe and supported; ED alcohol presentations for 10-24 year olds. Clinical Services Plan - primary and community care future vision encompasses relevant and holistic approaches to mental wellbeing including addiction issues.

18

	Social inclusion /REDS/ Matariki – to reduce the negative impact of drug use on individuals and their whanau /reduce the rate of violence experienced by individuals and whānau.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika using targeted (e.g. social supply to youth project in Wairoa) and universal approaches with greater proportional impact on the most vulnerable (e.g. reducing availability / 'alcohol and schools don't mix' initiative, monitoring licence applications, supporting community to oppose licences in high deprivation areas). Equity measures / tools will be applied to individual initiatives and programmes as they are planned and implemented.
Consumer Engagement	Steering Group membership includes Consumer Council and Youth Council members.
Other Consultation /Involvement	Steering Group membership includes provider services – Medical, Community Women and Children, Maternity, Mental Health, Primary Care Directorate, Health Improvement & Equity Directorate including Public Health, Māori and Pacific health leadership and youth representation. Hawke's Bay DHB and Health Hawke's Bay designed an Alcohol Screening & Brief Intervention Survey disseminated widely to health services and general practice. Results were shared with the Steering Group and will inform next steps. Community mobilisation project (see "shift attitudes to alcohol" section).
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the substantial activity led by population health.
2. **Note** the new landscape to obtain buy-in from Clinical Services using a broad based social harm reduction approach, especially for screening and brief intervention.
3. **Approve** the next steps.

HBDHB Alcohol Harm Reduction Strategy 2017-22 | Progress Report

Author(s): **Designation:**	Rachel Eyre, Medical Officer of Health Rebecca Peterson, Acting Team Leader/Population Health Advisor
Date:	**February 2019**

OVERVIEW

A Position Statement on reducing alcohol-related harm was adopted by the HBDHB Board in November 2016. In September 2017 the Board endorsed the alcohol harm strategic framework (refer to Appendix One) and priorities and supported the establishment of a steering group reporting to Clinical Council. The strategy informs a broad programme of work including public health regulatory functions under the Sale and Supply of Alcohol Act 2012, intersector activities, work in key settings e.g. schools, sports clubs and community led initiatives e.g. social supply. The Steering Group agreed to focus initially on reviewing and improving the health service response to alcohol-related harm in the form of screening and brief advice (SBI)[1]. Due to competing pressures, limited resourcing and capacity for clinical leadership this component of the programme of work has not progressed.

System-wide solutions are currently being sought to resolve how alcohol harms can best be addressed by our DHB, alongside a number of other 'social harm' issues, which may have more political traction and community/stakeholder resonance. This should be balanced against the need to maintain focus on alcohol related impacts on the community.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives on the activities to date. Refer to Appendix Two for a summary on the progress on implementation of the Alcohol Harm Reduction Strategy.

1) Address underlying drivers of alcohol use

Population Health and Māori Health (Health Improvement & Equity Directorate) advocate for strong policy levers to reduce alcohol-related harm through the writing of submissions that target Central and Local Government. The following submissions have been completed over the past year

- Joint Alcohol Strategy (Napier City and Hastings District Councils)
- Energy Labelling of Alcohol Beverages
- Sale & Supply of Alcohol (Renewal of Licences Amendment Bill (No 2)
- Tax Working Group on 'The future of tax'
- Mental Health & Addictions Inquiry

The interim outcome for the Tax Working Group is yet to be confirmed, with recommendations made to include reviewing the rate structure of alcohol excise with the intention of rationalising and simplifying it. This will continue to require public health input.

[1] SBI has proven to be an effective prevention intervention, particularly in primary care. It is demonstrated to be effective for young people, men, pregnant women and general populations. It has also shown to be cost effective in the ED. (full references available on request)

The Mental Health & Addictions Inquiry report has delivered strong recommendations regarding alcohol reform; most importantly for Government to take a bolder approach to the sale and supply of alcohol. Reference has been made to the recommendations laid out in the New Zealand Law Commission's report in 2010, including to:

- Increase the price of alcohol through excise tax increase
- Regulate promotions that encourage increased consumption or purchase of alcohol
- Regulate alcohol advertising and sponsorship
- Increase the purchase age of alcohol to 20 years
- Reduce availability, such as the hours that licenced premised are open or the proliferation of outlets.

Internally, Population Health have made recommendations to the current HBDHB's Drug and Alcohol Free Policy (2014) including provision of alcohol at the Hawke's Bay Health Awards. Additional to this, the DHB Communications team were also provided with feedback on the proposed questions within the HB Health Awards survey. The outcome was to allow alcohol to be sold at the event but no longer provided free.

2) Shift attitudes towards alcohol

Community mobilisation workshops have been delivered to a range of community leaders with the aim of increasing knowledge and understanding of the Sale and Supply of Alcohol Act 2012, targeting Māori and high deprivation communities, informing them on how they can have more say. Following this, the HBDHB population and public health staff designed an Alcohol Networks e-newsletter that has an extensive distribution list, keeping the audience abreast of opportunities, hot topics and research findings.

Public Health staff have requested Hastings District Council to make licence applications more visible to communities by asking for placement of these on their website and further work of this nature is planned e.g. designing an alcohol harm reduction advocacy toolkit for community. This is in response to a Hawke's Bay community survey data gathered in 2015, indicating people wanted fewer bottle stores, more alcohol free events and entertainment and shorter alcohol outlet hours. Another joint activity across Population Health, Māori Health and the Child Development Services included a presentation to Kahui Kaumatua on alcohol licensing and availability.

3) Limit availability and everyday exposure

Alcohol and schools don't mix: Young people and under age exposure literature review was presented and endorsed by HBDHB Board in May 2018. The intent was to provide evidence on exposure to alcohol and harms to young people and share data around special licence applications made by schools over the past few years. The proposed outcome of the project was to work more closely with the education sector to advance a whole of school approach to alcohol. The target is to have no schools applying for alcohol special licences for fundraising events where minors are present.

Subsequently, the Population Health alcohol team has developed and publicised widely the *Healthy Events and Fundraising Guide* and planned and delivered a comprehensive 'Alcohol and Schools Don't Mix' Communication and Risk Management Plan. The success of the latter piece of work was strong clinical leadership, an evidence base, tools to support schools and encourage effective communication.

The 'Alcohol and Schools Don't Mix' report and a subsequent school special licence opposition (Port Ahuriri School Food and Music Festival) received significant media attention and provided an opportunity for our DHB to show leadership nationally. We received national support from the Health Promotion Agency, Ministry of Health and the current Children's Commissioner. Dr Russell Wills was our front-line champion who was interviewed extensively in the media. The DHB continues to work with the Child Health Team, Ministry of Education and Ministry of Health to support alcohol-free schools. A presentation on alcohol and young people was made to the Secondary Schools Principals Association. Preliminary data suggests a high proportion of schools in Hawke's Bay have now developed an alcohol policy.

Reducing the availability of, and exposure to alcohol in our highest needs communities, is a core activity for the Population Health alcohol team. A recent example of this work is the Medical Officer of Health's opposition to a new off-licence store in a high deprivation suburb of Hastings (Akina, Parkvale). Opposing such a licence application requires comprehensive research and data analysis and working with the community to ensure their views are heard. The decision has been to allow this particular off-licence with an expectation of closer monitoring by Police. This decision is now being appealed by the Medical Officer of Health to the Alcohol Regulatory Licensing Authority.

The 'One for One' host responsibility campaign (encouraging one non-alcoholic drink/preferably water for every alcoholic beverage) has been successfully transitioned to a more sustainable model. The Hawke's Bay Hawks Basketball Club and Church Road Winery have both shown leadership by using promotional material (flags, bar mats, poster, and hand sanitisers) during season events. The Hawks also instituted an 'alcohol-free family zone'. In addition, the Napier City and Hastings District Councils' Joint Alcohol Strategy Reference Group (of which the DHB are a key member) are currently progressing a project to create branding to promote an increase in 'alcohol-free events' and 'alcohol-free family zones' at events. This project is funded by the Health Promotion Agency's 'Community Action on Alcohol Partnership Fund'.

Discussions have occurred at CEO level across local government and with local MPs, Police, HBDHB executives and Medical Officer of Health raising concerns around the ineffectiveness of the current legislation, especially in regards to the Local Alcohol Policy process at minimising alcohol-related harm. All four of our territorial authorities have Local Alcohol Policies with variable status. Concerns have also been raised identifying mechanisms to increase quality data collection and community voice and to influence legislative change e.g. increasing excise tax and reducing marketing (especially via digital media targeting young people). A Private Members Bill is currently being drafted that would dispense with the LAP appeal process.

The tri-agencies (Police, Councils, Health) are holding discussions on how the licensing process is working and how we engage more effectively to reduce alcohol related harm through our joint agency working. A Joint Agency Protocol / Memorandum of Understanding is being considered.

4) Providing appropriate and accessible health services

To raise awareness, engage health services and identify workforce needs regarding alcohol screening and brief intervention, the Steering Group requested we administer a health sector wide screening and brief intervention survey. We partnered with Health Hawke's Bay to design a survey and disseminated this via Survey Monkey across health services and general practices (maternity and the child development service were excluded as they were surveyed in 2017). Findings endorsed the level of concern regarding alcohol harm from health services, with over 72.5% either very or extremely concerned about alcohol related harm. Refer to appendix three for detailed findings.

General practice (Health Hawke's Bay) screening & brief intervention

Health Hawke's Bay are working to review and update alcohol screening and brief intervention patient dashboard. Discussions are underway on adapting the Whanganui PHO's dashboard, revising resources, tools and referral pathways. Testing with initial practices will occur before wider rollout.

Workforce development

The Health Promotion Agency (HPA) are in discussion with the Ministry of Health and Matua Rāki to review how best to provide screening and brief intervention information and training to the health sector. This work will involve a review of what is currently available, what is missing and what could be better packaged for delivery at a local or national level. There will be an opportunity for HBDHB to act as a pilot site, informing and testing the design of this information including content and format. An integrated approach that achieves consistent messaging about alcohol and other drug harms and how to minimise these harms for whānau is essential.

Integration
It has been proposed that we facilitate alcohol screening and brief intervention across clinical services. The context is that we are facing competing health service and resource pressures, with strategic perspectives to take an integrated "social harm reduction" approach to address a range of harms such as alcohol and other drugs, family violence, suicide prevention and smoke free. The conversation was raised at the Steering Group in November 2018 and there was general support for an integrated approach. Further discussions will be required to understand the implications of an integrated approach, in particular, the impact this may have on implementation of the HBDHB Alcohol Harm Reduction Strategy.

To explore integration as well as continue to implement the strategy, we propose to take opportunities at both the management and operational level to join across other harm prevention initiatives, with a view to develop an integrated, whānau centred approach. This will result in regular meetings between coordinators to explore through joint planning, agreed shared measures/outcomes and initiatives, linking key messages and workforce opportunities. This will require discussion as to which groups are best brought together and what the synergies might be and how the various interest groups will be represented. We will need to understand what mix of topic-specialist and strategic expertise will be required, what level of mandate and decision making around use of resource/commissioning. Clarity will be required to understand how any changes to structure will enable more effective and efficient use of resources at all levels to optimise health gain. Overall management of this work will continue to be overseen by the Executive Director, Heath Improvement and Equity.

The opportunity to connect with local place based initiatives will allow more community development approaches that are positive and asset based and which are meaningful to the communities who are most affected. At the same time there may be merit in forming an overarching group to consider an integrated approach to screening (e.g. for domestic violence, depression, alcohol and tobacco use).

In addition, the need for our collective leadership, advocacy for policy change and systems change are essential to make real progress, aside from identifying service solutions. The wider political context is important across a number of commercial determinants of health through the marketisation of alcohol, tobacco and unhealthy food, driving our current increase in long term conditions.

Leadership
At a local level, there are two key areas for our DHB to lead and influence. Firstly, there is evidence based public health/population preventive initiatives that in essence support the policy changes advocated by the Law Commission. Secondly, there is the more bio-medical early intervention and treatment related aspects, such as improving access to screening, brief intervention and treatment options to cater from mild through moderate to serious addiction issues.

Health professionals need to have an increased awareness of alcohol harms as a health issue so that they can support both areas. For the second, health professionals need to be comfortable to have the conversation about alcohol as a normal part of patient and whānau interaction, akin to the smoking question and brief advice introduced over 20 years ago. Professional development, screening tools and referral pathways need to be developed to support a better co-ordinated early intervention approach, resource for which will need to be sourced. It is noted that smoking cessation has had significant funding attached, while alcohol SBI is still under-resourced.

By investing in both population prevention strategies and early intervention for individuals there is the opportunity to reduce the costs to our DHB (conservative estimate of $3 million in 2016 due to bed days only from wholly attributable conditions and not injuries). This allows us to prevent hospitalisations due to the 200+ acute and chronic conditions related to alcohol. A significant benefit from reducing alcohol harms is to reduce the social costs and misery to families and whānau caused by inappropriate alcohol consumption, enabling safer communities for all.

(Note: Harms from alcohol outweigh all other drugs and harms to others outweighs harm to self[2] and Berl economist Ganesh Nana has estimated that alcohol harm costs the country $7.85 billion a year, including factors such as unemployment, the labour market, the costs on the court and health systems and road crashes[3]). Working more closely with Police in particular will strengthen what we do for community gain and currently we are exploring how we can improve our sharing of data.

WIDER CONTEXT

Consideration is now being given by EMT members to consolidate work across a number of areas within the wider context of social harm, whilst ensuring that the work on alcohol harm is not side-lined. Recent results have identified alcohol as the leading cause of health loss (from death and disability) in New Zealand adults, age 15-49 years. It is estimated that approximately half of serious violent crimes are related to alcohol and it is well known that alcohol is a risk factor for suicide through either acute intoxication or through the effects of heavy chronic use, especially among young men. Recent results from the NZ Health Survey demonstrate that Hawke's Bay hazardous drinking levels are still significantly higher than nationally (one in four adults, compared to one in five in New Zealand as a whole) and amongst the highest in the country.

It is also highly important to note the Treaty of Waitangi WAI 2575 Health Services Outcomes Kaupapa Inquiry[4] claim is currently progressing through the Waitangi Tribunal. Stage two will address alcohol or *waipiro* (alcohol was referred to as 'stink water' by Māori) as a key factor driving social, health and economic inequities between Māori and non-Māori. The claim cites a breach of the Treaty of Waitangi as a result of the Crown's failure to enact the recommendations made by the Law Commission report in 2010. In particular, increasing the price of alcohol, raising the drinking age to 20 and restricting alcohol advertising and sponsorship. The claimants objected to the Government failing to ensure the Sale and Supply of Alcohol Act was consistent with the Treaty of Waitangi. This hearing is expected to begin from mid-2019.

NEXT STEPS

1. The Steering Group and programme manager to continue to maintain focus on reducing alcohol harms, while discussing and developing a perspective to broaden its focus to include a range of harms.
2. Continue to progress with Health Hawke's Bay screening and brief intervention programme.
3. DHB leadership to support the continuation of the Alcohol Harms Steering Group (or its equivalent) to oversee progress on Alcohol Harm Reduction Strategy implementation including its structural position within the organisation.
4. Seek input from the Clinical Council and governance groups on how best to implement SBI and achieve health services engagement.
5. Continue to prioritise the target populations as identified within the Strategy (children and young people, pregnant women, Māori, Pacific, high deprivation populations).

[2] King, L., Nutt, D., & Phillips, L. (2010) *Drug Harms in the UK: a multicriteria decision analysis.* The Lancet, Volume 376, 1558-65.
[3] https://www.radionz.co.nz/news/national/364192/higher-alcohol-tax-needed-to-reduce-harm-economist
[4] https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

RECOMMENDATION

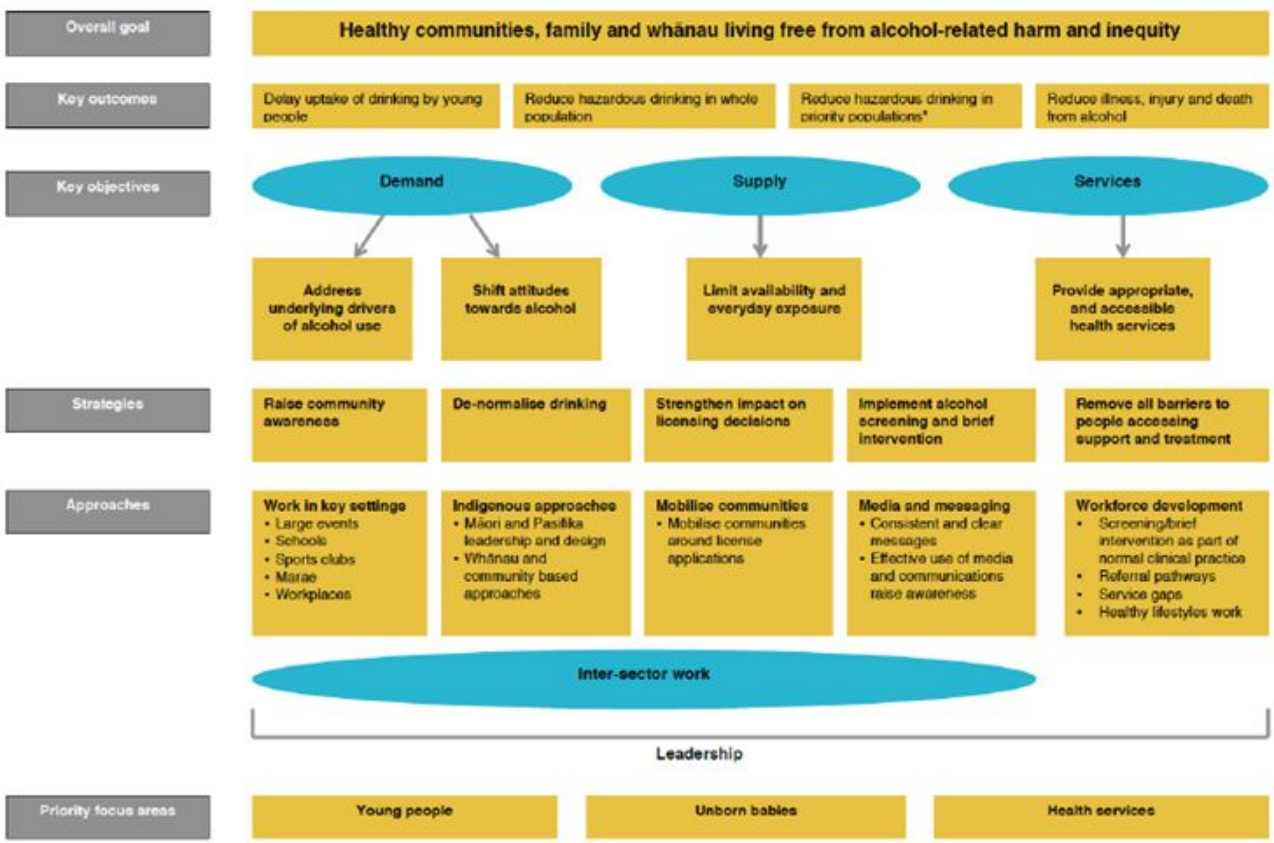
It is recommended that the HBDHB Board:

1. **Note** the substantial activity led by population health.
2. **Note** the new landscape to obtain buy-in from Clinical Services using a broad based social harm reduction approach, especially for screening and brief intervention.
3. **Approve** the next steps.

ATTACHMENTS

- Appendix One: Hawke's Bay District Health Board Alcohol Harm Reduction Strategy 2017-2022
- Appendix Two: Alcohol Harm Reduction Strategy Progress Report Summary Table
- Appendix Three: The place of Alcohol in Schools: Alcohol & Young People Report and Communications Plan (available on request)
- Appendix Four: Hawke's Bay Alcohol Screening & Brief Intervention Survey 2018 Findings (available on request)

Appendix One: HBDHB Alcohol Harm Reduction Strategic Framework and Timeline



* Priority populations: Young people, Māori, Pasifika, Pregnant women

HBDHB Alcohol Harm Reduction Timeline 2016- 2019

Activity	**Date**
"First" DHB alcohol strategy planning workshop with key DHB alcohol stakeholders (subsequently referred to as 'Alcohol Advisory Group')	4 Feb 2016
Second meeting of Alcohol Advisory Group	21 March 2016
Production of video clip to support Position Statement https://vimeo.com/174437689	April-June 2016
Dr Paul Quigley presented to HBDHB Grand Round on screening and brief intervention in the Wellington Emergency Department	May 2016
Professor Jennie Connor and Doug Selman visit to Hawke's Bay on causal relationship between alcohol and cancer	Aug 2016
Presentations to DHB committees (two rounds) including Issues/Discussion paper followed by a draft Position Paper	June-Sept 2016
Fetal Alcohol Awareness Day - awareness raising by HBDHB	Sept 2016
DHB Board adopts Position Statement	Nov 2016
Alcohol Advisory Group reconvened to oversee stakeholder engagement process and strategy development	2 May 2017
Stakeholder engagement process	May/June 2017
Alcohol Advisory Group meeting to review results of stakeholder engagement process	7 June 2017
Stakeholder workshop – stakeholder engagement results and draft strategic framework presented	5 July 2017
Strategy to DHB Committees and Board for approval	July/Sept-2017
Steering Group formed	December 2017

Appendix Two: Alcohol Harm Reduction Strategy Progress Report Summary Table

OBJECTIVE 1: ADDRESS UNDERLYING DRIVERS OF ALCOHOL USE (POLICY, LEGISLATION)		
Progress	**Activity**	**Progress**
	• Submissions focused on policy reform e.g. alcohol advertising, sponsorship and taxation • HBDHB Alcohol & Drug Policy review • HDC alcohol licence applications notification on website	• 5 alcohol specific submissions completed • Policy control group received feedback *Led by Health Improvement & Equity Directorate*
Planned	• HBRC removal of alcohol advertising from public buses and support positive messaging • Ethics of association policy for the DHB to demonstrate leadership • Submit on private Members Bill removing LAP appeal rights (if drawn)	*To be led by Health Improvement & Equity Directorate (primarily Population Health)*

OBJECTIVE 2: SHIFT ATTITUDES TOWARDS ALCOHOL (COMMUNITY INITIATIVES)		
	Activity	**Progress**
Progress	• Mobilising communities project – workshops for communities to learn about the licensing process • Alcohol networks e-newsletter • Social supply community action project *Te Wairoa He Hāpori Haumaru*	• 12 workshops held with range of agencies and/or groups • 4 newsletters, distribution list • Rangatahi programme, whānau hui, alcohol free events e.g. Wairoa Sports awards, Wairoa A& P show *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Community Advocacy Guidelines • Māori wardens project • Samoan Rugby Club initiative • *Te Wairoa He Hāpori Haumaru* Whānau champions project planning • *Pre-testie bestie* localisation campaign	*To be led by Health Improvement & Equity Directorate*

Objective 3: Limit availability and everyday exposure (Settings e.g. schools, events…)		
	Activity	**Progress**
Progress	• Alcohol and schools don't' mix: young people and under age exposure report and presentations including to Secondary School Principals • Port Ahuriri School special licence opposition • Bottle-O new licence opposition • One for One host responsibility campaign at large and small events • Data and public health expertise provided for all territorial authorities developing and negotiating Local Alcohol Policies (LAP) • CEO discussions across territorial authorities, police, MP's, HBDHB executives and Medical Officer of Health regarding the ineffectiveness of the LAP process in limiting harms of alcohol	• Endorsed by Board; Communication & Risk Management Plan • Schools fundraiser guide • National support from Health Promotion Agency, Ministry of Education, Ministry of Health, Children's commissioner, Primary Principals Association (HB) Chair • One for One collateral accessible and promoted as part of the host responsibility licensing process • Wairoa District Council LAP in draft; Central HB LAP approved; Hastings and Napier LAP appealed, negotiations underway *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Alcohol free events project (Joint Alcohol Strategy Project-NCC / HDC)	*To be led by Health Improvement & Equity Directorate (primarily Population Health)*

Objective 4: Providing appropriate and accessible health services		
	Activity	**Progress**
Progress	• Steering Group formed, Terms of Reference agreed priority to focus on health services response to alcohol harm reduction • Screening & brief intervention survey • Health Hawke's Bay refreshing dashboard for general practice screening and brief advice • Working with Maternity services to review the Alcohol & pregnancy "*top 5 for my baby to thrive'* messaging to include zero alcohol	• 5 meetings since Dec 2017. Inconsistent chair / leadership during this time • Survey findings shared with Steering Group, inform future activity • Updated messaging, to be socialized *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Primary care screening & brief intervention workforce development plan – delivered in the community • Communication plan to ensure consistent messaging across health services • Alcohol Activation Wall 'ease up on the drink' campaign • Potential for health practitioner awareness raising campaign such as Dry July, Sober October	*To be led by Health Hawke's Bay* *To be led by Health Improvement & Equity Directorate (primarily Population Health)* *To be led in partnership between Health Improvement & Equity Directorate (primarily Population Health) & Emergency Department* *To be led by People and Quality with Health Improvement & Equity Directorate support*

People & Quality Dashboard

HAWKE'S BAY District Health Board Whakawāteatia

2018/19- Q2 Oct – Dec

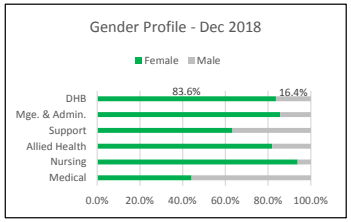
Key Highlights

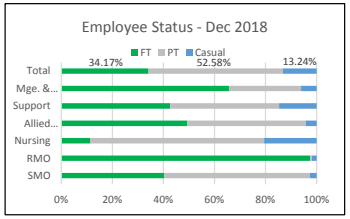
Contracted FTE shows a 5.0% increase since December 2017 (Medical up 5.5% and Nursing up 6.1%)

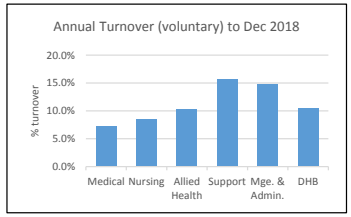
Employee status shows increase in part-time and reduction in casual positions since Dec. 2017.

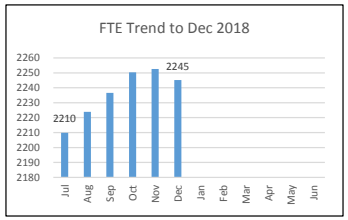
Annual turnover at 10.4% - this is lower than the average across central regions.

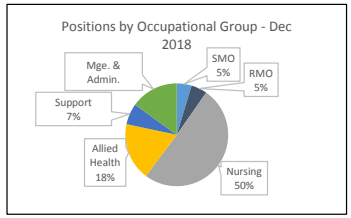
Our People

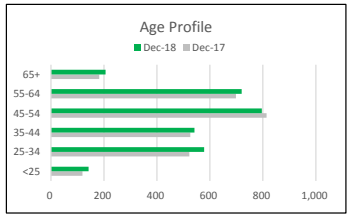












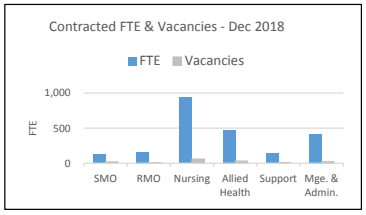
Key Highlights

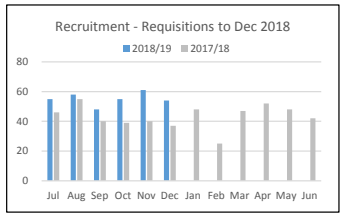
Average recruitment costs slightly below 2017/18

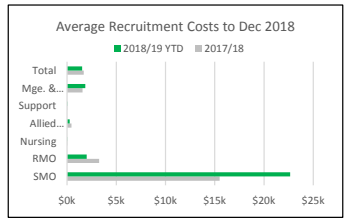
Vacancies as at Dec. 2018 (FTE)

SMO	17.70
RMO	3.00
Nursing	57.93
Allied Health	30.90
Support	7.25
Management & Admin	22.73

Our People Recruitment







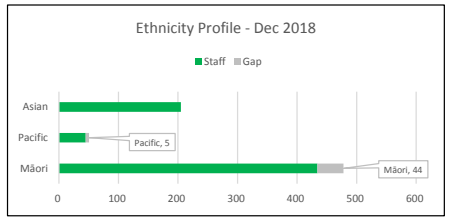
SMO costs due to advertising nationally and international, agency costs and costs associated with interviews and travel.

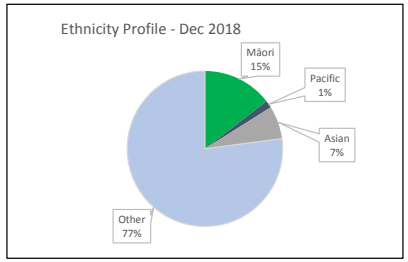
Key Highlights

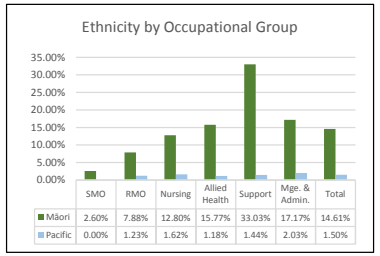
Still 44 Māori (and 5 Pacific) employees off meeting our targets for 2018/19.

HBDHB compares favourably against mid-sized DHBs (1st), Central Region (1st) and 20 DHBs (4th) when looking at Māori representation (Māori staff as % of Māori population)

Our People's Diversity







	SMO	RMO	Nursing	Allied Health	Support	Mge. & Admin.	Total
Māori	2.60%	7.88%	12.80%	15.77%	33.03%	17.17%	14.61%
Pacific	0.00%	1.23%	1.62%	1.18%	1.44%	2.03%	1.50%

Key Highlights

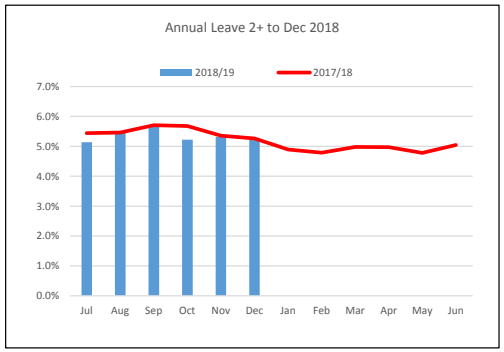
YTD sick leave as at December 2018 is 3.1% compared to 3.3% for the same period last year.

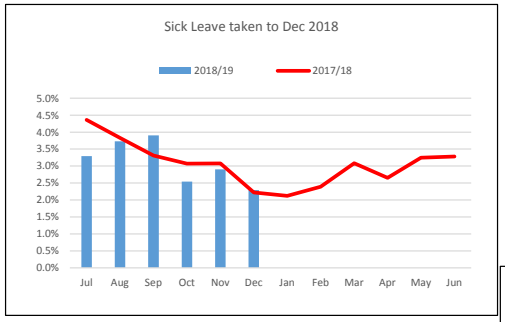
Annual Leave 2+ years = 149 (5.2%) compared to 143 (5.3%) this time last year.

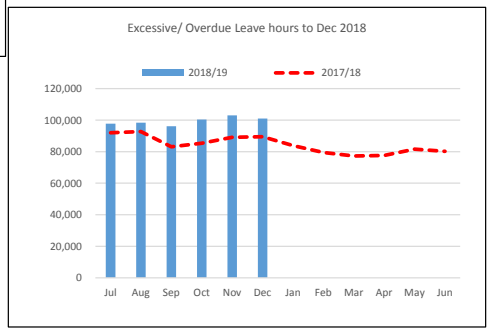
Excessive/ overdue leave hours 100,977 at average of 74.8 per employee. Compared to 89,505 at average of 70.8 per employee last year.

Employees to be encouraged to take more leave to rest and recharge over the summer months. Targets being set and to be monitored.

Our People's Wellbeing





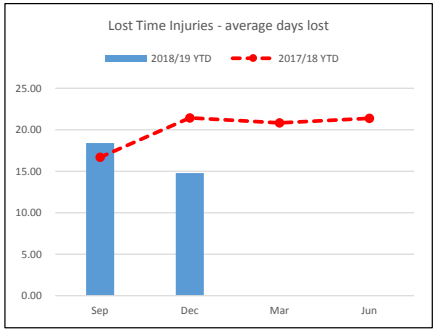


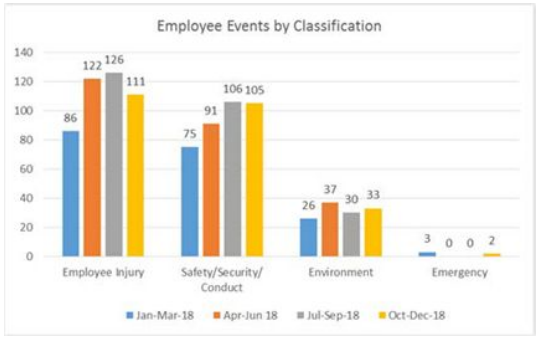
Key Highlights

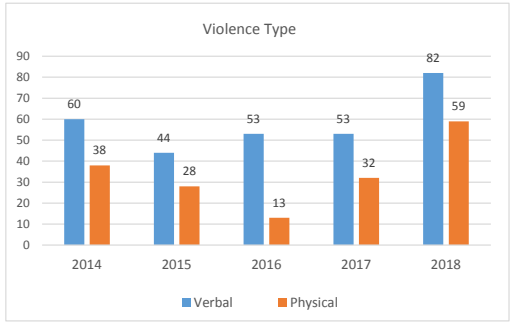
Lost Time Injuries:
YTD = 14.8 days compared to
YTD 2017/18 = 21.4 days

There has been a steady increase in the number of employee related events, specifically in relation to abuse/assaults. Significant work is being undertaken in 'hot spots' to support staff and provide them with the necessary skills to de-escalate these situations. At an organisational and central regions level a group are working together to identify the key issues and put in place a programme of work to reduce the current levels of occupational workplace violence.

Our People's Safety







HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 2 2018/19** 14
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director of Primary Care Directorate
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	February, 2019
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Success: Raising Healthy Kids, Acute Readmissions, PHO Enrolment Areas of Progress: Faster Cancer Treatment, Wait Times for diagnostic (colonoscopy), Immunisations Areas of Focus: Health Target – ED, Average Length of Stay, Mental Health Waiting Times
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the contents of this report

20

HBDHB PERFORMANCE FRAMEWORK
Quarter 2 2018/19

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	February 2019

OVERVIEW
The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP).

As this report ends 31th December 2018, the results in some instances may vary to those presented in other reports.

BACKGROUND
The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2018/2019
The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2018/19
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- *Achieving Government's priorities and targets (Policy priorities)*
- *Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)*
- *Providing quality services efficiently (Ownership/Provider Arm)*
- *Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)*

MINISTRY OF HEALTH ASSESSMENT CRITERION

Progress towards each target or measure will be assessed using the following criterion:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2018/19	Target 2018/19
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

Table of Contents

PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 96% and Māori at 98% against a target of 95%.

- The number of B4 school checks carried out for the year to date to December was 54% compared to the target of 50%

- Acute Readmissions (all ages) – The DHB achieved a result of 12.2%, this was favourable to the target of less than 12.5%

- PHO Enrolment – We achieved the target of 95% for all ethnicities

Areas of Progress

- Health Target – Faster Cancer Treatment has improved from 81% in the previous quarter to 88% however this is still below the target of 90% (page 9)

- Semi Urgent Colonoscopies – The overall rate has increase by 15% and is currently 69% compared to the target of 70% (page 30)

- Health Target - Immunisation at 8 months has improved from 91% in the previous quarter to 93.3% this quarter, the target if 95% (page 10)

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Health Target – Shorter Stays in ED result for Q2 was 88% this is still below the target of 95% (page 8)

- Average Length of Stay – We achieved a result of 2.37 for acute against a target of less than 2.3. The Elective result was 1.59 against a target of less than 1.45 (page 28)

- Mental Health wait Times – We failed to achieve target for both waiting times at 3 and 8 weeks. The target for waiting at 3 weeks is 80%, the mental health provider arm achieved 74.9% and Addictions achieved 66.7%. The target for waiting at 8 weeks is 95%, the mental health provider are achieved 91.6% and Addictions achieved 88.9% (page 35)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- PHO Enrolment – We achieved the target of 95% for all ethnicities
- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 96% and Māori at 98% against a target of 95%.
- Access to Mental Health: Māori results for all age groups (0-19, 20-64, 65+) are favourable to target
- Breast Screening – Māori achieved a rate of 70% against a target of 70%

Areas of Progress

- Immunisation at 2 years – Māori has improved from 91.2% in the previous quarter to 94.1% this quarter, this result is still short of the target 95%. Pacific achieved a result of 100% (page 13)
- DNA – Both the Māori and Pacific rates of DNA have improved over the Q2 period which is pleasing to see. The Māori decreased by 1.7% and now sits at 10.5%, the Pacific rate has decreased by 2.6% and now sit at 9.6% against a target of 7.5% (page 31)

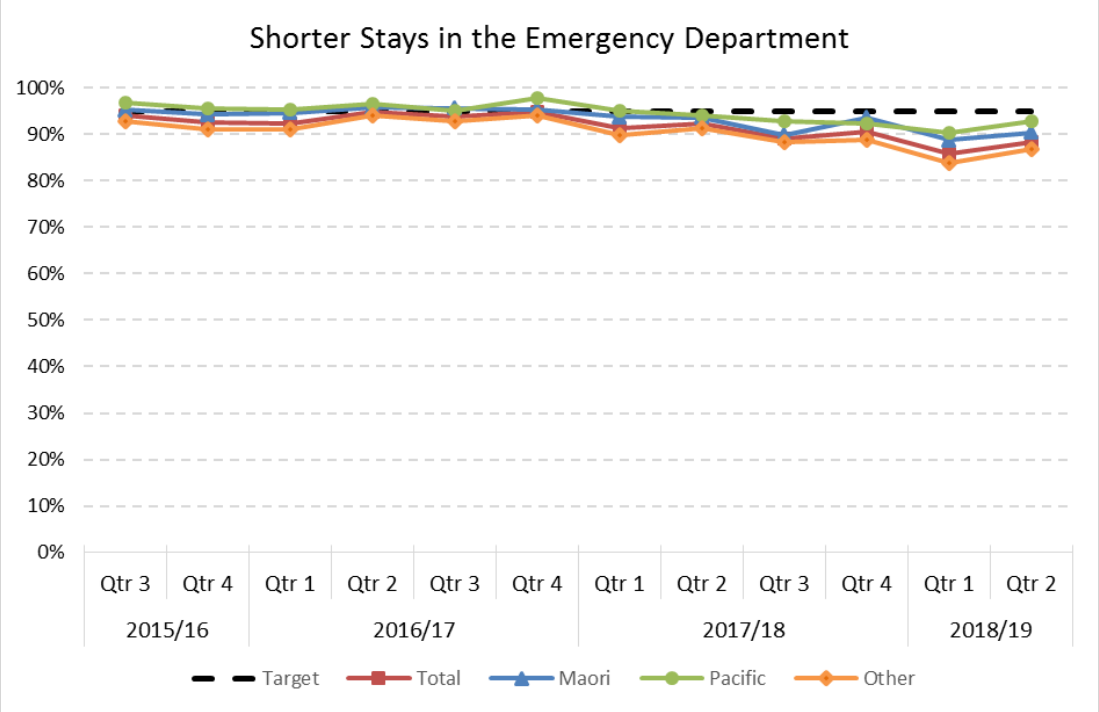
Areas of Focus

- Rate of Section 29 orders per 100,000 population – Māori Rates are currently 392 per 100,000 against the target of <81.5 and are 3 times higher than the non-Māori Rate (page 37)

HEALTH TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2018/19	Trend Direction
Total	93.9%	85.9% (U)	88.3% (U)	≥95%	▲
Māori	95.3%	88.7% (U)	90.4% (U)	≥95%	▲
Pacific	96.2%	90.3% (U)	92.7% (U)	≥95%	▲
Other	93.0%	83.9% (U)	86.7% (U)	≥95%	▲



Data Source: HBDHB

Comments:
This quarter the DHB have been embedding a process at the daily integrated operations centre meetings that now include all clinical areas and support services to enable early identification of issues, barriers to patient flow e.g. early identification of discharges and potential for early transfer of ED and AAU patients to inpatient beds. In addition this process includes coverage of nursing and medical staffing resource issues and proposed resolutions, early identification of issues related to capacity and resources enables planning and intervention. The DHB is monitoring refreshed criteria based discharge processes (numbers) for inpatient areas with the aim of improving patient flow and creating capacity for acute admissions earlier in the day. Surgical Services are reviewing the surgical registrar roster patterns and SMO on-call role functions to determine how they can better support acute surgical flow through ED. This has occurred in response to a sustained increase in breaches due to surgical review delay.

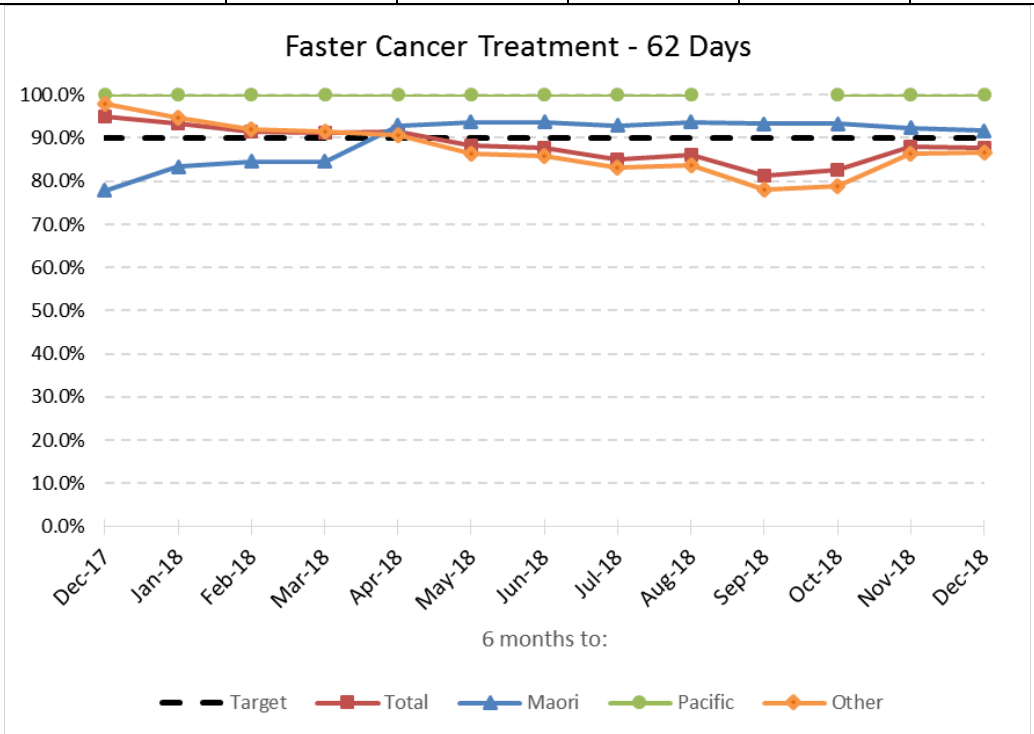
Barriers to achieving target include high levels of hospital bed occupancy (including ICU/HDU) constraining acute patient flow and increasing ED length of stay. Many streams of work being undertaken under executive level sponsorship including 'stranded' patient initiative (identifying/addressing barriers for people with excessive LOS), implementation of Criteria-based discharge processes across acute ward areas and continued evolution of Integrated Operations Centre activity.

1 October to December 2017
2 July to September 2018
3 October to December 2018

Next Quarter the DHB will continue to review Triage processes in ED front of house, expanding nursing utilisation and practice change in triage. This includes streamlining and standardising triage processes, early identification of triage 2 patients, and early implementation of treatment/pathways. The DHB will also continue to progress the GEM (Geriatric Evaluation and Management) model aimed at improved process development and referral for elderly patients. Suitable patients taken directly from ED setting e.g. post fall, requiring mobility support, and incorporating the frailty assessment process and pathway. A Business case has been developed with executive support to seek approval to implement the Emergency Q IT solution. This is a tool aimed at giving people information that may help them choose urgent care over ED based care for a range of conditions amenable to treatment in primary care. Emergency Q has been successfully trialled at Waitemata DHB and is currently been adopted by Counties Manukau DHB.

Health Target: Faster Cancer Treatment –
patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer

Key Performance Measures	Baseline [4]	Previous result [5]	Actual to Date [6]	Target 2018/19	Trend direction
Total	95.0%	81% (U)	88% (U)	≥90%	▲
Māori	78.0%	93% (F)	92% (F)	≥90%	▼
Pacific	100.0%	-	100% (F)	≥90%	*
Other	98.0%	78% (U)	87% (U)	≥90%	▲

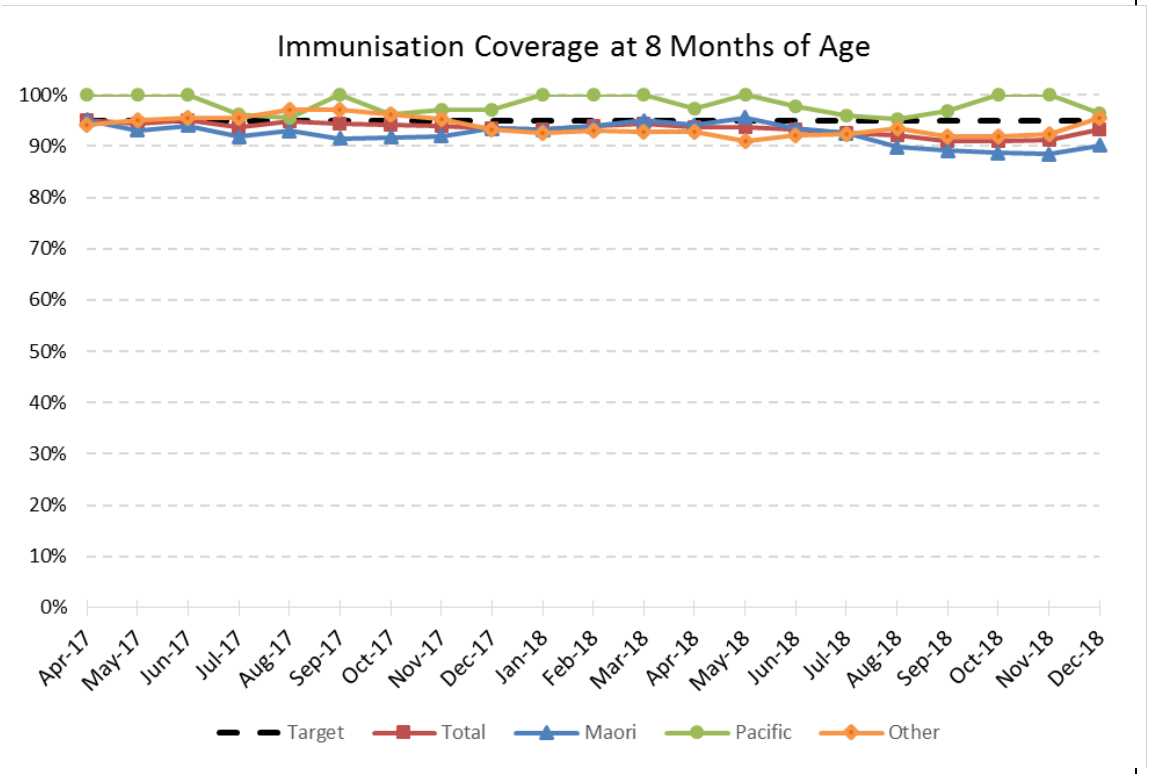


Data Source: HBDHB

Comments:
HBDHB are pleased to see an overall increase from 81% in the previous quarter to 88% this quarter. For the months of October, November and December 2018 HBDHB monthly compliance has been 100% which will be reflected in the next quarterly report. Clinical consideration and co-morbidities are a factor impacting on delays to treatment.

4 6 months to December 2017
5 6 months to September 2018
6 6 months to December 2018

Health Target: Increased immunisation % of 8 month olds fully immunised					
Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2018/19	Trend direction
Total	95.0%	91% (U)	93.3% (U)	≥95%	▲
Māori	93.0%	89.1% (U)	90.2% (U)	≥95%	▲
Pacific	97.0%	96.8% (F)	96.4% (F)	≥95%	▼
Other	86.0%	92% (U)	95.6% (F)	≥95%	▲



Data Source: National Immunisation Register

Comments:

HB is continuing to struggle to meet the 8 month target of 95%, although there has been an improvement this quarter it remains difficult get over the 95% line, and we continue to have a gap in equity. The systems that are in place will allow us to achieve 95% and equity if the population is wanting this. There is resource going into maternal immunisation, antenatal education and educating immunisation stakeholders, we do have outreach, and a drop in clinic to provide options for whanau. Outreach continues to work at capacity and struggles with access to some whanau and the complexity within the community - housing, attitude to immunisation, health literacy all factors that are having an impact. 2019 provides an opportunity to look at our systems and ensure that we are closing any gaps identified, the last two years with schedule changes and the introduction of cold chain standards stretched our resource so having a year of no changes and a set start date for influenza gives us the chance to relook at any systems that can be improved.

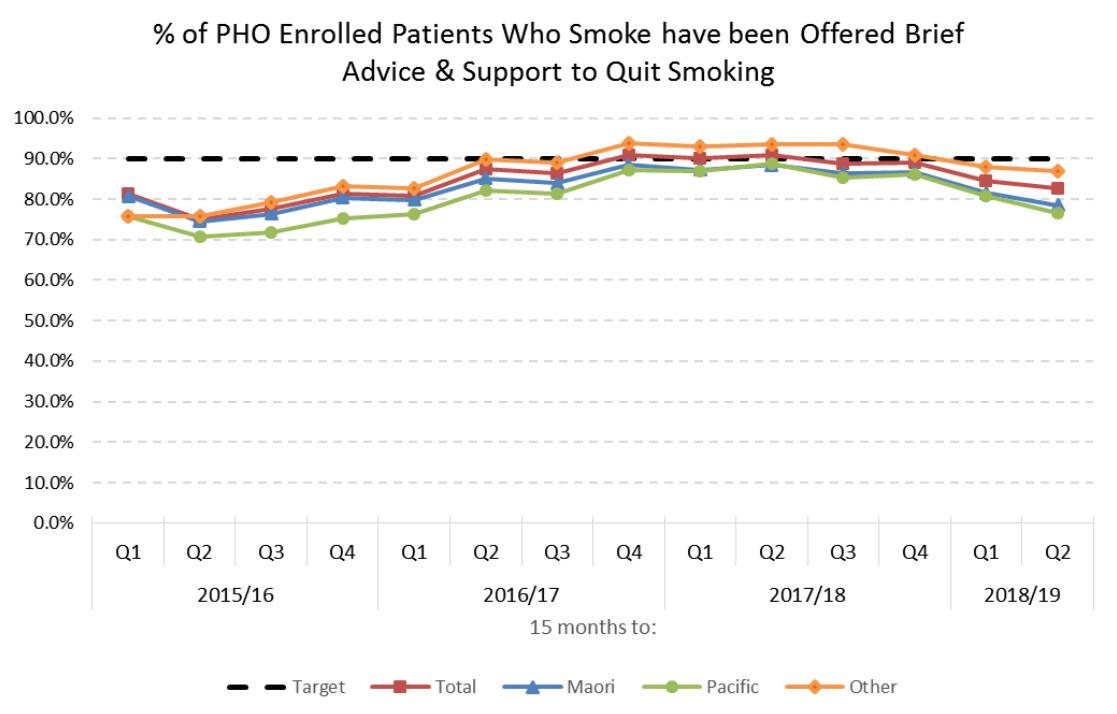
7 October to December 2017. Source: National Immunisation Register, MOH

8 July to September 2018. Source: National Immunisation Register, MOH

9 October to December 2018. Source: National Immunisation Register, MOH

Health Target: Better help for smokers to quit – Primary Care
% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2018/19	Trend direction
Total	90.2%	85% (U)	83% (U)	≥90%	▼
Māori	88.5%	82% (U)	79% (U)	≥90%	▼
Pacific	88.8%	81% (U)	77% (U)	≥90%	▼
Other	93.6%	88% (U)	87% (U)	≥90%	▼



Source: PHO

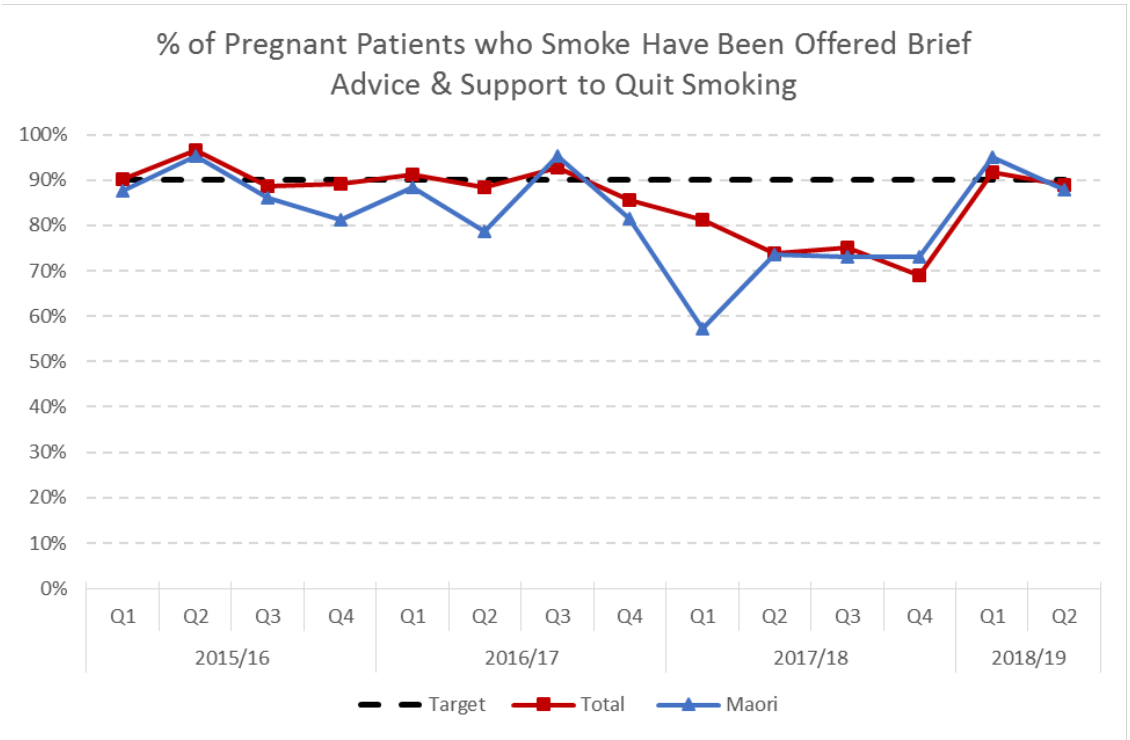
Comments:
We have undertaken several activities in the quarter to support improving performance including maintaining Smoking brief advice (SBA) as an agenda item for practice managers' meetings, nurse leadership meetings and clinical facilitation visits. Additional resource were offered to practices to support SBA with a specific focus on Māori and Pasifika smokers. The PHO have formulated a plan which has been approved to provide an additional clinical resource to assist practices with dedicated time to offer SBA outside of face to face clinical hours. There will be a particular focus on Māori and Pacific smokers being offered support to quit, to maximise the resource other aspects of patient care will be addressed at the same time where appropriate.

10 15 months to December 2017. Source: DHB Shared Services
11 15 months to September 2018. Source: DHB Shared Services
12 15 months to December 2018. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity

% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2018/19	Trend direction
Total	86.7%	92% (F)	89% (U)	≥90%	▼
Māori	84.0%	95% (F)	88% (U)	≥90%	▼



Source: HBDHB

Comments:

We are battling generational dependence on tobacco and women feeling socially isolated from whanau and peers if they continue to be smokefree. The HBDHB Smokefree team have attended several meetings with Population Health, Maternity Services and Management, to discuss the high rate of our non- smokefree pregnant women in the bay and how to help them to stop smoking. The Maternity Clinical Educator would like all her staff to have a smokefree education update this year. We are also in the process of organising an update to LMC's (lead maternity carers) with smokefree showcasing our Increasing Smokefree Pregnancy 12 week Stop Smoking programme and introducing the Te Haa Matea (HB Stop Smoking Services) Stop Smoking Practitioners to the Midwives as they discuss client profiles. This education session will count to LMC study hours.

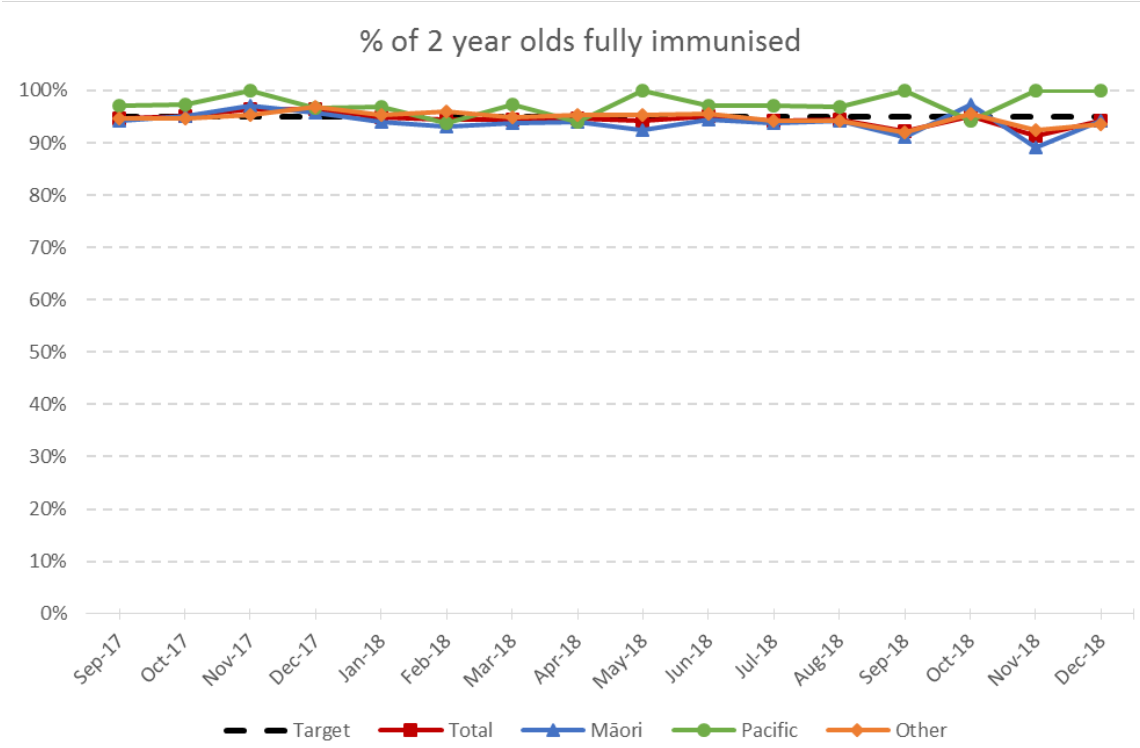
13 October to December 2017. Source: DHB Shared Services

14 July to September 2018. Source: DHB Shared Services

15 October to December 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Increase Immunisation – 2 Years % of 2 year olds fully immunised					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date[18]	Target 2018/19	Trend direction
Total	94.0%	92.1% (U)	94.1% (U)	≥95%	▲
Māori	95.0%	91.2% (U)	94.1% (U)	≥95%	▲
Pacific	96.0%	100% (F)	100% (F)	≥95%	▬
Other	86.0%	92% (U)	93.5% (U)	≥95%	▲

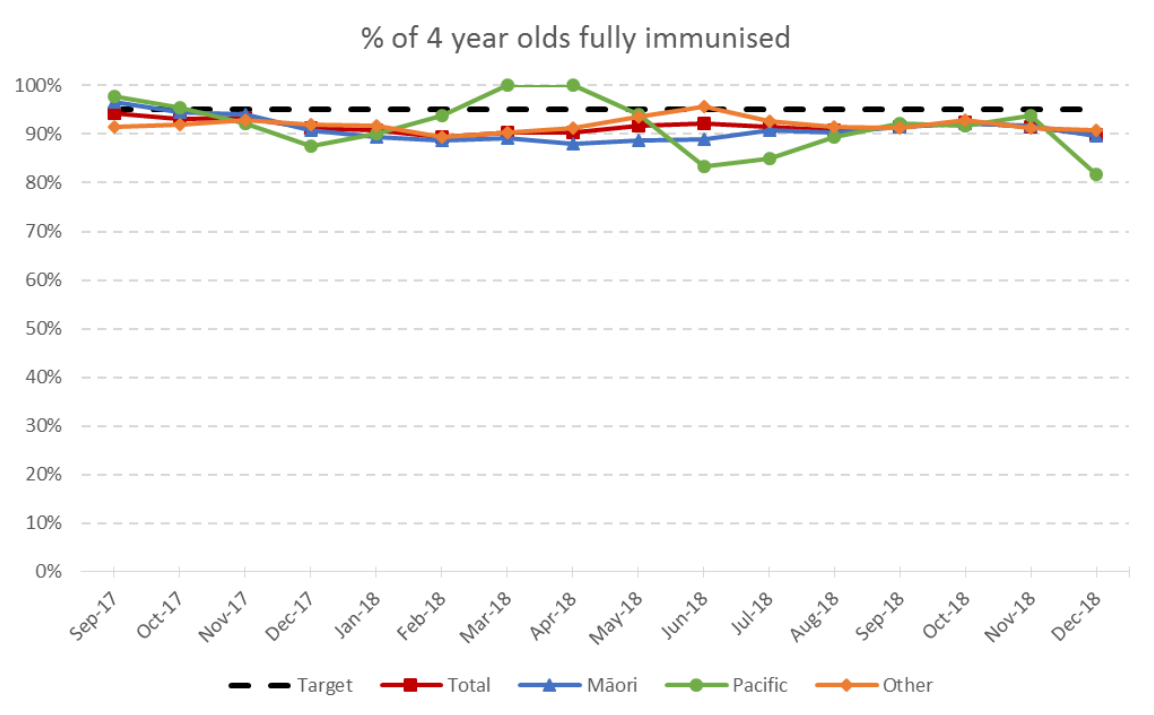


Data Source: National Immunisation Register

Comments:
We have good systems in place to track and trace children and there is resource going into maternal immunisation, antenatal education and educating immunisation stakeholders, we do have outreach, and a drop in clinic to provide options for whanau. Outreach continues to work at capacity and struggles with access to some whanau and the complexity within the community - housing, attitude to immunisation, health literacy all factors that are having an impact.

16 October to December 2017 . Source: National Immunisation Register, MOH
17 July to September 2018. Source: National Immunisation Register, MOH
18 October to December 2018. Source: National Immunisation Register, MOH

Increase Immunisation – 4 Years % of 4 year olds fully immunised					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2018/19	Trend direction
Total	94.0%	91.4% (U)	89.9% (U)	≥95%	▼
Māori	93.0%	91.5% (U)	89.7% (U)	≥95%	▼
Pacific	96.0%	92.1% (U)	81.8% (U)	≥95%	▼
Other	86.0%	91.3% (U)	90.8% (U)	≥95%	▼

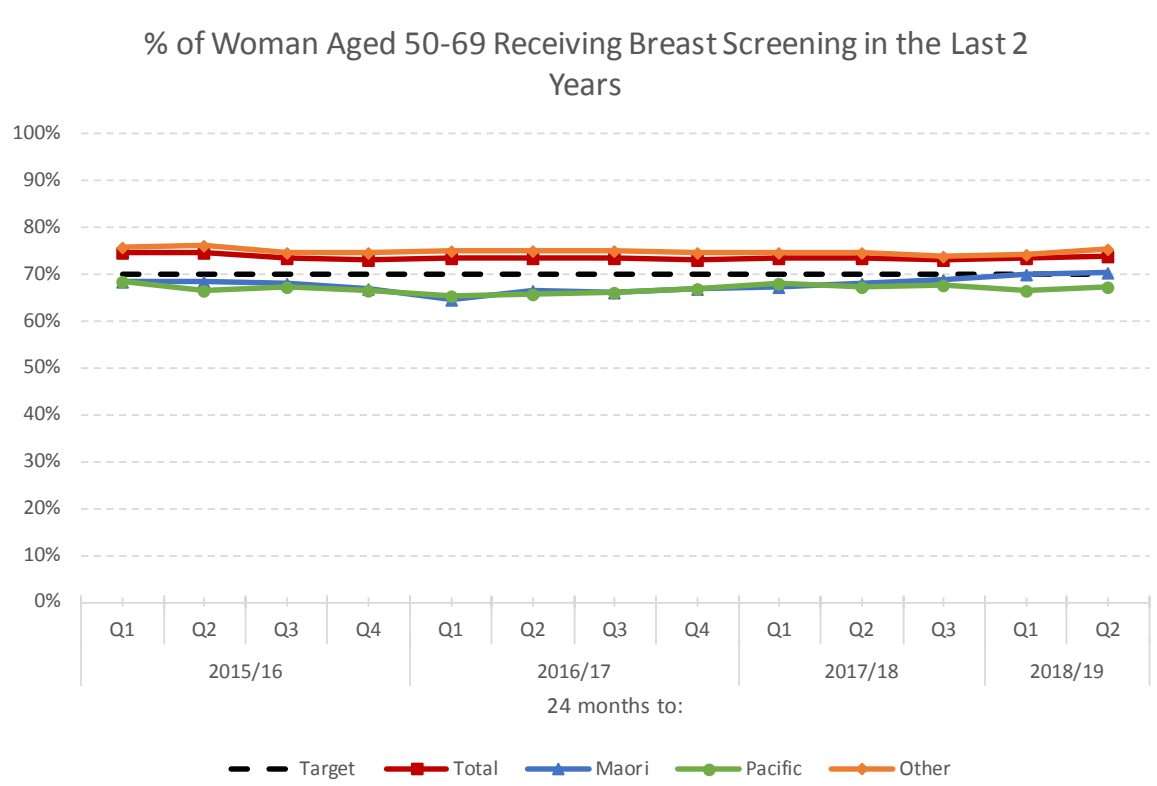


Data Source: National Immunisation Register

Comments:
HBDHB have good systems in place to track and trace children and there is resource going into maternal immunisation, antenatal education and educating immunisation stakeholders, we do have outreach, and a drop in clinic to provide options for whanau. Outreach continues to work at capacity and struggles with access to some whanau and the complexity within the community - housing, attitude to immunisation, health literacy all factors that are having an impact.

19 October to December 2017 . Source: National Immunisation Register, MOH
20 July to September 2018. Source: National Immunisation Register, MOH
21 October to December 2018. Source: National Immunisation Register, MOH

Improve breast screening rates % of women aged 50-69 years receiving breast screening in the last 2 years					
Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2018/19	Trend direction
Total	73.6%	73.4% (F)	73.7% (F)	≥70%	▲
Māori	68.0%	70% (F)	70.4% (F)	≥70%	▲
Pacific	67.5%	66.4% (U)	67.2% (U)	≥70%	▲
Other	74.8%	74.1% (F)	75.5% (F)	≥70%	▲



Data Source: BreastScreen Aotearoa

Comments:

All Māori and Pacific women identified as unenrolled on the BSA from the following General Practice lists: Totara Health–Nelson Street Flaxmere, Heretaunga Hauora, The Doctors-Hastings and Gascoigne and Hastings Health Centre received a letter advising them if they had a mammogram either at the Flaxmere Mobile and or fixed site in September and October they would receive a $20 Grocery koha on confirmation of having their mammogram. Through the month of November and December our Pacific Community Support Worker has been contacting the Pacifica women on the Totara Health list encouraging them to have a mammogram, many of the Pacifica women will require a visit as we have not been able to contact them via phone. When booking women for a cervical smear in the Community if they are 45 and over we will check their breast screening status. Three Pacific women had their first mammogram in quarter 2 and received a $20 grocery koha. We still have the DNA process in place for Māori and Pacific women who DNA their mammogram appointment. Unfortunately we have not been receiving the DNA's on a regular pattern as agreed with BSCC, despite a number of requests. We will be monitoring them in Q3 and will follow up if none are received. We are in progress to obtain access to the BSCC Register this will help us to identify women quicker and we will also provide the information to the Support to Service providers

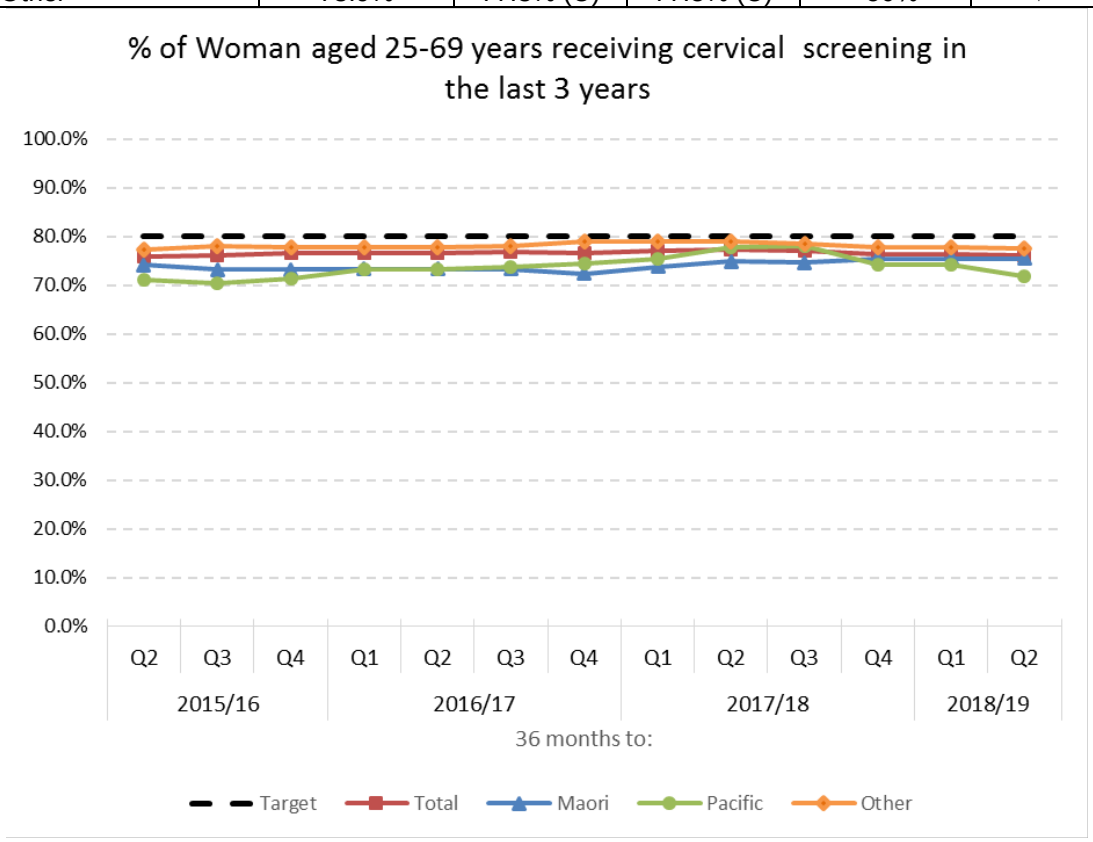
22 24 months to December 2017. Source: BreastScreen Aotearoa

23 24 months to March 2018. Source: BreastScreen Aotearoa

24 24 months to September 2018. Source: BreastScreen Aotearoa

Improve cervical screening rates
% of women aged 25–69 years who have had a cervical screening event in the past 36 months

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2018/19	Trend direction
Total	77.4%	76.3% (U)	76% (U)	≥80%	▼
Māori	74.9%	75.5% (U)	75.5% (U)	≥80%	▬
Pacific	77.7%	74.1% (U)	71.9% (U)	≥80%	▼
Other	78.9%	77.8% (U)	77.5% (U)	≥80%	▼



Data Source: National Cervical Screening Programme

Comments:
The focus has continued on improving coverage for Māori, It has been challenging due to transience with contact details constantly changing and many women having multiple personal problems and challenges in their lives that cervical screening is not a priority. Obtained data from the following practices in Q1 to identify unscreened and under screened Māori and Pacific women. HBDHB are planning to send letters on behalf of the practices inviting the women to have a free smear and receive a $20 grocery koha, Support services were also offered with information given on the nearest Independent Service Provider and the practices' opening hours In a separate panui. (The Doctors-Hastings, Hauora Heretaunga, Totara Health, Maraenui Medical Centre, The Doctors-Napier, Hastings Health Centre). We have identified 919 Māori & 189 Pacific women unscreened, 770 Māori & 88 Pacific women under screened and 1194 Māori and Pacific women overdue < less than 5years. In Q4 data matching will be repeated to evaluate the uptake. The HBDHB Population Screening team has been contacting women identified on the following lists offering a smear at the DHB clinic or in the community: Maraenui Medical, Totara Health and The Doctors – Napier lists. We commenced late in Q2 visiting and arranging visits to general practices to discuss management and updating of the CX Karo reports, recalling women at an earlier interval i.e. commence recalls at 32 months, discussing support to services and referral pathway, and obtaining agreement to on-refer

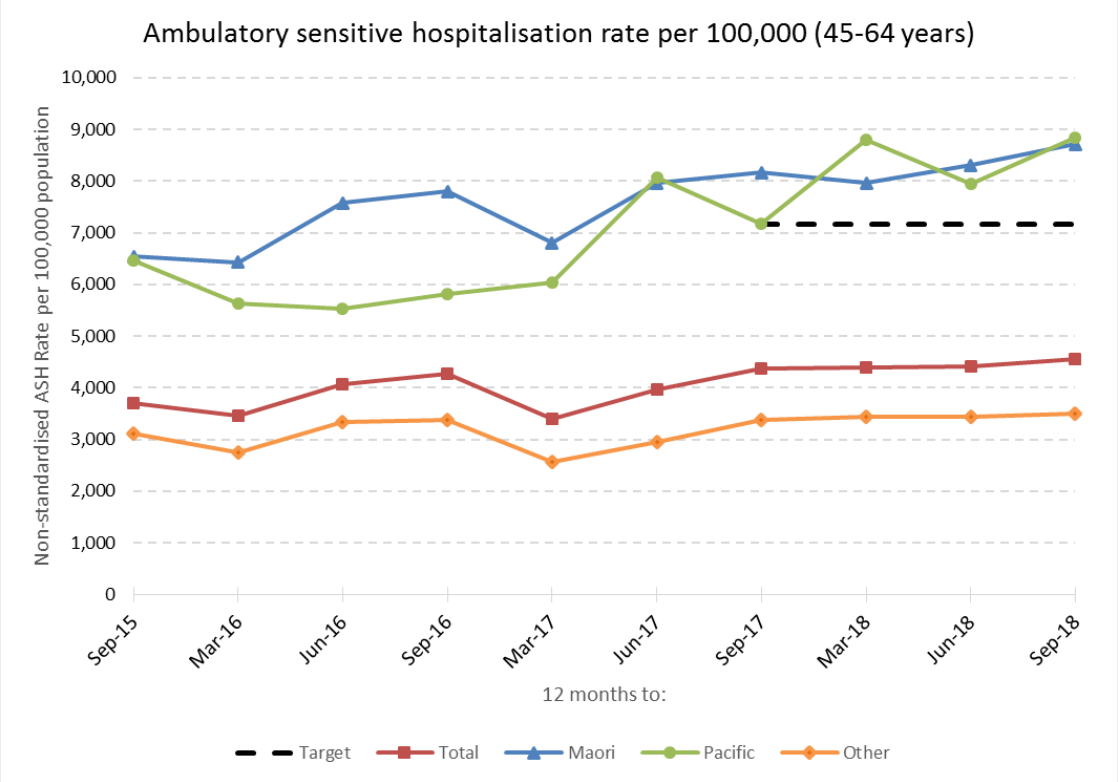
25 26 months to December 2017 Source: National Cervical Screening Programme
26 36 months to June 2018 Source: National Cervical Screening Programme
27 36 months to September 2018. Source: National Cervical Screening Programme

priority women to support to service providers. HBDHB Continue to try to connecting with midwives to discuss a referral pathway. Progress has been slow and in this Quarter further discussions were hampered by the midwives strike planning. Independent Service Provider Choices has access to the NCSP-Register which will assist their outreach and clinic work. Te Taiwhenua o Heretaunga are still working with the Register Central Team to obtain access. Cervical Screening T-shirt's have been purchased for general practice staff to wear to promote screening, the T-shirts will be distributed in Q3. HBDHB Population Screening attended a Pasifika playgroup for Samoan women and their babies, eight mothers were present and consented to being followed up. There is continued focus on Pacific women who are overdue for a cervical smear, and when possible working with the HBDHB Pacific Team if language is a barrier. Hawke's Bay has only one Asian sample taker and we are looking to increase the workforce for this group. Cost is a barrier for some European/Other women to have a smear. . It is anticipated that screening coverage will increase due to the reduction in cost to see a GP if the women hold a Community Services Card.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Reduce ASH 45-64
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years

Key Performance Measure	Baseline[28]	Previous result [29]	Actual to Date [30]	Target 2018/19	Trend direction
45-64 years: Total	4,370	4,414 (F)	4,564 (F)	-	▼
45-64 years: Māori	8,092	8,302 (U)	8,710 (U)	≤7,159	▼



Source: Ministry of Health

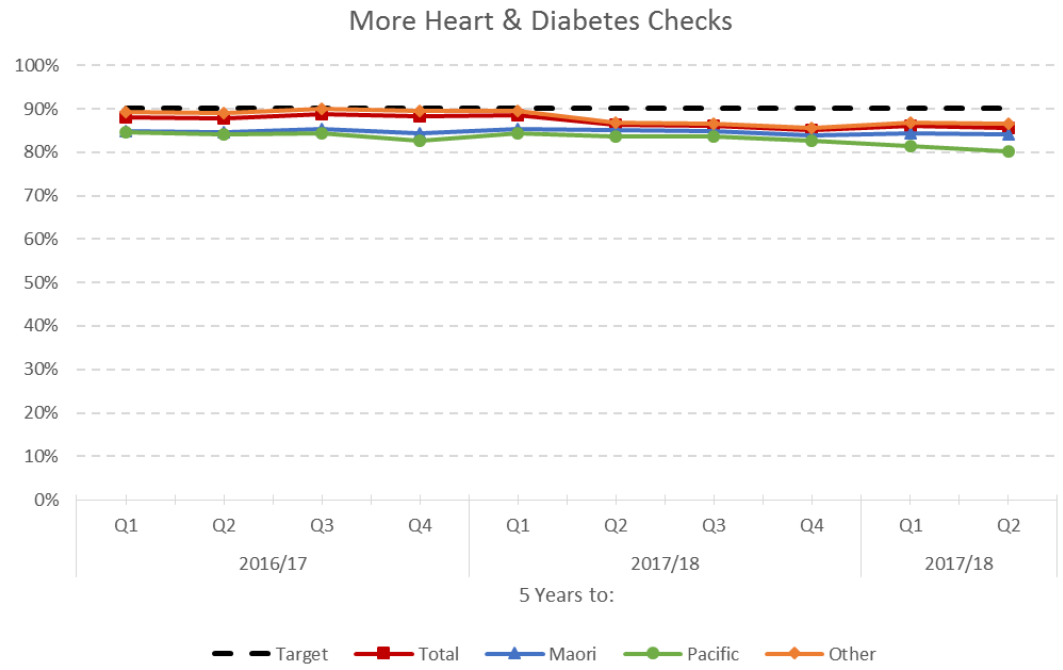
Comments:
ASH rates for Māori and Pasifika remain the focus of the DHB will all activities within the SLM Improvement plan focused on these population groups. All activities are on track. COPD and Cardiac remain areas of concern. A working group has been formed focusing on top 5 LTC - addressing readmission rates from a collective approach across all disciplines identifying common actions to improve coordination of care and transitions of care.

28 12 months to September 2017
29 12 months to March 2018
30 12 months to September 2018

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)

% of the eligible population will have had a CVD risk assessment in the last 5 years

Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 2018/19	Trend direction
Total	86.3%	86.1% (U)	86% (U)	≥90%	▼
Māori	85.0%	84.3% (U)	84% (U)	≥90%	▼
Pacific	83.6%	81.5% (U)	80% (U)	≥90%	▼
Other	86.7%	86.8% (U)	87% (U)	≥90%	▲



Source: Ministry of Health

Comments:

HHB (Health Hawke's Bay) has budgeted $40.00 for completion of each CVDRA to general practice for this younger cohort, the assessment is free to the patient. Assessments can be prearranged or opportunistic when presenting for care. HHB would use the Karo management report to identify each assessment on a monthly basis and recompense general practice accordingly through a "buyer created tax invoice". In addition HHB will pay general practice 40% of their SLM Performance Payment to achieve the 90% coverage for the younger cohort by 30 June 2019. Using the monthly Karo CVDRA management report HHB will fund an independent nurse to review the overdue files from the total population, where all the components required for an assessment are recorded within the past 12 months a non-face-to-face CVDRA will be completed. HHB plan to work in partnership with Hawke's Bay businesses with high numbers of younger Māori, Pacific and Asian employees. Businesses could be contacted and eligible staff offered CVDRA free of charge. HHB are also working with Local Communities, planning to liaise with local initiatives and groups such as "Patu Gym" & "MAC Rugby Club" to raise awareness of the free CVDRA for the younger cohort. Health Hawke's Bay have three POC testing units, which can be used at community events and loaned out to practices.

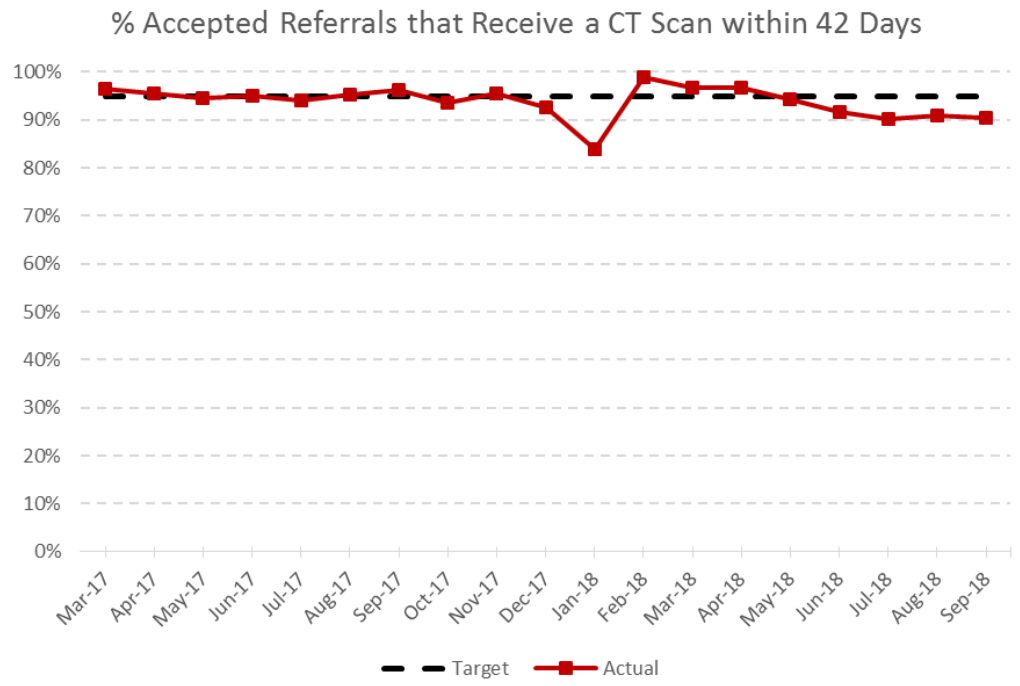
31 5 years to December 2017. Source: Ministry of Health

32 5 years to June 2017. Source: Ministry of Health

33 5 years to September 2017 . Source: Ministry of Health

Less waiting for diagnostic services
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)

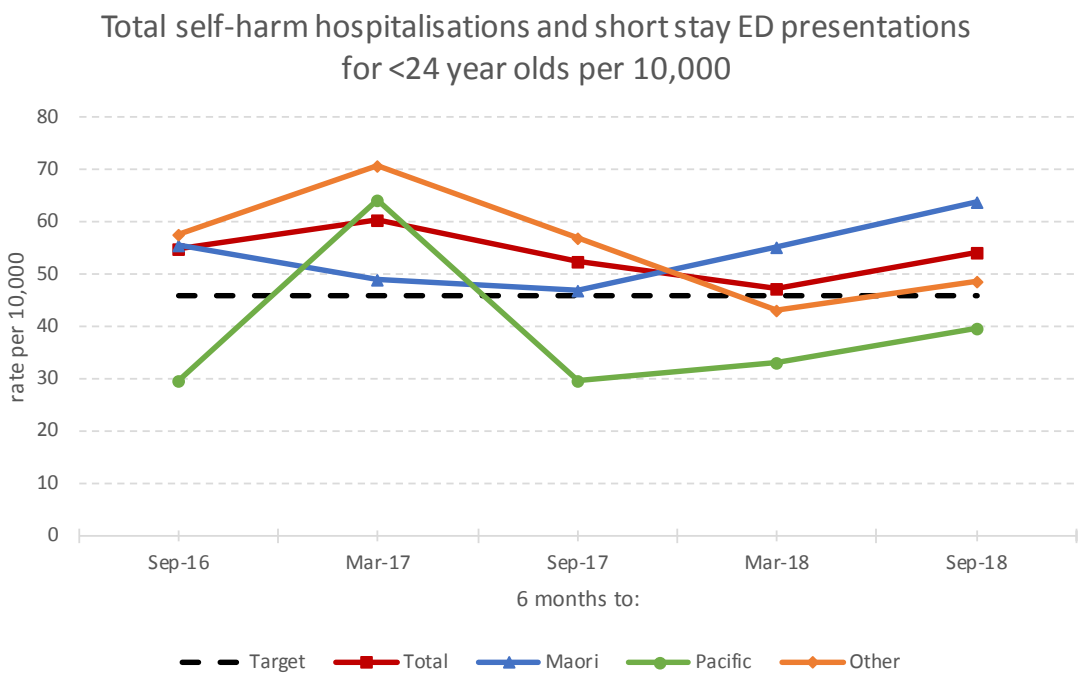
Key Performance Measures	Baseline [34]	Previous result [35]	Actual to Date [36]	Target 2018/19	Trend direction
Total	92.5%	91% (U)	92% (U)	≥95%	▲



Comments:
Results were delayed from the Ministry. Comments will be added for CT for the board.

34 December 2017. Source: Ministry of Health
35 September 2018. Source: Ministry of Health
36 December 2018 . Source: Ministry of Health

Improved youth access to health services - SLM Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000					
Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 2018/19	Trend direction
Total	47.3	47.3 (U)	54.3 (U)	≤45.8	▼
Māori	55.2	55.2 (U)	63.9 (U)	≤45.8	▼
Pacific	33	33 (F)	39.8 (F)	≤45.8	▼
Other	43.1	43.1 (F)	48.7 (U)	≤45.8	▼



Data source: Ministry of Health

Comments:
Reported through SLM Report

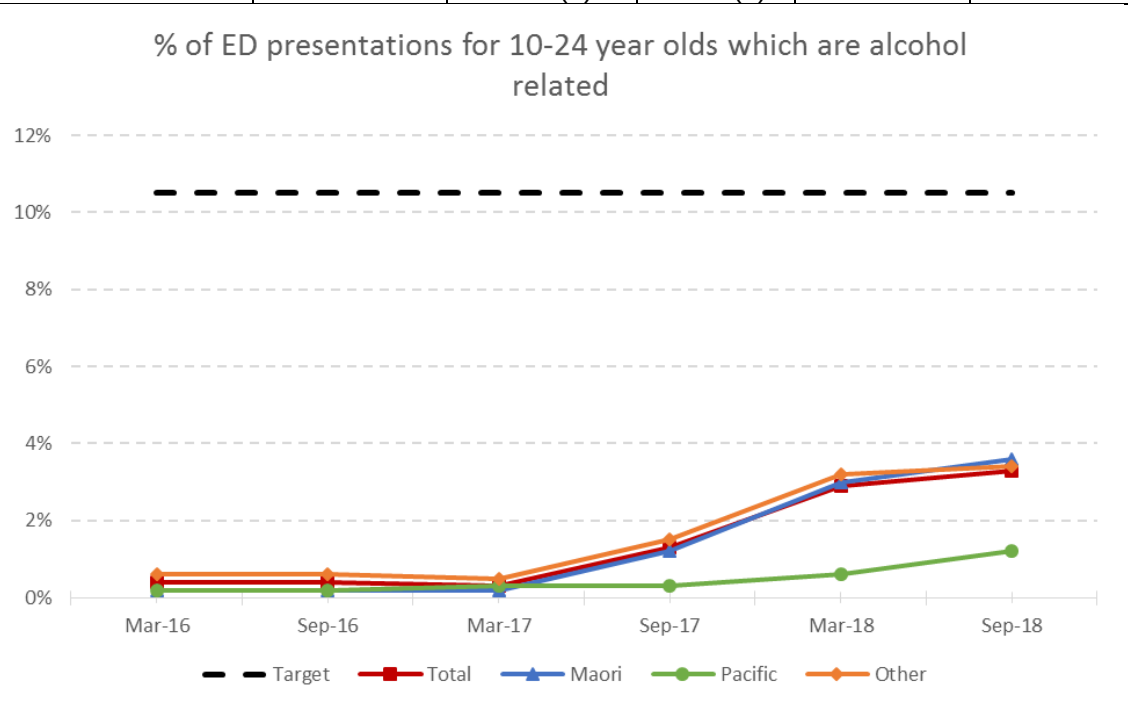
37 6 months to March 2018. Source: Ministry of Health

38 6 months to March 2018. Source: Ministry of Health

39 6 months to September 2018. Source: Ministry of Health

Improved youth access to health services - SLM
% of ED presentations for 10-24 year olds which are alcohol related

Key Performance Measures	Baseline [40]	Previous result [41]	Actual to Date [42]	Target 2018/19	Trend direction
Total	10.5%	2.9% (F)	3.3% (F)	≤10.5%	▼
Māori	11.0%	3.0% (F)	3.6% (F)	≤10.5%	▼
Pacific	7.0%	0.6% (F)	1.2% (F)	≤10.5%	▼
Other	11.0%	3.2% (F)	3.4% (F)	≤10.5%	▼



Data source: Ministry of Health

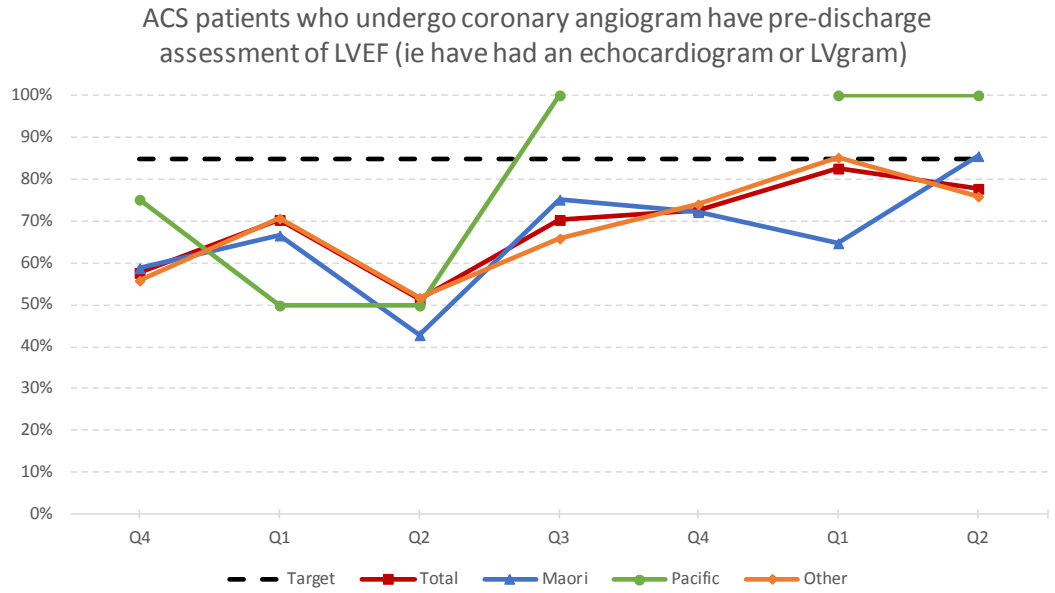
Comments:
Reported through SLM Report

40 6 months to March 2018. Source: Ministry of Health
41 6 months to September 2017. Source: Ministry of Health
42 6 months to March 2018. Source: Ministry of Health

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Patients with ACS receive seamless, coordinated care across the clinical pathway
ACS Left Ventricular Dysfunction (LVEF) assessments >85% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF.

Key Performance Measures	Baseline [43]	Previous result [44]	Actual to Date [45]	Target 2018/19	Trend direction
Total	51.3%	82.1% (U)	77.8% (U)	≥85%	▼
Māori	42.9%	64.7% (U)	85.7% (F)	≥85%	▲
Pacific	50.0%	100% (F)	100% (F)	≥85%	▬
Other	51.6%	85.3% (F)	75.8% (U)	≥85%	▼



Source: ANZACS QI

**Gaps in the chart indicate no Patients of that ethnicity were treated in that quarter*

Comments:
As a new indicator it has taken a period of time to assess our practise now that it is measured. The DHB recognise that we were underperforming in this area, and have addressed this in the last few months and expect the data to reflect this next quarter.

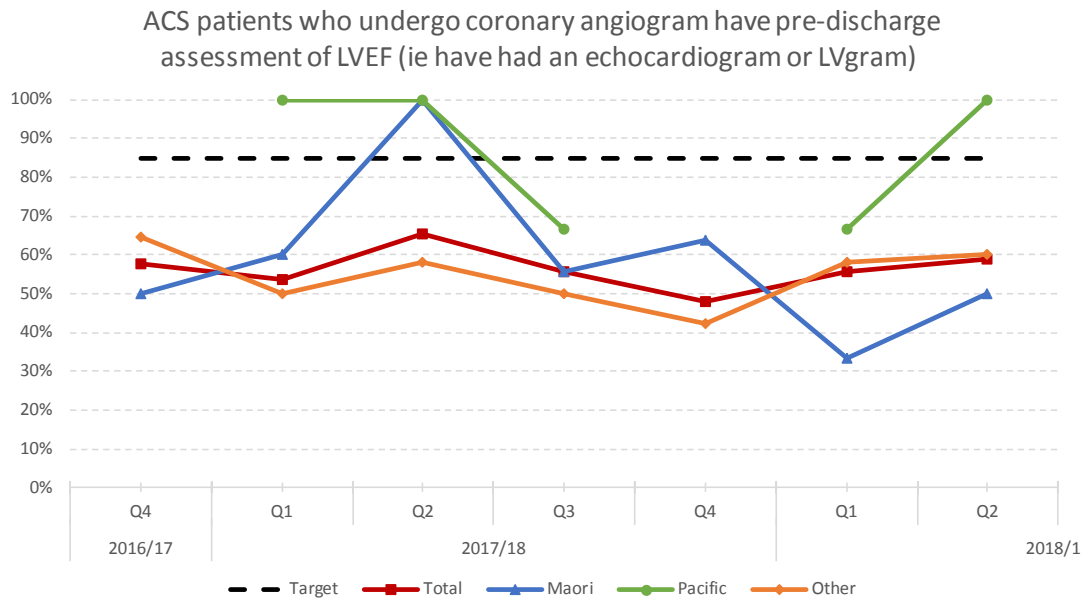
43 September to November 2017. Source: Ministry of Health

44 June to August 2018. Source: Ministry of Health

45 September to November 2018 Source: Ministry of Health

Patients with ACS receive seamless, coordinated care across the clinical pathway
Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)

Key Performance Measures	Baseline [46]	Previous result [47]	Actual to Date [48]	Target 2018/19	Trend direction
Total	55.6%	55.6% (U)	58.8% (U)	85%	▲
Māori	33.3%	33.3% (U)	50.0% (U)	85%	▲
Pacific	66.7%	66.7% (U)	100.0% (F)	85%	▲
Other	58.0%	58.0% (U)	60.0% (U)	85%	▲



Source: ANZACS QI

Comments:
Variance to practice in this area is around use of ACEi/ARB meds. These are prescribed in accordance with guidelines on a case by case basis (per clinical lead cardiologist and TAS meetings).

46 September to November 2017. Source: Ministry of Health
47 June to August 2018. Source: Ministry of Health
48 September to November 2018 Source: Ministry of Health

Equitable access to care for stroke patients ***% of potentially eligible stroke patients who are thrombolysed 24/7***					
Key Performance Measures	Baseline [49]	Previous result [50]	Actual to Date [51]	Target 2018/19	Trend direction
Total	5.9%	20% (F)	7.4% (U)	≥10%	▼
Māori	5.8%	11% (F)	5.8% (U)	≥10%	▼
Source: HBDHB					
Comments: This indicator is like to fluctuate from quarter to quarter due to the small number involved. HBDHB were close to achieving target this quarter and are satisfied that all clinically eligible patients were treated.					

Equitable access to care for stroke patients ***% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway***					
Key Performance Measures	Baseline [52]	Previous result [53]	Actual to Date [54]	Target 2018/19	Trend direction
Total	90.0%	83% (F)	75.6% (U)	≥80%	▼
Māori	90.0%	75% (U)	83.3% (F)	≥80%	▲
Source: HBDHB					
Comments: HBDHB were only 2 patients short of meeting target, there were a few more existing inpatients having strokes this quarter and it was clinically appropriate that they remained in their existing ward (e.g. cardiac), we are developing a new pathway to ensure all patients join the stroke pathway when clinically appropriate.					

49 October to December 2017. Source: Ministry of Health

50 April to June 2018. Source: Ministry of Health

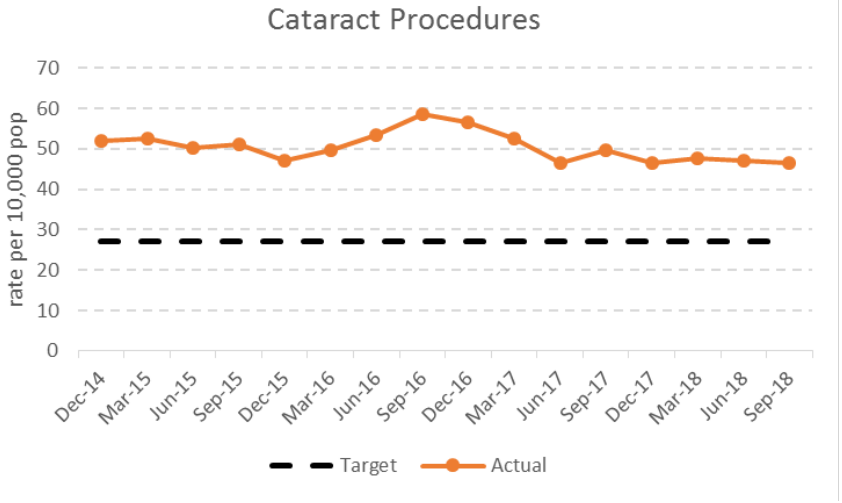
51 July to September 2018. Source: Ministry of Health

52 October to December 2017. Source: Ministry of Health

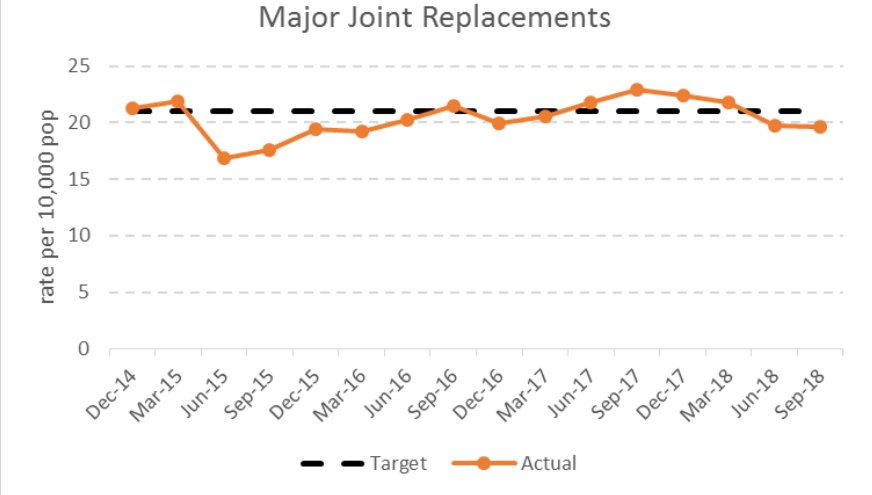
53 April to June 2018. Source: Ministry of Health

54 July to September 2018. Source: Ministry of Health

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline[55]	Previous result[56]	Actual to Date [57]	Target 2018/19	Trend direction
Major joint replacement	22.4	19.77 (U)	19.59 (U)	≥21	▼
Cataract procedures	46.6	47.04 (F)	46.45 (F)	≥27	▼
Cardiac procedures	4.8	5.32 (U)	5.27 (U)	≥6.5	▼
Percutaneous revascularization	11.9	12.67 (F)	13.2 (F)	≥12.5	▲
Coronary angiography services	36.4	38.09 (F)	39.55 (F)	≥34.7	▲



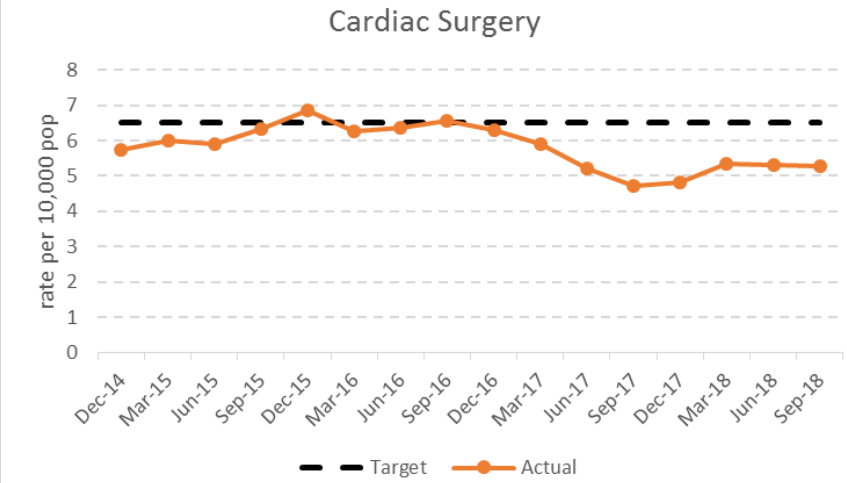
Source: Ministry of Health

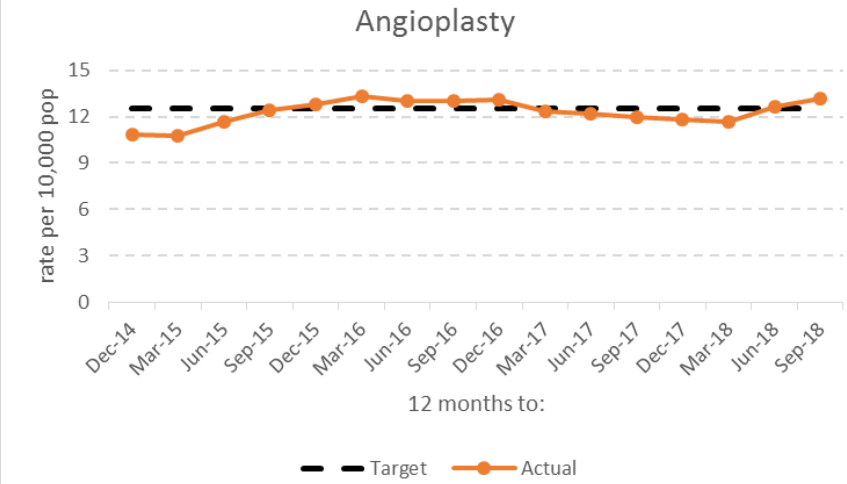


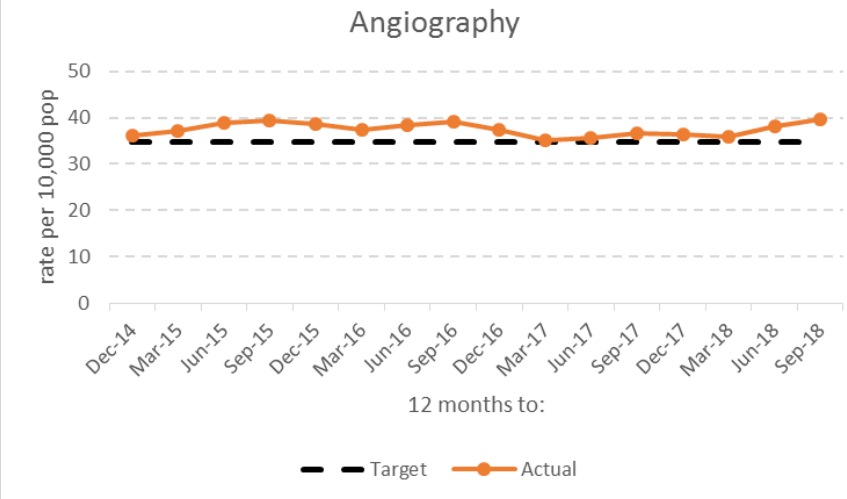
55 12 months ending December 2017. Source MoH

56 12 months ending June 2018. Source MoH

57 12 months ending September 2018. Source MoH





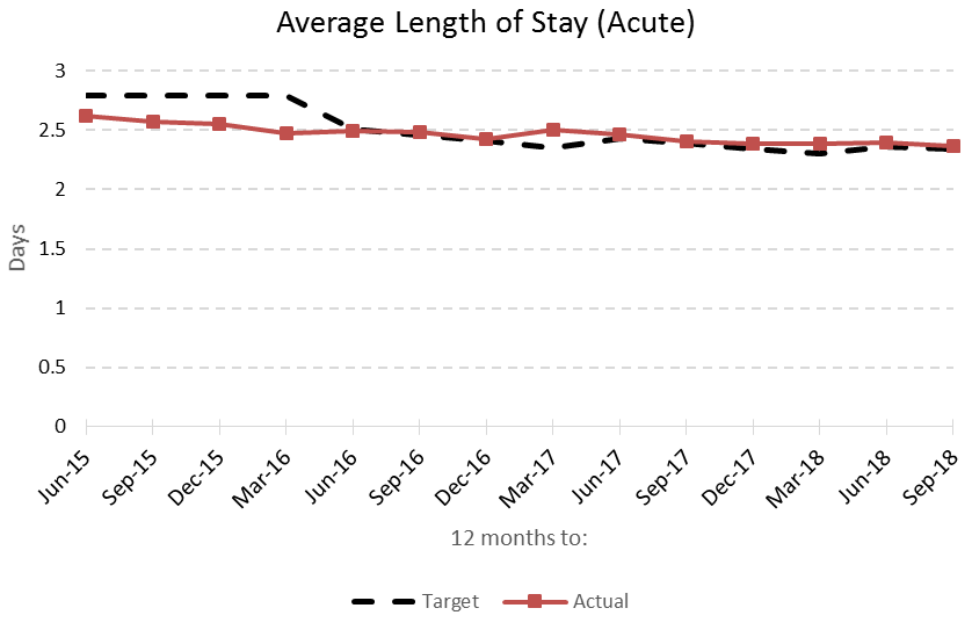


Comments:
Cardiac Surgery: The reason for the low standard intervention rates will be that we do not have enough referrals for surgery. We manage all patients referred for surgery and do not have a large waitlist, while there are at times capacity constraints at our tertiary provider, this does not impact on the standard intervention rates, the number of referrals do.

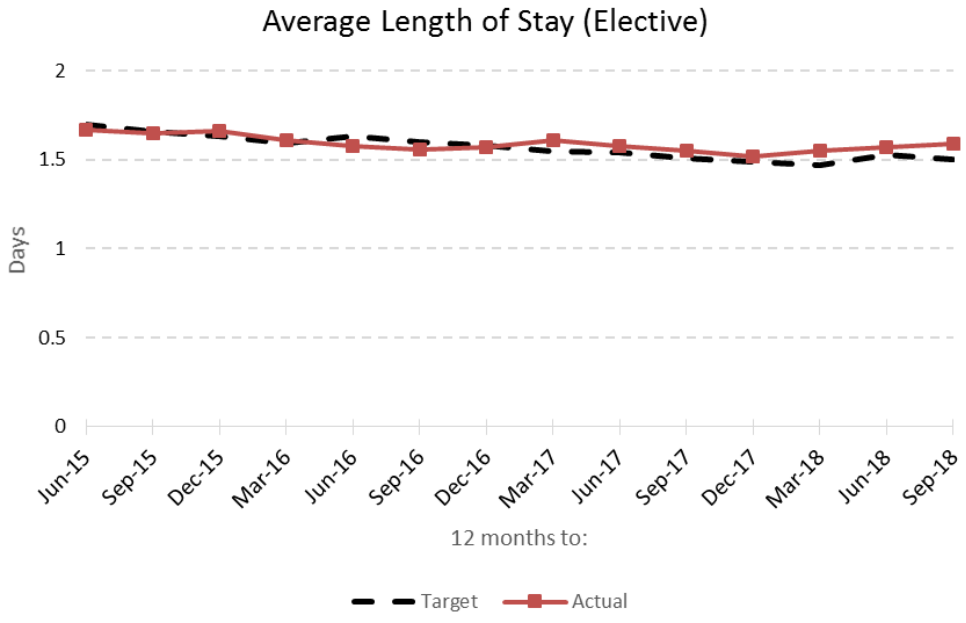
20

Shorter stays in hospital
Length of stay (days)

Key Performance Measures	Baseline [58]	Previous result [59]	Actual to Date [60]	Target 2018/19	Trend direction
Acute	2.39	2.40 (U)	2.37 (U)	≤2.3	▲
Elective	1..52	1.57 (U)	1.59 (U)	≤1.45	▼



Source: Ministry of Health



Source: Ministry of Health

Comments:

58 12 months to September 2017.Source: Ministry of Health
59 12 months to June 2018. Source: Ministry of Health
60 12 months to September 2018. Source: Ministry of Health

Orthopaedics continue to expand enhanced recovery pathway with growing success. The CNS (clinical nurse specialists) are working collaboratively with all teams to help patients through complex elective surgery. Gynaecology and Urology are attempting to move more previously overnight stay electives into day cases and also move into Outpatient procedures. Clinical Capital equipment purchase list is being reviewed for 2019/20 with a high priority assigned to new capital that will see patient having treatment in outpatients, rather than go to theatre. The Orthopaedic CNS has completed follow up visits at home/residential care to post op NOFs and joint surgery, assessment and education was given, plus links to further support services as required. We have objectives of preventing complications like constipation from opioids leading to obstructions and acute admission/ wound infections risk decreased/more mobilisation with less risk of respiratory complications. Currently services such as respiratory, cardiology, diabetes, renal, cancer and vascular, that significantly influence our bed days are working to improve two key areas Care coordination and Transition of Care. A key work stream intended to reduce the length of stay is investigating the development of evidence based COPD and Congestive Heart Failure treatment pathway to fast track patients who present with these health issues.
To utilise limited resources efficiently and improve care coordination our Business Intelligence team are developing a tableau data system to better understand the population living with chronic conditions. Furthermore, it provides an opportunity (where necessary) for the services to work in a more integrated way to improve patient outcomes.

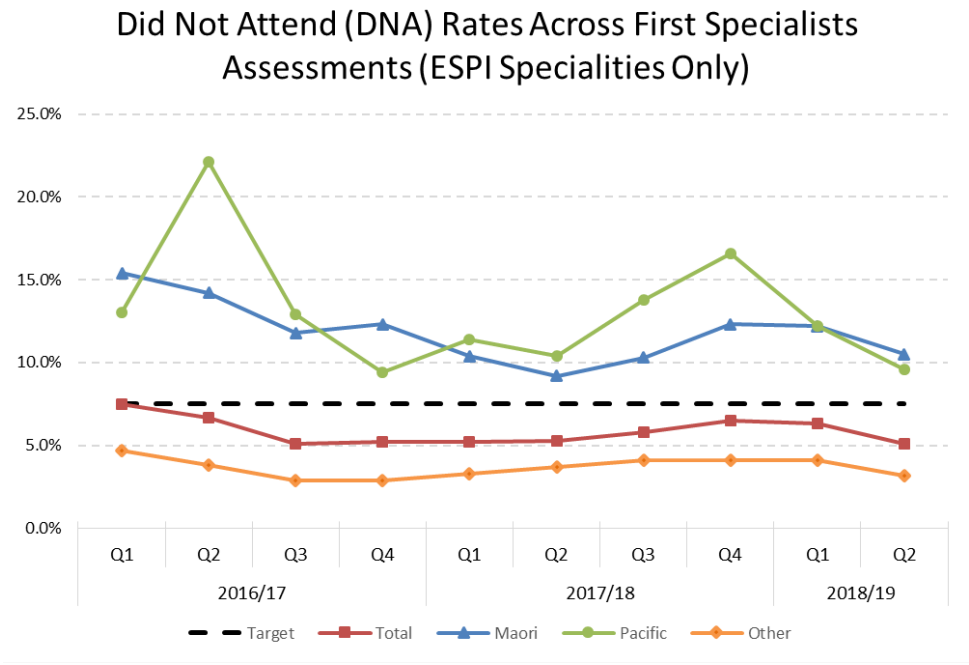
Quicker access to diagnostics					
Key Performance Measures	Baseline [61]	Previous result [62]	Actual to Date[63]	Target 2018/19	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days	87.8%	97.5% (F)	100% (F)	≥95%	▲
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	93.5%	94% (F)	95% (F)	≥90%	▲
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	59.0%	54% (U)	69% (U)	≥70%	▲
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	68.0%	60% (F)	55% (U)	≥70%	▼
Comments: Results were delayed from the Ministry. Comments will be added for non-urgent and surveillance for the board.					

61 December 2017.

62 September 2018.

63 December 2018.

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [64]	Previous result [65]	Actual to Date [66]	Target 2018/19	Trend direction
Total	5.3%	6.3% (F)	5.1% (F)	≤7.5%	▲
Māori	9.2%	12.2% (U)	10.5% (U)	≤7.5%	▲
Pacific	10.4%	12.2% (U)	9.6% (U)	≤7.5%	▲
Other	3.7%	4.1% (F)	3.2% (F)	≤7.5%	▲



Source: HBDHB

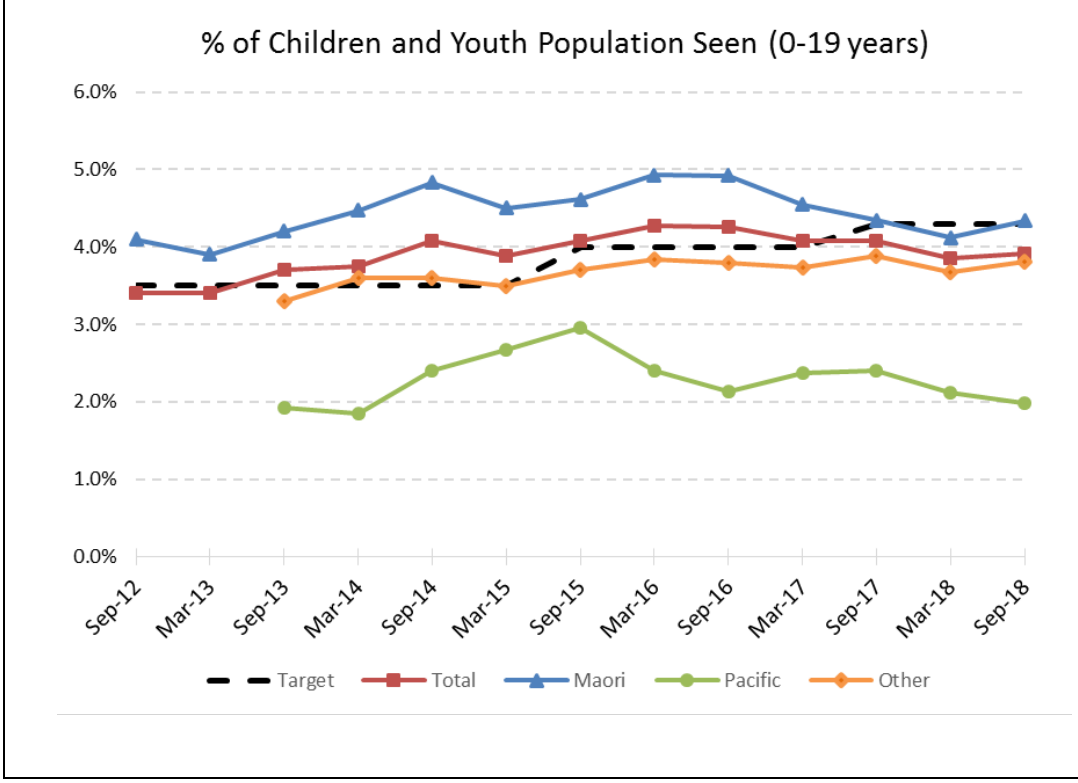
Comments:
Quarter 2 reflects a stable and consistent period across Outpatient clinics. The total DNA rate is well below the target of 7.5%, with monthly overall attendance rates for FSA of around 95% for Q2. It must be noted that overall volumes of patients requested to attend FSA in December was extremely light compared with other months which helped to keep DNA in check. FSA attendance for December was 1,174 patients compared with 1,650 for November and 1747 in October. Despite the fact that overall HBDHB are tracking a positive trend in FSA attendance across all ethnicities, unfortunately inequity continues to be reflected in our FSA attendance statistics. Maori DNA as a percentage continues to track at twice that of 'Other Population', with Pacific continuing to track as a percentage at 3 times more likely to DNA than 'Other population'. The two specialties that show the greatest barriers for our Maori and Pacific population to attend FSA appointments are in Paediatrics and Dental. Administration Services will resume meetings with Pacific Navigators, and Kaitakawaenga in Q3, to focus on these two specialties to understand what the real barriers are that are preventing Pacific and Maori attendance.

64 October to December 2017. Source: Ministry of Health
65 July to September 2018. Source: Ministry of Health
66 October to December 2018 . Source: Ministry of Health

Better mental health services, Improving access, Better access to mental health and addiction services

Proportion of the population seen by mental health and addiction services

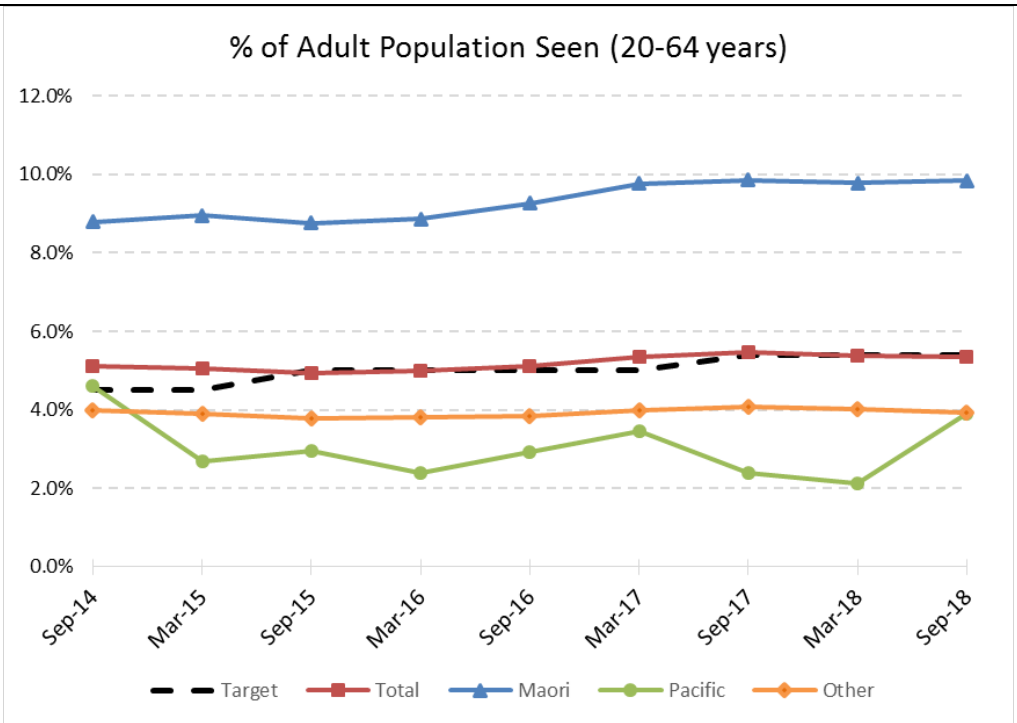
Key Performance Measures	Baseline [67]	Previous result [68]	Actual to Date [69]	Target 2018/19	Trend direction
Child & youth (0-19)					
Total	4.1%	3.86% (F)	3.92% (F)	≥4.3%	▲
Māori	4.3%	4.12% (F)	4.34% (F)	≥4.3%	▲
Pacific	2.4%	2.12% (U)	1.99% (U)	≥4.3%	▼
Other	3.9%	3.67% (U)	3.81% (F)	≥4.3%	▲
Adult (20-64)					
Total	5.5%	5.39% (F)	5.34% (F)	≥5.4%	▼
Māori	9.9%	9.78% (F)	9.84% (F)	≥5.4%	▲
Pacific	2.4%	2.12% (U)	3.91% (U)	≥5.4%	▲
Other	4.1%	4.02% (U)	3.93% (U)	≥5.4%	▼
Older adult (65+)					
Total	1.1%	1.12% (F)	1.05% (F)	≥1.15%	▼
Māori	1.3%	1.33% (F)	1.47% (F)	≥1.15%	▲
Pacific	0.7%	0.59% (U)	0.86% (F)	≥1.15%	▲
Other	1.1%	1.1% (F)	1.01% (F)	≥1.15%	▼

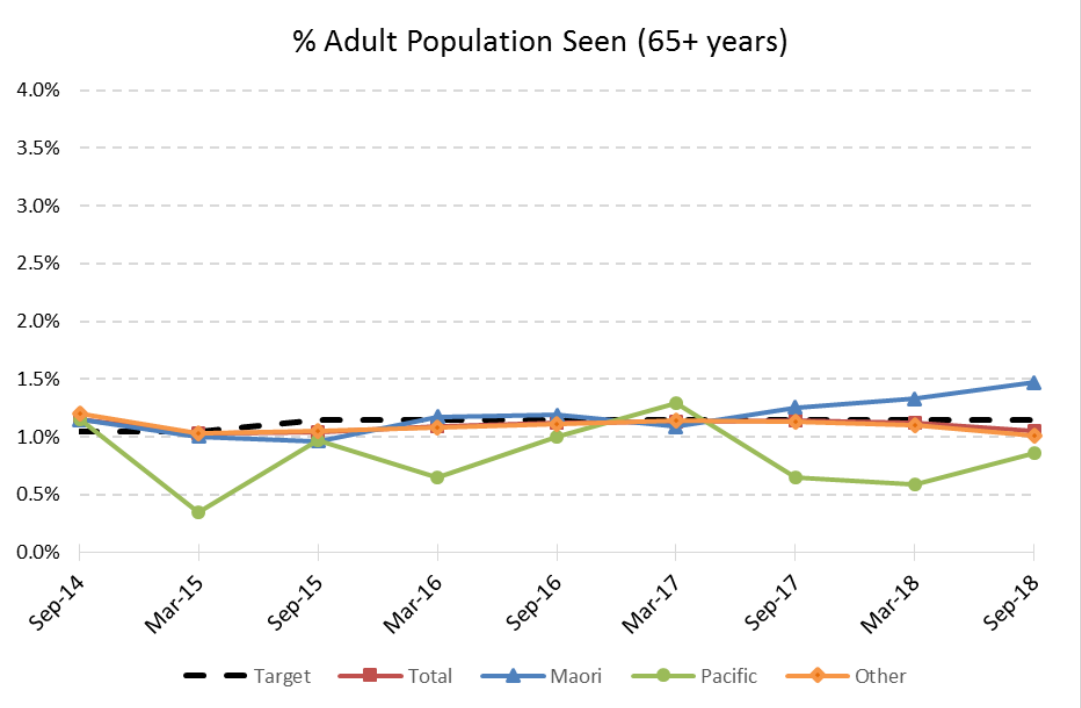


67 12 months to September 2017

68 12 months to March 2018

69 12 months to September 2018

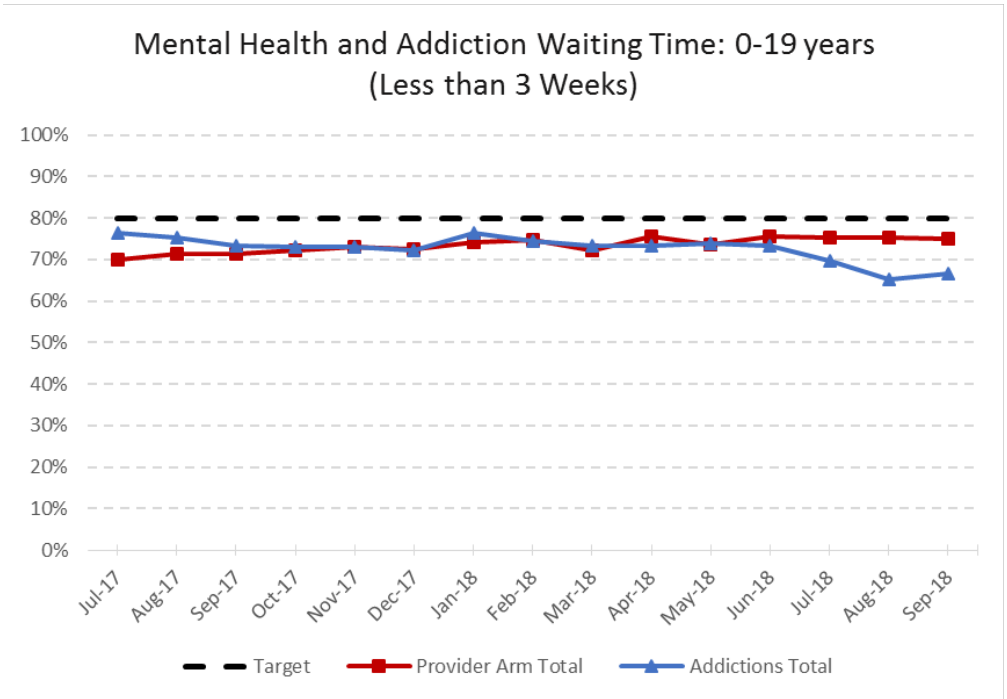




Comments:
HBDHB total variance from the target is 9.1%. This is fairly consistent with our previous access figures. Reasons for this may be due to the following: HBDHB have continued to run therapy groups with NGOs and supporting community organisations to be able to run groups on their own. This may have impacted on our access rates as more clients may have been seen by PHOs & NGOs and not referred to secondary services (CAFS). We improved our relationship with Child Development Unit (CDU), this includes a new pathway for joint referrals and a new pathway for ADHD management, and this may have reduced the number of referrals coming to CAFS specifically those for ADHD assessments. We revived our joint consultation MDTs with NGOs (e.g. Directions and Birthright). Collaboration with these organisations may have

reduced the number of clients referred to CAFS. We had several vacant positions which severely impacted on our capacity to see clients, we are working hard to recruit into these positions. We are putting strategies in place to improve engagement including putting measures in place to work more collaboratively with the Pacific team to increase access for pacific clients. Also we are refining our Māori cultural pathway to improve our access for Māori clients. Currently, for Māori clients we involve Kaitakawaenga to ensure that the families engage with CAFS. We are working on system that will make it easier to provide cultural support for Māori clients. We encourage clinicians to call families a day before the appointment to remind them of their appointment to reduce DNAs.

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [70]	Previous result [71]	Actual to Date [72]	Target 2018/19	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks					
Total	72.5%	75.2% (U)	74.9% (U)	≥80%	▼
Māori	76.4%	80.6% (F)	79.8% (F)	≥80%	▼
Pacific	82.6%	94.4% (F)	94.4% (F)	≥80%	—
Other	70.2%	70.5% (U)	70.5% (U)	≥80%	—
<8 weeks					
Total	91.2%	92% (U)	91.6% (U)	≥95%	▼
Māori	94.1%	93.6% (U)	92.6% (U)	≥95%	▼
Pacific	91.3%	100% (F)	100% (F)	≥95%	—
Other	88.7%	90.5% (U)	90.5% (U)	≥95%	—
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks					
Total	72.1%	65.2% (U)	66.7% (U)	≥80%	▲
Māori	61.1%	60% (U)	68.9% (U)	≥80%	▲
Pacific	100.0%	100% (F)	100% (F)	≥80%	—
Other	85.7%	73.3% (U)	60% (U)	≥80%	▼
<8 weeks					
Total	95.6%	89.1% (U)	88.9% (U)	≥95%	▼
Māori	94.1%	93.6% (U)	92.6% (U)	≥95%	▼
Pacific	100.0%	100% (F)	100% (F)	≥95%	—
Other	100.0%	100% (F)	93.3% (U)	≥95%	▼

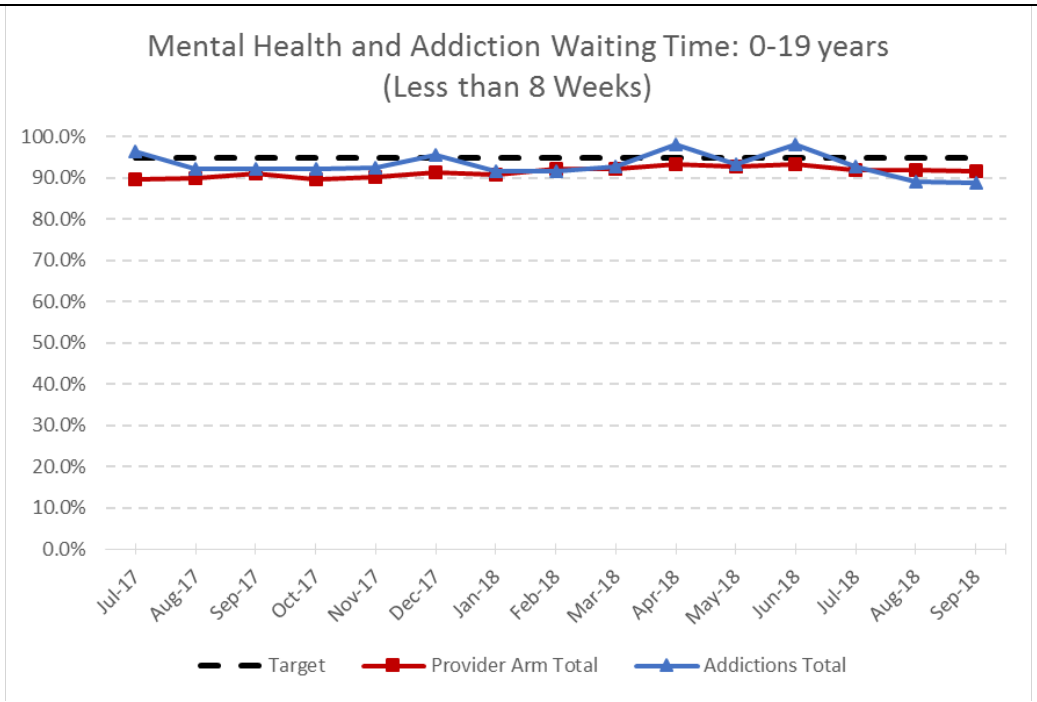


20

7012 months to December 2017

71 12 months to March 2018

72 12 months to September 2018



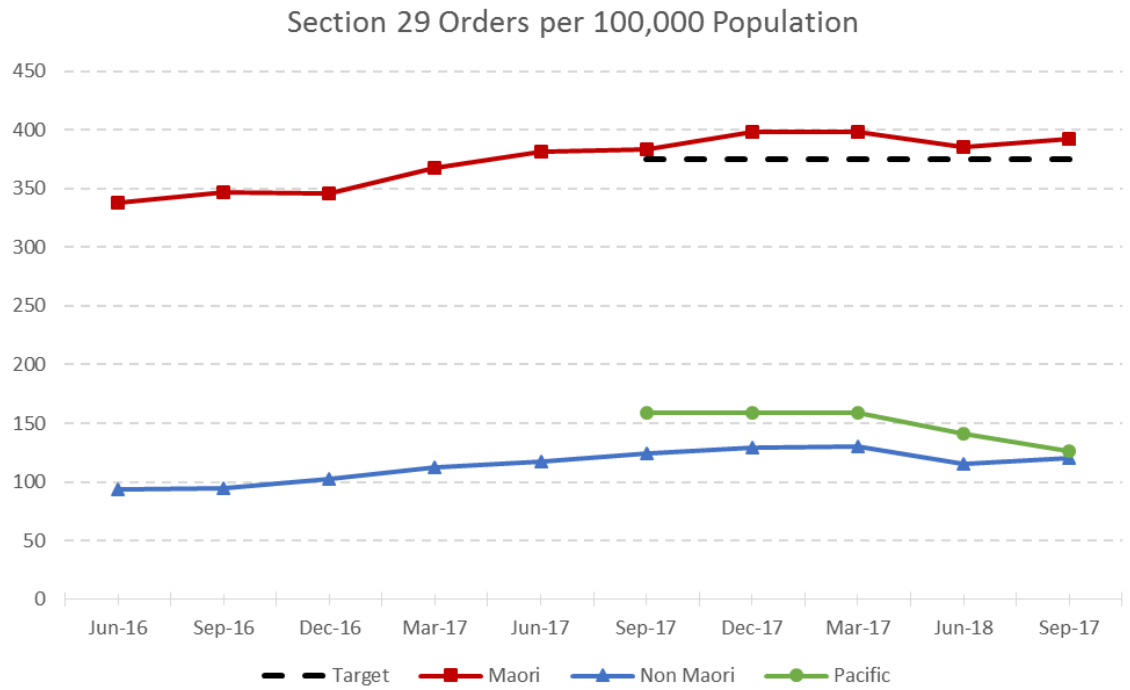
Source: Ministry of Health

Comments:
Several processes have been put in place to reduce waiting times, these include working closely with families to identify a time and location that works for them. This means that CAFS offers more options for families and accommodate their busy schedules as well e.g. the young person can be seen at school or home or at a location closer to their home. We encourage our staff to call the families to confirm appointments and remind them of their appointments a day before to ensure that they attend their appointments. We do not have a text reminder system/service and this is something that we are considering. We will be talking to our information services department about this. For Addictions the variance is more than 10% because these clients sometimes do not have fixed addresses and they are difficult to get hold of, also some of them do not have cell phones which makes it hard for CAFS to contact them. To remedy this we employed a Community Support Worker who will chase these clients. We hope this will reduce DNAs for this group of clients.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders

Rate of s29 orders per 100,000 population

Ethnicity	Baseline [73]	Previous result [74]	Actual to Date [75]	Target 2018/19	Trend direction
Māori	398	385 (U)	392 (U)	≤375	▼
Pacific	159	141 (F)	126 (F)	≤375	▲
Non- Māori	129	115 (F)	120 (F)	≤375	▼



Data Source: HBDHB

Comments:

There is a continuing high ratio of Māori to non-Māori subject to long term treatment under the provisions of the MH(CAT) Act is likely to be related to a number of factors. Disease factors; a current research paper notes that Māori have a two to threefold increased prevalence and incidence of schizophrenia, compared to the rest of the New Zealand population. The authors postulate that the increased burden of schizophrenia in Māori is a consequence of the increased consumption of high-potency cannabis over the last 40 years and the more recent increase in methamphetamine use. [Mellsop G W & Tapsell R. A hypothesis arising from the epidemiology of schizophrenia in Māori. Australian and New Zealand Journal of Psychiatry. 2019, 53(1):13-14.] Societal factors; Institutionalised racism, failure to account for long-term collective trauma in health care policy, and cultural competency as a concept that allows the dominant culture to regulate what sort of problems are recognised and what kinds of social or cultural differences are worthy of attention. [Pihama L, et al. 2017. Investigating Māori approaches to trauma informed care. Journal of Indigenous Wellbeing 2(3): 18-26.] Identify any specific performance issues and provide a high level resolution plan. I would suggest that Māori research would evidence that the DHBs current cultural competency training needs revision to enable the health workforce to make the correlation between historical events, political agendas, economics and ill health. It should include an awareness of how social conditioning has shaped the health professionals attitudes, beliefs and practice.

73 October to December 2017

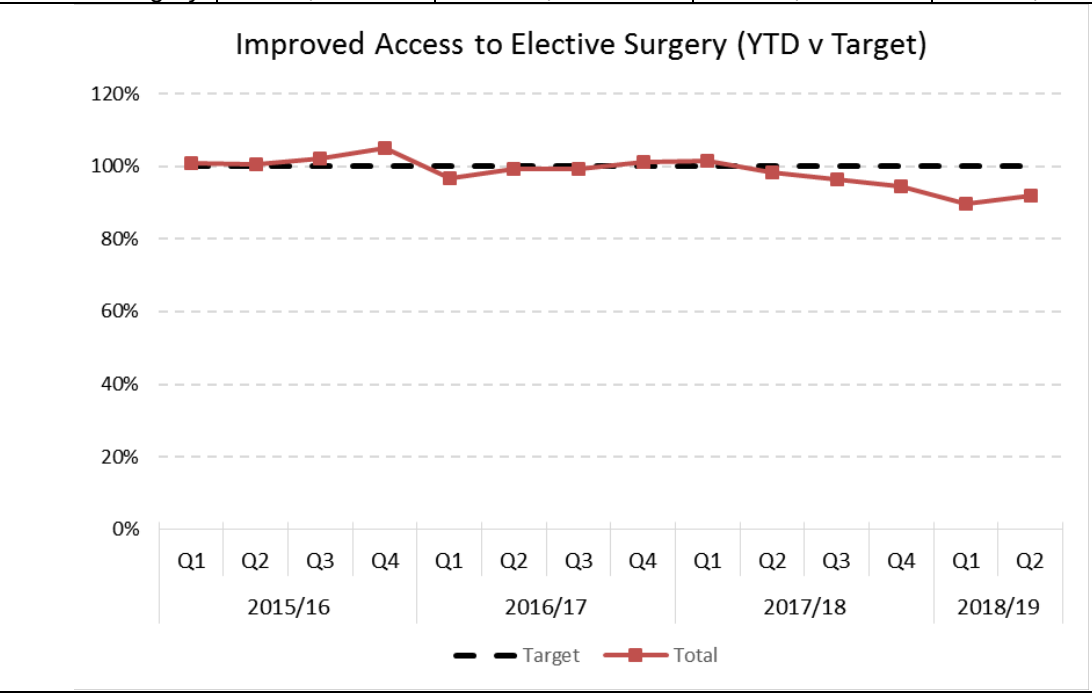
74 12 months to June 2018

75 12 months to September 2018

Specific public health and mental health provisions to address the use of high potency cannabis and methamphetamine and to provide early and clinically effective treatment of emergent psychotic illness in the local Māori population should also be given a high priority.

Health Target: Improved access to elective surgery (discharges)

	Baseline [76]	Actual to Date [77]	Period Target	Target 2018/19 [78]
Elective Surgery	7,467	3,383	3,682	7,753



Comments:
We are expecting surgical discharges gap to close as the year continues from 90% to 94% as our schemes within production plan come on line, enabling us to provide a greater range of capacity off site within Hawke's Bay. However with further strikes occurring during December and January they will put at risk elective discharges. Increase in demand from acute patients requiring surgery has increase elective cancellations.

76 2016/17 Source: Ministry of Health

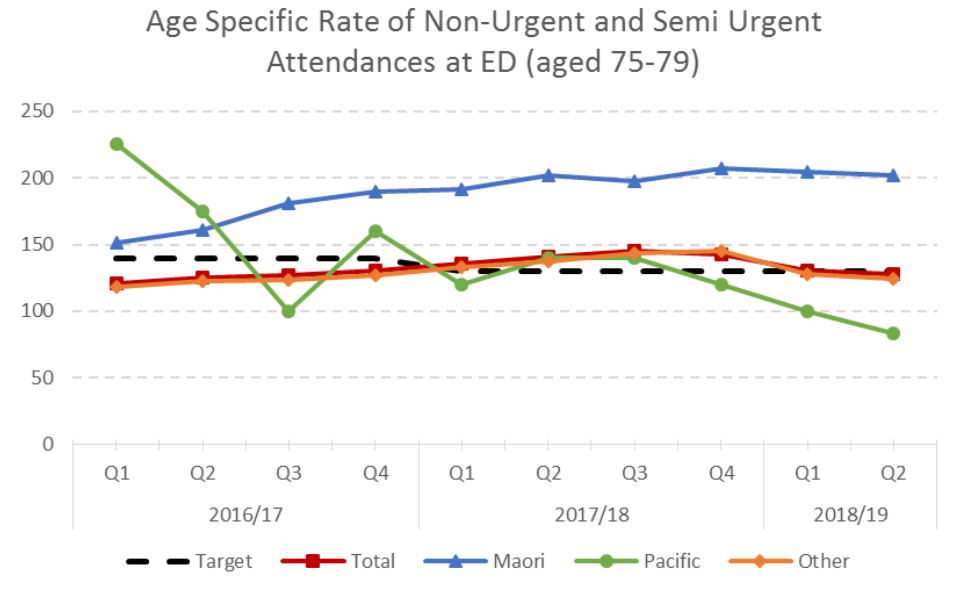
77 July 2018 to December 2018 Source: Ministry of Health

78 July 2018 to June 2019 Source: Ministry of Health

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

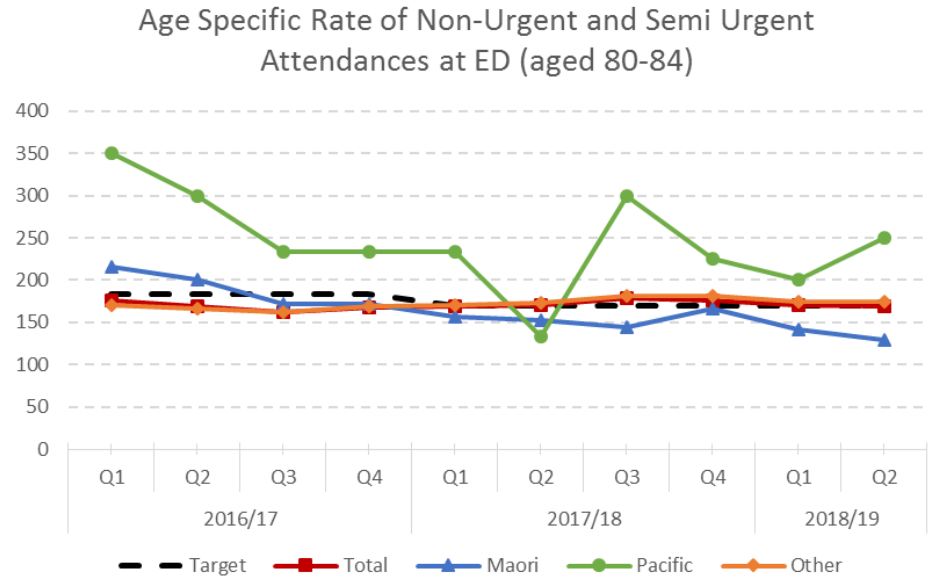
Better access to acute care for older people
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)

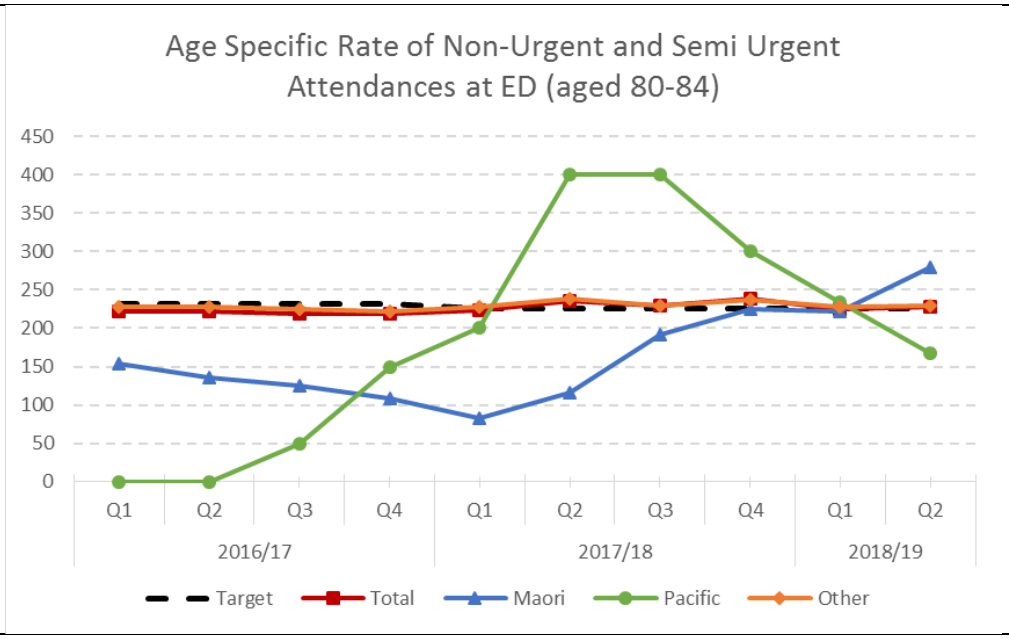
Age Band	Baseline [79]	Previous result [80]	Actual to Date [81]	Target 2018/19	Trend direction
Age 75-79					
Total	137.8	130.4 (U)	127.5 (F)	≤130	▲
Māori	202.1	204.4 (U)	202.2 (U)	≤130	▲
Pacific	140.0	100 (F)	83.3 (F)	≤130	▲
Other	111.2	127.7 (F)	124.7 (F)	≤130	▲
Age 80-84					
Total	170.8	169.8 (F)	169.1 (F)	≤170	▲
Māori	202.1	204.4 (U)	202.2 (U)	≤130	▲
Pacific	140.0	100 (F)	83.3 (F)	≤130	▲
Other	111.2	127.7 (F)	124.7 (F)	≤130	▲
Age 85+					
Total	239.0	225.2 (U)	227.5 (U)	≤225	▼
Māori	202.1	204.4 (U)	202.2 (U)	≤130	▲
Pacific	140.0	100 (F)	83.3 (F)	≤130	▲
Other	111.2	127.7 (F)	124.7 (F)	≤130	▲



Source: HBDHB

79 12 months to December 2017
80 12 months to September 2018
81 12 months to December 2018.





Comments:
HBDHB's 75 and over year old Pacific population represents 0.01% (120) of the total Hawke' Bay population, and for Maori 830 for the same age group. For the next quarterly report, the team will drill down into the Maori NHI numbers attending ED to identify if there are any patterns that might help inform how preventive care could be delivered more effectively to this age group. As previously mentioned, for Pacific the DHB has chosen to focus on more effective Chronic Disease management in the 40-65 year old Pacific population as demonstrated within the Annual Plan, as we see this will have the biggest impact for the Pacific population as a whole.

Better community support for older people Acute readmission rate: 75 years +					
Key Performance Measures	Baseline	Previous result [82]	Actual to Date [83]	Target 2018/19	Trend direction
Total	13.0%	12.6% (U)	12.6% (U)	≤11%	▬
Māori	11.5%	11.3% (F)	11.8% (U)	≤11%	▼
Pacific	5.7%	8.6% (F)	10.7% (F)	≤11%	▼
Other	13.2%	12.8% (U)	12.7% (U)	≤11%	▲
Comments: The 75+ result was 12.6% against a target of 11%. We have a NOF pathway (fast track to ATR) resulting in earlier rehab/less deconditioning which we hope further helps to reduce readmission rates.					

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note and appropriately act on the contents of this report**

82 12 months to June 2018

83 12 months to September 2018

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 2, 2018/19

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	96%	88%	*	90%	*	93%	*	87%	*
Faster Cancer Treatment	≥ 90%	95%	88%	*	92%		100%	-	87%	*
Increased Immunisation	≥ 95%	95%	93%	*	90%	*	96%		96%	*
Better Help for Smoker to Quit (Primary Care)	≥ 90%	90%	83%		79%		77%		87%	
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	87%	89%		88%		-	-	-	-
Raising Health Kids	≥ 95%	98%	96%		98%		93%		94%	

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Hospital)	≥ 95%	96%	96%		96%		94%		96%	
% of 2 year olds fully immunised	≥ 95%	94%	94%	*	94%	*	100%		94%	*
% of 4 year olds fully immunised	≥ 95%	94%	90%		90%		82%		91%	
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	74%	*	70%	*	67%	*	76%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	76%		76%		72%		78%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	98%	98%	*	99%	*	92%	*	97%	*
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6320	6000	7865		8658		17183		5886	
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 6761	4370	4564		8710		8833		3500	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	67%	65%		53%		36%	*	76%	
% of new-borns enrolled in General Practice by six weeks of age	≥ 55%	-	72%		67%		86%	*	73%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	86%	86%		84%		80%		87%	*
SLM Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	≤ 45.8	47.3	54.3		63.9		39.8		48.7	
SLM % of ED presentations for 10-24 year olds which are alcohol related	≤ 11%	-	3%		4%		1%		3%	

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	74%	71%	*	88%	*	-		72%	*
ACS Left Ventricular Dysfunction (LVEF) assessments >85% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF.	≥ 85%	51%	78%		86%	*	100%		76%	
Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)	≥ 85%	66%	59%	*	50%	*	100%	*	60%	*
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 10%	6%	7%		6%		-		-	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	90%	76%		83%	*	-	-	-	-
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	38%	81%		100%		-	-	-	-
Major joint replacement	≥ 21	22.4	19.59		-	-	-	-	-	-
Cataract procedures	≥ 27	46.6	46.45		-	-	-	-	-	-
Cardiac surgery	≥ 6.5	4.8	5.27		-	-	-	-	-	-
Percutaneous revascularisation	≥ 12.5	11.9	13.20	*	-	-	-	-	-	-
Coronary angiography services	≥ 34.7	36.4	39.55	*	-	-	-	-	-	-
Length of stay Elective (days)	≥ 1.45	1.52	1.59	*	-	-	-	-	-	-
Length of stay Acute (days)	≥ 2.3	2.39	2.37		-	-	-	-	-	-
Acute readmissions to hospital		13%	12%		11%		12%		13%	
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	88%	100%	-	-	-	-	-	-	-
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	94%	95%	*	-	-	-	-	-	-
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	59%	69%	*	-	-	-	-	-	-
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	68%	55.0%		-	-	-	-	-	-
Did not attend (DNA) rate across first specialist assessments	≤ 7.5%	5%	5%	*	11%	*	10%	*	3%	*
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4.3%	4.1%	3.9%	*	4.3%	*	2.0%		3.8%	*
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5.4%	5.5%	5.3%		9.8%	*	3.9%	*	3.9%	
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 1.2%	1.1%	1.1%		1.5%	*	0.9%	*	1.0%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	73%	75%		80%		94%		71%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	72%	67%	*	69%	*	100%		60%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	92%		93%		100%		91%	
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	96%	89%		93%		100%		93%	
Rate of s29 orders per 100,000 population	≤ 375	0	-	-	392		126	*	120	
Total acute hospital bed days per capita (per 1,000 population)		378	408		621		522		356	*
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	≥ 3682	-	3383	-	-	-	-	-	-	-

Document Owner: Chris Ash

February 2019
Section 4
1

20.1

OUTPUT CLASS 4: Rehabilitation and Support Services	Target		Baseline	Total		Maori		Pacific		Other	
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥	80%	98%	100%	*	-	-	-	-	-	-
% of older patients given a falls risk assessment	≥	90%	98%	90%		-	-	-	-	-	-
% of older patients assessed as at risk of falling receive an individualised care plan	≥	90%	96%	91%	*	-	-	-	-	-	-

Not Reported in Q2				
SLM Number of babies who live in a smoke-free household at six weeks post natal	≥	95%	66%	Data unavailable from MoH
% of girls fully immunised – HPV vaccine	≥	75%	0%	Reported in Q4
% of 65+ year olds immunised – flu vaccine	≥	75%	59%	
% of infants that are exclusively or fully breastfed at 3 months	≥	60%	51%	
% of new-borns enrolled in General Practice by three months of age		0%	0%	
% of eligible pre-school enrolments in DHB-funded oral health services	≥	95%	0%	Reported in Q3
% of children who are carries free at 5 years of age	≥	64%	0%	
% of enrolled preschool and primary school children not examined according to planned recall		10%	0	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥	85%	0%	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9		0.96	0	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≥	65%	0%	
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥	95%	0%	Data validation in process
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥	90%	0%	
SLM Amenable Mortality Relative Rate between Māori and NMNP		2.15	0	Reporting in Q4
% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	≥	60%	0%	
Response rate for Patient Experience Surveys - inpatient and general practice				
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years				
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years				
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years				
Acute readmission rate: 75 years +				
Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments				
% of people having homecare assessments who have indicated loneliness				
Conversion rate of Contact Assessment(CA) to Home Care Assessment where CA scores are four-six for assessment urgency				
Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment				
Number of day services				

HAWKE'S BAY District Health Board Whakawāteatia	**Health Finance, Procurement and Information Management System Business Case** 20
	For the attention of: **HBDHB Board**
Document Owner:	Carriann Hall, Executive Director Financial Services
Month:	February 2019
Consideration:	For Decision

RECOMMENDATION

That the HBDHB Board:

a. **Approve** the shared vision for the development and implementation of a national shared procurement catalogue, data standards, data repository, and compliance processes to improve procurement value for money; and the full participation of Hawke's Bay DHB in the implementation of this

b. **Approve** the provision of $20,309 in additional funding as the PBF determined share for Hawke's Bay DHB, to design how a shared national catalogue, chart of accounts and data repository will operate and how it would provide the compliance necessary to deliver procurement benefits as contemplated by the business case

c. **Notes:**

- that the FPIM business case recommends a single system for the 10 DHBs with immediate system risk issues and to investigate options for a national shared catalogue. This pathway preserves the potential for all DHBs to migrate to a single system in the future
- that HBDHB does not have immediate system risk issues and is not one of the 10 DHBs. HBDHB will provide a roadmap and recommendations on future development of Financial Management Information System, noting that a decision not to join Oracle will trigger an impairment review, with the potential of full impairment of $2.7m relating to HBDHB investment in National Oracle System (NOS)
- that the attached FPIM business case has been approved for release by the FPIM Governance Board (chaired by the Director-General of Health)
- that the staged approach and recommended pathway contained in the business case have been endorsed by the FPIM Governance Board
- that the recommendations have been reviewed and endorsed by Executive Director Financial Services HBDHB
- that this programme and business case has been subject to Gateway Review
- that this business case is predicated on the work being led by NZ Health Partnerships at this stage, noting that as the next stages of the programme progress further work will also be required to define and agree the operating model including the ongoing role of NZ Health Partnerships
- that Ministry of Health and NZ Health Partnerships representatives are available to join Board meetings to assist DHB decision-making processes, and a decision is requested by mid-March 2019.

21

INTRODUCTION

1. As required by Cabinet, a new business case for the Health Finance Procurement and Information Management System (FPIM) – formerly known as the National Oracle Solution (NOS) – has been completed and provided for DHBs' consideration.

2. The Governance Board – chaired by the Director-General of Health – has endorsed the overall approach proposed in the business case and has approved its distribution to DHBs. The Executive Steering Committee (including four DHB Chief Executives) and the NZ Health Partnerships Board (including four DHB Chairs) have endorsed releasing the business case to the sector.

3. The business case recommends a phased approach to implementing a national, unified system for finance, procurement and information management. The approach will enable DHBs with end of life finance and procurement systems to mitigate their risk of operational failure, in parallel with work to design and implement the necessary building blocks and operating model to deliver the clean data and purchasing compliance required to achieve procurement benefits through PHARMAC.

4. The business case recommends that the DHBs who have not signalled an immediate requirement to address their risk through an upgraded Oracle EBS solution would remain on their current systems should they choose to do so, and commit to ensuring they can interface with a shared national catalogue and common chart of accounts being used nationally. This represents a fundamental shift from the 'single national system' (based on one instance of an Oracle solution) that has been proposed in the past.

5. The business case is predicated on NZ Health Partnerships leading the work at this stage, with strong DHB, Ministry and PHARMAC involvement. However, it is noted that this may change as a result of the review of NZ Health Partnerships currently underway (FOCUS) and the wider health and disability system review.

6. Because of the systems risk faced by the 10 DHBs that are seeking to move to a single FPIM system, it is critical that work starts as soon as possible for these DHBs. The sector is working with the Ministry to accelerate the timeline for the build of the National Technology to address the systems risk for these 10 DHBs.

7. The sector is also working with the Ministry to expedite the design work to build on the national shared catalogue, and establish the Chart of Accounts and data requirements as soon as possible.

INVESTMENT OBJECTIVES

8. The primary objectives for the FPIM programme are:

#1 Address risks from end of life systems

9. At least 10 DHBs covering 73% of the country by PBF (and approximately 80% of the procurement spending) have immediate risk related to end of life finance, procurement, and supply chains systems. These DHBs are relying on the FPIM programme to remediate these issues.

10. The core finance, procurement, and supply chain systems have a wide reach into the operations of the DHBs. These DHBs are therefore increasingly at risk of systems failures or outages which will have severe consequences, including impacting on hospital operations. A failure of this kind would have wide societal impacts.

#2 Achieve savings from procurement

11. PHARMAC manages the procurement of medical devices at a spend of $640 million pa across 388 suppliers. PHARMAC assesses that 2% savings pa can be achieved on this total by DHBs purchasing from national contracts and conservatively estimates 7% savings pa when DHBs fully comply with these contracts – i.e. purchasing according to the full conditions and not procuring medical devices outside of these contracts. This incremental increase of 5% represents a possible $32 million pa in cost avoidance across all DHBs for medical devices.

12. Gaining value from PHARMAC model for medical devices requires:

    a. A national catalogue used by all DHBs for procurement

    b. Common data standards for procurement-related data at all DHBs

    c. A national procurement data repository for analysis and reporting

    d. Compliance of procurement against the national catalogue for close to 100% of sector at the point of procurement. A high compliance level across the sector is required to enable effective market share agreements to be negotiated and this requires all DHBs to fully commit to implementation and use of the national catalogue.

13. There is at least another $102 million pa of true national procurement (identified by NZ Health Partnerships) where equivalent savings could be found in indirect products and services, i.e. non-medical, and capital procurement. When this is added in, the cost avoidance reaches $37.1 million pa (based on $640 million medical devices and $102 million other pa, a total of $742 million pa with savings at 5%).

OPTIONS CONSIDERED

14. A range of options has been identified to achieve the investment objectives. The diagram below summarises the options identified, showing which options address which of the critical investment objectives.

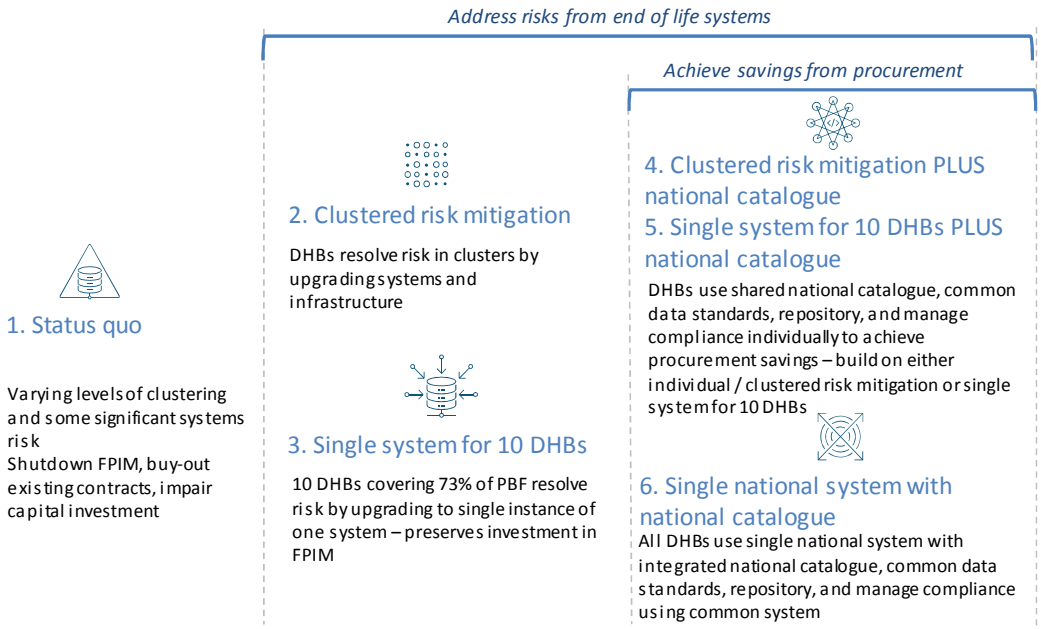


Figure 1 Options considered

15. Note that it is assumed that non-Oracle EBS DHBs and Oracle EBS DHBs who have not "self-selected" as part of the 10 DHBs will continue to undertake remedial action on their own systems as required.

Pathway Forward

16. The business recommends the following pathway through these options.

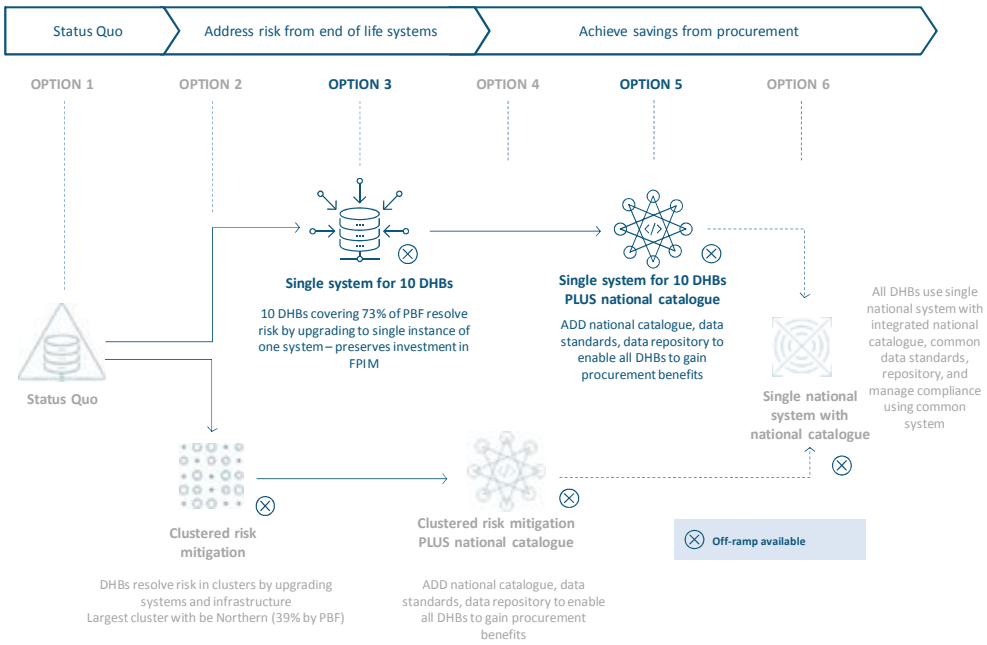


Figure 2 Options pathway

17. The 10 self-identified DHBs with systems risk will address their risk by moving to Option 3 Single system for 10 DHBs. This will provide them with an up-to-date finance, procurement, and supply chain systems running on modern infrastructure.

18. In parallel with this, work will start to design and build on the existing national shared catalogue to enable the whole sector to achieve procurement savings, not just those using FPIM (Option 5). The business case asks for all DHBs to fund the high-level design work.

19. This scope of this work will include technology (interfacing to multiple different systems), data standards (to address low levels of current data quality), data analysis and reporting, common Chart of Accounts, significant data cleansing, changes in procurement processes, operating model, and governance. DHBs will be heavily involved in this work, as will PHARMAC.

20. This pathway also preserves the potential for all DHBs to migrate to a single system in the future (Option 6).

FUNDING REQUIRED

21. To date, Hawke's Bay DHB has invested $2.9m capital, of which $200k was impaired at the end of 2017/18. The funding requested to complete this phase of the work is:

    a. Capital expenditure (CAPEX) of $20k in additional funding as the share of HBDHB to design how a shared national catalogue, chart of accounts and data repository will operate and how it would provide the compliance necessary to deliver procurement benefits as contemplated by the business case. There is a risk this could be impaired at a later date

b. Furthermore, HBDHB is required to contribute towards seven-year operating expenditure (OPEX) to cover sector licensing, hosting, and technical support of $107k

POTENTIAL IMPAIRMENT

22. There are impairment implications for each DHB regarding their current investment in FPIM. This is a subjective area and further work is required with CFOs, PwC, and Audit New Zealand on the impairment treatments. NZ Health Partnerships will coordinate this work to ensure a consistent approach is taken by all DHBs.

23. The treatments in the business case are based on previous guidance from PwC. The assumptions in the case have been discussed with CFOs and general agreement reached.

24. NZ Health Partnerships is the owner of the FPIM asset on behalf of the DHBs and so is responsible for assessing what impairment, if any, of the asset is required each year. Each DHB is responsible for assessing the value of its investment in NZ Health Partnerships and making an appropriate adjustment.

25. NZ Health Partnerships currently holds an asset value of $74.560 million for FPIM. This includes an impairment of $5.773 million and a full capital call of $12 million.

26. If a DHB does not intend to move to the shared Oracle system, thereby not using the FPIM asset, it will potentially need to impair the asset up to the value it holds. Following a small impairment at the end of 2017/18, HBDHB currently holds $2.7m (based on 2016-17 PBF splits). HBDHB will provide the Board with a roadmap and recommendation on the future development of Financial Management Information System.

27. **Independent Quality Assurance**

28. The FPIM programme and business case have been subject to a Gateway Review. The review notes that:

    a. The business case is well written, comprehensive, and has a high level of support.

    b. The review team endorses the proposed approach taken by the business case.

29. The business case has also undergone two Better Business Clinics whereby the Ministry of Health, the Treasury, Ministry of Business Innovation and Employment and the Government Chief Digital Officer provided feedback to help strengthen its form and content.

30. The business case has also been independently reviewed by Link Consulting and the key financial assumptions have been tested through a Quantitative Risk Assessment led by Broadleaf Capital International.

WHAT WILL BE DIFFERENT THIS TIME?

31. It needs to be acknowledged that this programme has had a long and difficult history. A key question is, “What will be different this time?”. This is covered in more detail in the business case, but in summary:

    a. The governance has been significantly strengthened with an overarching governing board chaired by the DG of Health and with involvement from a DHB Chair, PHARMAC Chair, NZ Health Partnerships chair (ex officio) and an independent health governance expert

    b. The programme is taking a fundamentally different approach to achieving the required benefits – we are no longer asking all DHBs to migrate to a single system (but are retaining that possibility for the future)

c. FPIM is already operational for four DHBs and the outstanding issues are being resolved – we are not starting from scratch

d. Operationalising of the target service model for FPIM is already underway

e. This business case includes DHB implementation costs and change planning requirements

f. A benefits realisation plan supported by the strengthened governance has been developed

g. There are reduced risks and interdependencies in the proposed approach

h. We are recommending an appropriate funding contingency informed by a Quantitative Risk Assessment – 29% capital and 15% operating.

DHB DECISIONS

32. In line with conversations at the national Chairs and Chief Executives Forum on 14 February, DHB decisions are requested by mid-March. It is acknowledged that this will require some DHBs to make decisions via extraordinary meetings or circular resolution.

33. Ministry of Health and NZ Health Partnerships' representatives are available to attend / dial into these meetings at DHBs' request.

34. DHBs are asked to advise FPIM Senior Responsible Owner, Steve Fisher, of their decision in writing once they are final via steve.fisher@nzhealthpartnerships.co.nz (0272 961 106).

NZ HEALTH PARTNERSHIPS

Health Finance, Procurement, and Information Management System

The foundations to help the health dollar go further

Business Case

Version 1.00

Date: 19 February 2019
Prepared for: Steve Fisher
Prepared by: David Cashmore

NZ HEALTH PARTNERSHIPS

"Building the foundations to help the health dollar go further"

Contents

NZ HEALTH PARTNERSHIPS

"Building the foundations to help the health dollar go further"

Document Control

	Position
Document ID	FPIM Business Case 2018 (v1-00).docx
Document Owner	Janet Emery
Issue Date	21 February 2019
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File Name	FPIM Business Case 2018 (v1-00).docx

Document History

Version	Issue Date	Changes
0.140	8 October 2018	Initial version with Strategic Case and outlines of other cases. First complete version provided for review.
0.153	23 October 2018	Updated with feedback. Strategic Case available for wider review.
0.180	20 November 2018	Full end to end version for internal review before issuing to central agencies for BBC clinic. Missing QRA and Oracle cloud conclusions.
0.190	26 November 2018	External review version for central agencies and DHBs. Excludes QRA, impairment, DHB allocation of costs, budget to date.
0.213	20 December 2018	Strategic and Economic Cases for noting and feedback from DHB Boards. Costs are provisional only.
0.307	12 February 2019	Full end to end with internal and external feedback applied to date. (To come: final financial review, remaining feedback from DHBs and CAs.)
0.400	15 February 2019	Full business case for review by Steering Committee and Governing Board.
1.00	19 February 2019	Full business case with feedback applied and proof-reading.

Document Review

Role	Name	Review Status
Project Manager	Janet Emery	

Document Sign-off

Role	Name	Sign-off Date
Project Manager	Janet Emery	
Senior Responsible Owner/ Project Executive	Steve Fisher	

NZ HEALTH PARTNERSHIPS

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1. Purpose

This business case recommends the next steps for meeting DHBs' finance, procurement, and supply chain needs and for supporting the health sector to gain maximum value from the goods and services it purchases.

The Health Finance Procurement and Information Management System (FPIM) – formerly known as the National Oracle Solution (NOS) – has been implemented in the Bay of Plenty, Canterbury, Waikato, and West Coast DHBs, albeit the full solution design is not yet complete.

The launch with the four "Wave One" DHBs was anticipated as the first phase of a plan to implement FPIM at all DHBs. Together, the Wave One DHBs represent 27% of the sector by volume (based on Population Based Funding – PBF).

Government has directed that further implementation be paused and that a business case be prepared to support the next steps for the remaining DHBs.[1]

This business case analyses the options available and recommends a path forward based on extensive consultation with DHBs and central agencies.

[1] Letter from DG Health to Megan Main, CE NZ Health Partnerships, 28 June 2018.

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2. Recommendations

This business case recommends:

That the 10 DHBS using Oracle EBS that have infrastructure and/or application risks that need to be remediated, namely Auckland, Bay of Plenty, Canterbury, Counties Manukau, Northland, Southern, Taranaki, Waikato, Waitemata, West Coast:

1. **Agree** to move to a single up to date instance of the Oracle E-Business Suite FPIM system on shared infrastructure at a capital cost of $41.010 million (including 29% contingency) [Option 3 as described in this business case]
2. **Agree** to the funding of implementation, ongoing licence and support costs and centralised support at an operating cost of $103.670 million (including 15% contingency) over seven years

That all DHBs:

3. **Agree** to implement a national shared procurement catalogue, data standards, data repository, and compliance processes to improve procurement value for money
4. **Approve** their PBF share of $600,000 operating funding for a 6-month design phase to cover how a shared national catalogue, Chart of Accounts and data repository will operate and how it would provide the compliance necessary to deliver procurement benefits:

DHB	PBF	High level design funding
Auckland	14.93%	89,561
Bay of Plenty	5.04%	30,240
Canterbury	11.41%	68,451
Capital & Coast	6.78%	40,693
Counties Manukau	9.36%	56,174
Hawkes Bay	3.38%	20,309
Hutt	3.02%	18,113
Lakes	2.25%	13,490
MidCentral	3.75%	22,492
Nelson Marlborough	3.01%	18,063
Northland	3.98%	23,907
South Canterbury	1.16%	6,953
Southern	6.46%	38,784
Tairawhiti	1.09%	6,522
Taranaki	2.35%	14,112
Waikato	9.65%	57,904
Wairarapa	0.79%	4,742
Waitemata	9.31%	55,868
West Coast	0.82%	4,897
Whanganui	1.45%	8,724
	100.00%	**$600,000**

21

NZ HEALTH PARTNERSHIPS

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3. Executive summary

3.1 Introduction

Each year DHBs spend billions of dollars buying goods and services using a variety of separate finance, procurement, and supply chain systems. Four DHBs use TechnologyOne, two DHBs share a JD Edwards system, one DHB uses SunSystems (and has announced an intention to move to TechnologyOne), and the remaining 13 DHBs use (or are about to use) Oracle E-Business Suite. These systems were selected by DHBs to meet their specific needs and have been upgraded and adapted over time.

While the various systems have different applications and processes there are at least two basic requirements that they all share.

- Firstly, they must be fit for purpose to support day-to-day operations allowing DHBs to manage how goods and services are sourced, ordered, delivered, stored, used, and paid for. They must also meet requirements for maintaining financial records, including budgets, as well as fit for purpose reporting tools.
- Secondly, they must provide this functionality at levels of risk considered acceptable by the executive teams and Boards of each DHB.

There are also opportunities for DHBs to work together to help mitigate the increasing fiscal demands facing the health system from an ageing population, the rising cost of new clinical equipment, and the growth of long-term conditions such as mental health issues and obesity.

The immediate opportunity is to increase procurement value for money for $640 million pa of medical devices (as contracted by PHARMAC) through a national shared procurement catalogue, data standards, a national data repository, and contract compliance at the point of procurement. While some of these components are in place in varying ways, national compliance and consistency is required if significant targeted savings are to be achieved. Data cleansing will be especially important – currently of the $5 billion pa health spending received by the Data Hub, only $1.3 billion of this can be matched at category or supplier level (26%).

This business case recognises that there are differing drivers for the best system to support different DHBs' finance, procurement, and supply chain needs. Further, it recognises that there is more than one way to deliver the desired procurement savings. But it also recognises that 10 DHBs are currently operating at unacceptable levels of risk with their finance, procurement, and supply chain systems and need an immediate solution.

The business case recommends a phased approach that will enable those DHBs with end of life systems to mitigate their risk of operational failure, in parallel with work to design a distributed system and operating model to deliver the clean data and purchasing compliance required to achieve procurement benefits.

This business case recommends that the DHBs who have not signalled an immediate requirement to address their risk through an upgraded Oracle EBS solution would remain on their current systems should they choose to do so, with a shared national catalogue and common chart of accounts being used nationally. This represents a fundamental shift from the single national system approach that has been proposed in the past.

The national shared procurement catalogue, data standards, data repository, and compliance processes will be critical to improving procurement value for money and achieving the anticipated savings.

3.2 Value proposition

The FPIM programme has five investment objectives. There are two primary objectives and three secondary objectives. These were developed and refined through a series of workshops and discussions with DHB CEs, CFOs, CIOs, and other subject matter experts. (Details on the issues faced and the investment objectives can be found in section 5. Strategic case.)

The primary objectives are:

#1 Address risks from end of life systems

At least 10 DHBs covering 73% of the country by PBF (and approximately 80% of the procurement spending) have immediate risk related to end of life finance, procurement, and supply chains systems. These DHBs are all using Oracle EBS and were relying on the FPIM programme to remediate these issues:

- The Wave One NOS DHBs – Bay of Plenty, Canterbury, Waikato, West Coast, between them covering 27% of the country by PBF – are running on temporary hardware arrangements and will need infrastructure remediation during 2019
- The Northern DHBs and Taranaki – Auckland, Counties Manukau, Northland, Waitemata, and Taranaki (which sits on the same platform) cover 40% of the country by PBF and need to remediate their infrastructure by early 2020
- Southern DHB needs an application upgrade to address its systems risk. Its Oracle system has been out of support since 2008 with no maintenance delivered since.

The core finance, procurement, and supply chain systems have a wide reach into the operations of the DHBs. These DHBs are therefore increasingly at risk of systems failures or outages which will have severe consequences, including impacting on hospital operations. A failure of this kind would have wide societal impacts.

The first of the primary investment objectives is therefore to solve the risks from end of life systems experienced by these 10 DHBs.

#2 Achieve savings from procurement

PHARMAC manages the procurement of medical devices at a spend of $640 million pa across 388 suppliers. PHARMAC assesses that 2% savings pa can be achieved on this total by DHBs purchasing from national contracts and conservatively estimates 7% savings pa when DHBs fully comply with these contracts – i.e. purchasing according to the full conditions and not procuring medical devices outside of these contracts.

This incremental increase of 5% represents a possible $32 million pa in cost avoidance across all DHBs for medical devices.

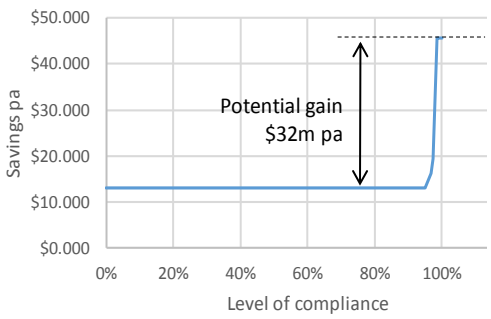
Gaining value from PHARMAC model for medical devices requires four things:

I. A national catalogue used by all DHBs for procurement

II. Common data standards for procurement-related data at all DHBs

III. A national procurement data repository for analysis and reporting

IV. Compliance of procurement against the national catalogue for close to 100% of sector at the point of procurement. A high compliance level is



required to enable effective market share agreements to be negotiated. This is illustrated in in the diagram above.

As can be seen, simply publishing the existing national catalogue to all DHBs, will not meet the above requirements.

There is at least another $102 million pa of true national procurement (identified by NZ Health Partnerships) where equivalent savings could be found in indirect products and services (i.e. non-medical) and capital procurement. When this is added in, the cost avoidance reaches $37.1 million pa (based on $640 million medical devices and $102 million other pa, a total of $742 million pa with savings at 5%).

It is important to note that together indirect and capital purchasing account for a far greater proportion of DHBs' spend than medical devices, but the current paucity of data (which will be addressed through FPIM) hampers the sector's ability to identify significant savings opportunities in these areas.

There are also many opportunities for local and regional collaborative procurement that could result in savings.

Secondary investment objectives

Other investment objectives have been identified. These are:

- #3 Better informed decision-making – from improved data quality and data availability
- #4 More efficient operations – from more efficient and effective processes and opportunities for shared services between DHBs
- #5 Improved supply management – from improved data across all DHBs.

3.3 Pathways to achieve the value

A range of options has been identified to achieve the investment objectives. The diagram below summarises the options identified, showing which options address which of the critical investment objectives. (Details on the options and how they compare can be found in section 6. Economic case.)

It is important to note that not all options are mutually exclusive. For example, moving from either Option 3 or 4 to Option 5 could be seen as a logical pathway rather than a choice of one option over another.

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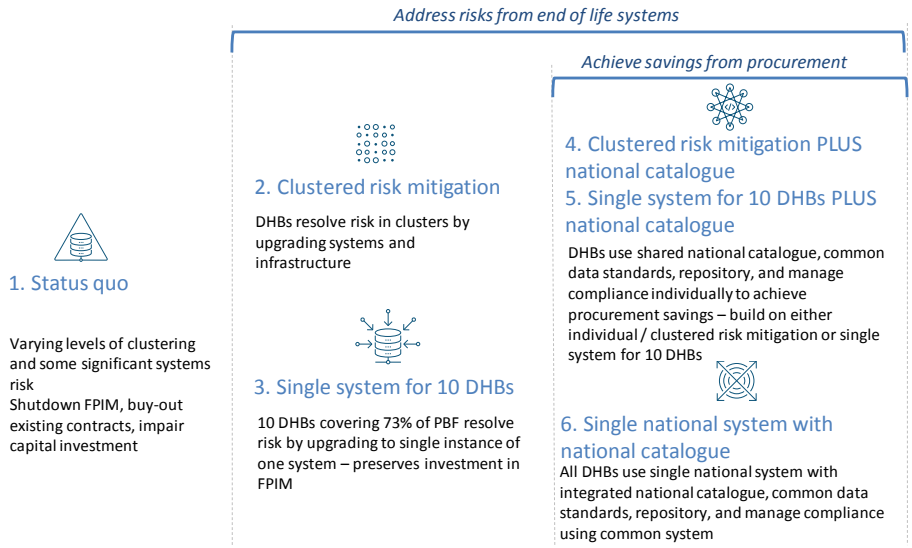

Figure 1 Options considered

Note that it is assumed that non-Oracle EBS DHBs and Oracle EBS DHBs who have not "self-selected" as part of the 10 DHBs will continue to undertake remedial action on their own systems as required.

These options can be seen as a pathway from the current environment as illustrated in the following diagram.

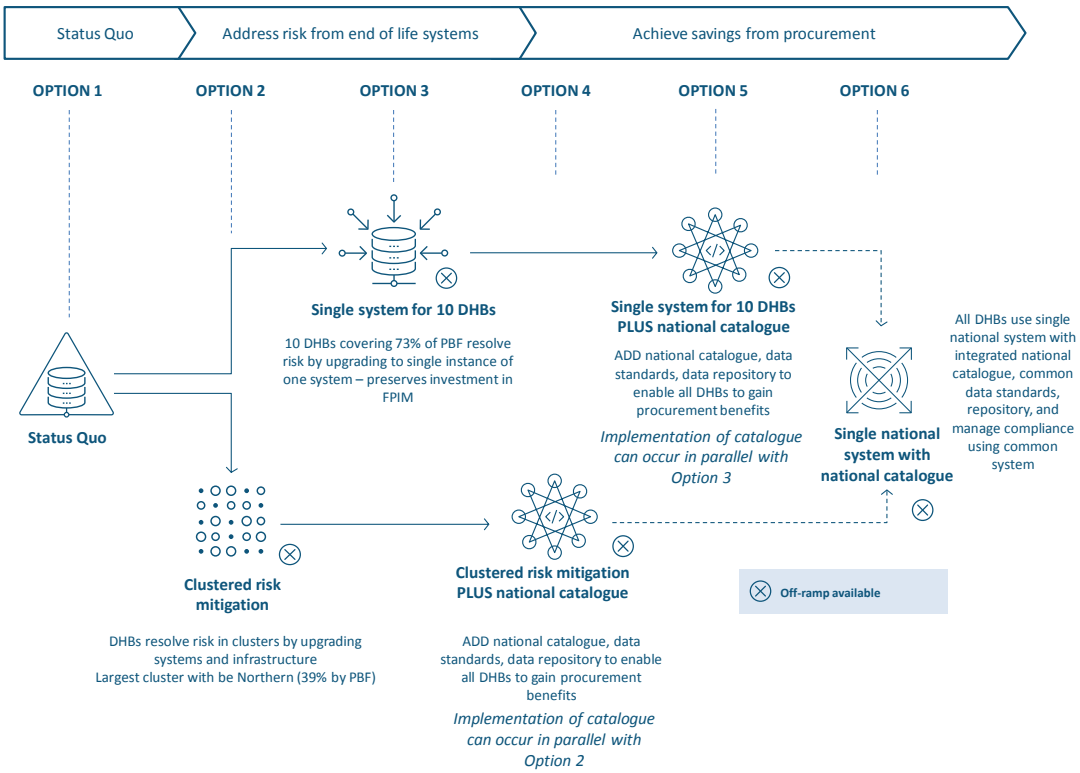

Figure 2 Options pathway

It should be noted that the development of the national shared catalogue, data standards (and data cleansing), data repository, and procurement compliance can be started immediately and developed in parallel with the work in Options 2 and 3 to address the risk from end of life systems.

3.4 Comparing the options / pathways

The following diagram summarises this business case's assessment of the options. Costs are for the whole sector.

Table 1 Comparison of options ($million)

OPTIONS	1. Status Quo / shutdown FPIM	2. Clustered risk mitigation	3. Single system for 10 DHBs	4. Clustered risk mitigation + catalogue	5. Single system for 10 DHBs + catalogue	6. National system & integrated catalogue
	Shuts down current FPIM programme and retains status quo – no risk mitigation	10 DHBs collectively mitigate their systems risk in clusters	10 DHBs collectively mitigate risk by moving to a single FPIM instance	Option 2 plus national shared catalogue for all DHBs	Option 3 plus national shared catalogue for all DHBs	Single national Oracle FPIM system for all DHBs with integrated catalogue
VALUE						
#1 Address risks from end of life systems	○	◔	◔	◔	◔	●
#2 Savings from procurement	○	○	○	◔	◔	●
CONCLUSION	*Option 6 provides best risk and procurement value; options 4 and 5 provide equivalent risk and procurement value to each other. Option 6 is therefore preferred on value basis only.*					
RISK						
Implementation risk	n/a	◔	◔	◔	◔	●
Operational risk	●	◔	◔	◔	◔	◔
Benefits realisation risk	n/a	○	○	◔ [1]	◑ [2]	◔
CONCLUSION	*All options entail significant implementation risk, with option 6 having the highest as it affects all DHBs. Option 5 provides the best balance of risk across categories, but will need careful management of benefits.*					
COSTS & FINANCIAL BENEFITS (EXCLUDING CONTINGENCY)						
Cash comparison (10 year)						
Capital		(29.989)	(33.891)	(58.782)	(49.783)	(65.077)
Operating	(14.115)	(110.147)	(125.244)	(139.678)	(137.774)	(137.843)
Total	**(14.115)**	**(140.045)**	**(159.135)**	**(198.460)**	**(187.557)**	**(202.920)**
Benefits		14.000	14.000	223.200	237.200	237.200
Net	**(14.115)**	**(126.045)**	**(145.135)**	**24.740**	**49.643**	**34.280**
NPV (at 7%)	(12.950)	(84.953)	(109.639)	(12.783)	4.899	(8.575)
CONCLUSION	*Option 5 provides the best NPV. But note that option 6 upgrades the systems for all DHBs, while option 5 only upgrades the systems of 10 DHBs, albeit 73% of the sector by PBF.*					
Cash plus impairment comparison (10 year)						
Net cash	(14.115)	(126.045)	(145.135)	24.740	49.643	34.280
Potential impairment	(56.000)	(56.000)	(22.000)	(56.000)	(22.000)	-
Net impact	**(68.115)**	**(182.045)**	**(167.135)**	**(31.240)**	**27.484**	**34.280**
CONCLUSION	*When the potential impact impairment is taken into account, option 6 provides the best net cash impact over the 10 year period and delivers a greater scope than option 5.*					

Notes
1. Benefits realisation risk medium/high because of difficulties in achieving data consistencies and compliance across disparate systems
2. Benefits realisation risk lower when compared with option 4 as 80% of medical device procurement will be on a single Oracle FPIM system

3.5 Choosing the best pathway

The following can be concluded from this comparison.

Option 1 Status quo / shutdown FPIM	Does not address the immediate risk of operational failure faced by the 10 DHBs using Oracle EBS who have self-identified as having high risk. Does not provide any procurement savings.	→	Reject
Option 2 Clustered risk mitigation	Resolves the risk for the 10 DHBs with immediate issues. It potentially continues the current fragmentation, but it is aligned to a shared national catalogue. While it appears attractive cost-wise, these costs are based on high level estimates only. If it is adopted its pathway is to a higher cost option when the catalogue is added, that of Option 4.	→	Reject on the basis that no alternative cluster has been identified by sector
Option 3 Single system for 10 DHBs	Resolves the risk for the 10 DHBs with immediate issues. Moves 80% of sector procurement to single platform, thereby simplifying data standards and procurement compliance. It consolidates the sector along a path towards a single national system (at some point in the future) and is aligned to a shared national catalogue. The National Technology (infrastructure) has already been designed, peer reviewed by PWC Australia, and the hardware is already in place.	→	Implement as matter of urgency
Option 4 Clustered risk mitigation plus national catalogue	Provides a means for Option 2 to have a national catalogue and common chart of accounts and so provide savings in procurement. It may be more challenging to implement and achieve the benefits than Option 5 Single system for 10 DHBs plus national catalogue.	→	Reject on the basis that no alternative cluster has been identified by sector
Option 5 Single system for 10 DHBs plus national catalogue	Provides the most promising solution to achieving the PHARMAC level savings without implementing a single national system. The national catalogue, data standards, data repository, and compliance can be implemented in parallel with Option 3. It enables the sector to build off the cluster of 73% by PBF / 80% of procurement spending on a single Oracle EBS instance without requiring other DHBs to change their preferred systems.	→	Implement Option 3 and in parallel start design of shared national catalogue and chart of accounts

	At this stage Option 6 appears to have the strongest case financially.		
Option 6 National system and integrated catalogue	However, it has a high implementation risk, higher risk of cost escalation, requires the short-term replacement of systems at seven DHBs, and will require the largest level of change management in DHBs. It should be preserved as a future pathway if possible, to keep the path open to future consolidation of systems across the sector and is most likely to be a cloud solution.	→	Preserve pathway to this state

3.6 Conclusions

On the basis of the analysis and conclusions, the following is recommended:

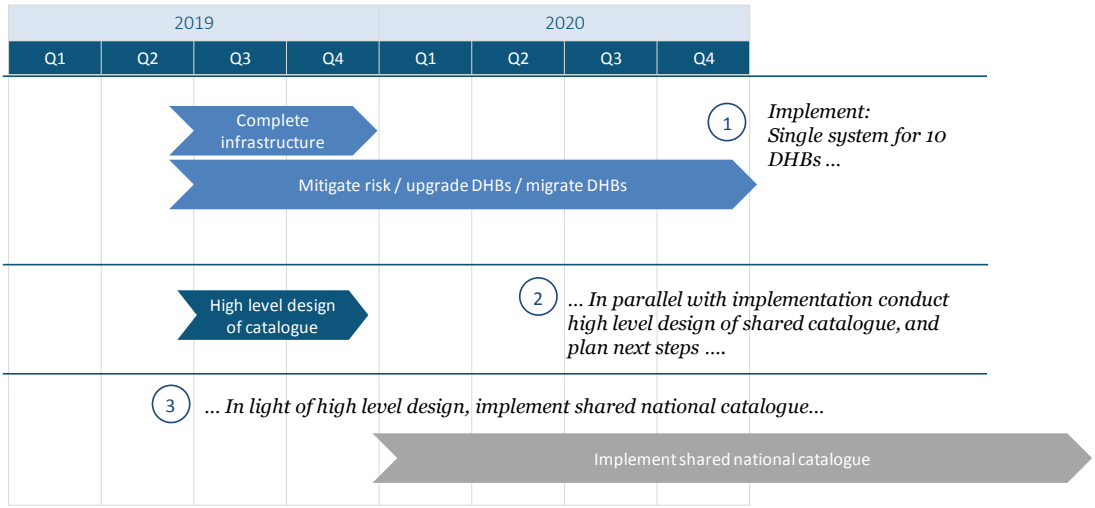

Figure 3 Decision-making plan

1. Option 3 Single system for 10 DHBs should start as soon as possible to mitigate the systems risk of 10 DHBs using Oracle EBS. This addresses immediate risks from end of life systems and preserves all future options.
2. A 6-month high level design should be conducted on a shared national catalogue to determine how it should be implemented and how the PHARMAC level benefits could be achieved.
    a. The scope of the high-level design will include technology (interfacing to multiple different systems), data standards (to address low levels of current data quality), data analysis and reporting, common Chart of Accounts, significant data cleansing, changes in procurement processes, operating model, and governance
    b. It will also include working with PHARMAC to ensure that their benefits realisation model provides incentives for DHBs to support it.
3. Implementation of the catalogue would start from late 2019 once analysis had been completed and agreement gained to move forward.

Note that NZ Health Partnerships is working with the Ministry of Health to enable the building of the infrastructure for Option 3 to continue before Cabinet "un-pauses" FPIM in its entirety.

NZ HEALTH PARTNERSHIPS

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3.7 Governance

Governance for the programme to implement the preferred option will balance the requirements of individual DHBs with the overall goals of the programme while recognising each DHBs ability to manage their own costs and quality of transition.

The governance structure has been designed to remove duplication and provide clear lines of reporting, responsibility and ownership. The structure is also intended to ensure leadership of the programme is collaborative and sector led through the inclusion of DHB senior executives in key roles.

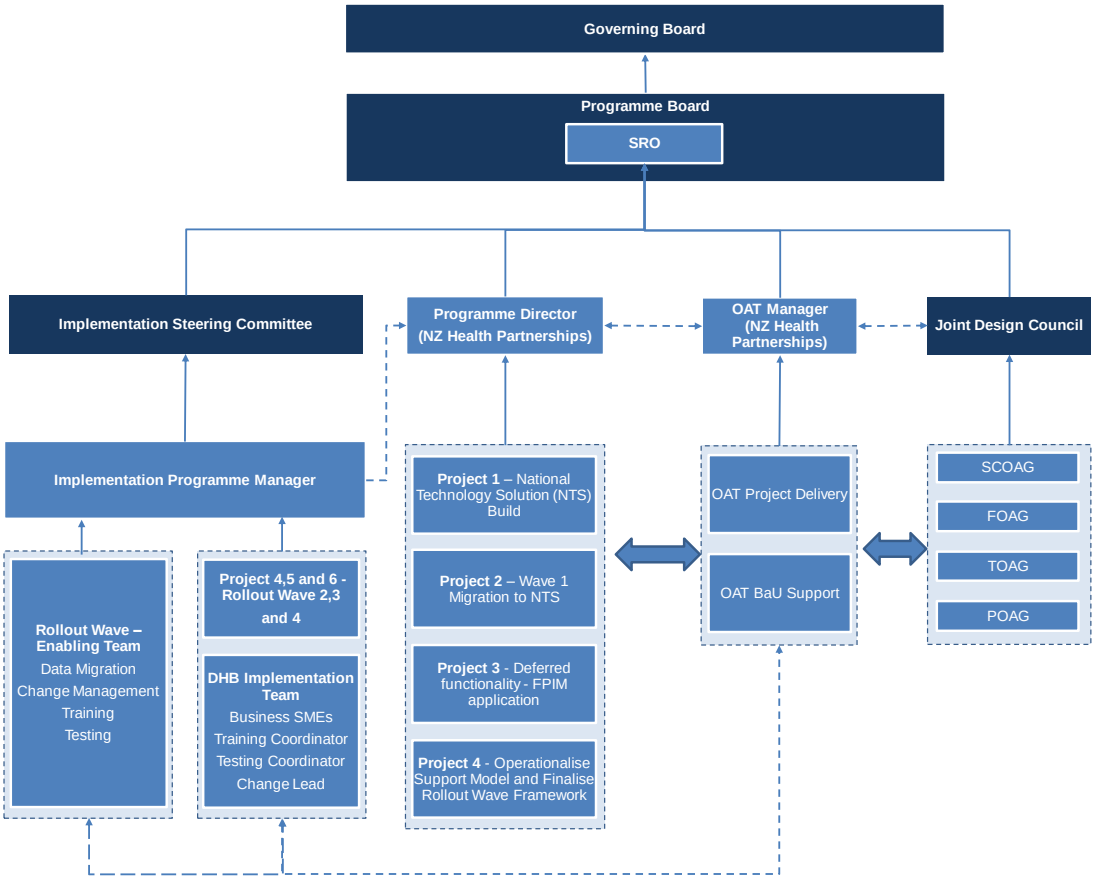

Figure 4 Proposed governance and management structure

The overarching Governing Board will be critical to the success of the programme. This is chaired by the Director General of Health and includes the chair of PHARMAC, a chair from a DHB, the chair of NZ Health Partnerships, and an external IT governance advisor.

3.8 Why it will be different this time

Through the consultation process two or three DHB stakeholders have asked *"What is or will be different this time?"* The key reasons are as follows:

- The programme is taking a fundamentally different approach to achieving the required benefits – we are no longer asking all DHBs to migrate to a single system (but are retaining that possibility for the future)
- The governance has been significantly strengthened with an overarching governing board chaired by the DG of Health and with involvement from the DHBs, PHARMAC, and NZ Health Partnerships
- FPIM is already operational for four DHBs and the outstanding issues are being resolved – we are not starting from scratch
- Operationalising of the target service model for FPIM is already underway
- This business case includes DHB implementation costs and change planning requirements
- A benefits realisation plan supported by the strengthened governance has been developed
- There are reduced risks and interdependencies in the proposed approach
- We are recommending an appropriate funding contingency informed by a Quantitative Risk Assessment – 29% capital and 15% operating.

See 9. Management case for details on plan for implementation of preferred option.

See APPENDIX E: Shared national catalogue high level design project brief for description of the high-level design work.

See 8. Financial case for details on costing and cost allocation to DHBs.

4. Introduction

4.1 Background

The genesis of FPIM stems back to 2012 when a national finance, procurement, and supply chain system along with shared services were first envisaged

In 2012 Health Benefits Limited prepared a business case for finance, procurement and supply chain shared services.[1] The scope of this business case was to support national procurement, a national supply chain, use of a common national Oracle finance, procurement, and supply chain system, and national finance shared services.

The business case estimated net benefits to the New Zealand Health sector of approximately $138 million over a five-year period (FY12/13 to FY16/17), and approximately $538 million over ten years (FY12/13 to FY21/22). The investment required to achieve these benefits was $88 million.[2] DHBs agreed to proceed with programme development.

The business case required an ambitious work programme and aggressive timelines. In 2014, when it became apparent that the programme was going to take longer and cost more to complete, re-planning was undertaken to look at options for reducing costs and maximising benefits.

In April 2015 shared services and the national supply chain model were removed from the scope, additional implementation funding was made available, and final implementation to all DHBs was delayed until December 2019

In 2015 the following key changes were made to the programme:

- Project programme costs increased from $88 million to $115 million. These costs included system integration costs that had been excluded from the original case. These increases were to be funded by individual DHBs
- Financial shared services were removed from scope
- Consolidated warehouse and logistics functions were removed from scope.

This left the scope of the programme confined to the development and implementation of a shared finance and procurement system for all DHBs. This system included local supply chain functionality for DHBs. The narrower scope of the programme was projected to deliver a net present value of $150 million and an IRR of 20% (as compared to $212 million for the equivalent scope in the original business case).[3]

Also, at this time, NZ Health Partnerships – a company owned equally by all 20 DHBs – took over the programme from Health Benefits Limited. The programme was renamed the National Oracle Solution (NOS).

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[1] Health Benefits Limited, *DHB Business Case: Finance, Procurement & Supply Chain Shared Services* (HBL, 2012).

[2] All costs are cash and are not discounted to take account of time value of money.

[3] Health Benefits Limited, *Business Change Case: Finance, Procurement and Supply Chain (FPSC) Programme* (HBL, 2015).

A 2015 stage gate report reconfirmed the NOS scope and estimated that the programme could be completed within the original budget, but with no financial or time contingency

The NOS scope was reconfirmed in November 2015, and a recommendation made to proceed to the build phase so that implementation could proceed. The revised budget indicated a "potential" to complete the programme of work within the costs and timelines expected by the DHBs. There was however no cost or time contingency. This was documented in a November 2015 stage gate report.

The DHBs and NZ Health Partnerships agreed that the NOS programme move to the build phase and that the first DHBs start preparations for implementation.

An August 2017 change control report against the 2015 case recommended that the NOS scope should remain unchanged and that it should continue as a series of interdependent projects

In August 2017, a change control report against the 2015 case recommended that DHBs reaffirm their commitment to the NOS programme and approve revised timelines and a further $22.8 million cost (including contingency) to complete the NOS programme. The governance and programme management disciplines were also strengthened to help ensure success.

The business case financials were updated to provide an IRR of 13.1% and an NPV of $87.37 million assuming the contingency was fully consumed.[4]

In October 2017, all DHBs agreed to the recommendations. The NOS programme continued with a target to implement the Wave One DHBs – Bay of Plenty, Canterbury, Waikato, and West Coast – in July 2018.

In April 2018, a Deloitte review concluded that the programme needed to strengthen its implementation planning and ensure that it can successfully deliver the sector outcomes and benefits

The Ministry of Health requested Deloitte to undertake a review of the NOS programme. The terms of reference for the review stated that it was "to consider whether the programme is currently set up to deliver successfully, and, if not, what actions should be considered to increase the likelihood of a successful implementation."

The review identified some issues with programme management, DHB capability to manage change, ongoing support, engagement with PHARMAC, and benefits realisation. It recommended that Wave One go-live should proceed along with the remainder of the currently proposed scope. It also recommended a stronger "owner and investor" mind-set to ensure that the benefits could be achieved.[5]

In June 2018 Government agreed that Wave One would continue but requested a "pause" for the remainder of the programme subject to a satisfactory business case being completed

In June 2018, the Ministry of Health advised NZ Health Partnerships that Cabinet agreed to approve the funding required to deploy NOS to the Wave One DHBs in July 2018. However, while Cabinet agreed to roll out the Wave One DHBs, it requested a pause on all other NOS programme activities. The Ministry of Health requested that NZ Health Partnerships develop a new NOS business case to support continuation of the NOS programme. This business case was to be comprehensive and address the following core requirements:

[4] NZ Health Partnerships, *NOS Revised Business Case – Change Control Report* (NZ Health Partnerships, 2017).

[5] Deloitte, *National Oracle System Programme Review* (Deloitte, 2018).

1. *"Identification and analysis of measurable full programme benefits (including savings from PHARMAC procurement of medical devices on a national scale)*
2. *Identification and analysis of full programme costs (including potential material impairment charges for DHBs, implementation and change management costs for DHBs and PHARMAC, capital depreciation etc.)*
3. *Assessment of the current condition of DHBs' financial management and procurement systems*
4. *Completion of missing and outdated artefacts including an updated benefits analysis, benefit realisation plan and agreed targeted operating model*
5. *Timing and sequencing for the next steps for the remainder of the programme*
6. *Re-evaluation of cloud-based technology solutions (including hybrid cloud/non-cloud solutions)*
7. *Lessons learnt from the programme to date."* [6]

This business case explicitly responds to these requirements

This business case:

1. Identifies the full programme benefits, with a specific emphasis on the medical device procurement using the PHARMAC model (See the Economic Case for how these have been identified and the Financial Case for detail on how they have been costed)
2. Identifies all the programme costs, including the DHB change management costs, capital depreciation, etc (See the Financial Case for detail on what has been included in the costs)
3. Assesses the current condition of the DHB's financial, procurement, and supply chain systems (See the Strategic Case, section 5.3.2 Many DHBs are facing immediate IT sustainability issues)
4. Includes an updated benefits analysis, benefits realisation plan, target operating model, and governance model (See the Economic and Financial Cases for the updated benefits analysis and the Management Case for the benefits realisation plan, governance, and operating model)
5. Shows the timing of the next steps of the programme (See the Management Case)
6. Describes the role of cloud-based technologies in the solution (See the discussion in the Economic Case in section 6.3.8 Pathway to the public cloud)
7. Shows how the lessons learned from the programme have been applied (See APPENDIX B: Lessons learned and how addressed).

Wave One went live with four DHBs in July 2018 – there are still unresolved issues

The first four DHBs —Bay of Plenty, Canterbury, Waikato and West Coast – went live on NOS on their current information technology infrastructure on 2 July 2018.

While the system itself is stable and performing well, some issues remain that require resolution. The most significant of these are:

- The Infrastructure complexity and cost were reduced from the original NOS scope in order to achieve the Wave 1 DHB implementation by July 2018, with the full expectation that the transition onto the NOS centralised highly resilient national infrastructure would follow within a

[6] Letter from DG Health to Megan Main, CE NZ Health Partnerships, 28 June 2018.

6-month timeframe. These DHBs will need to migrate to new infrastructure by the end of 2019 to mitigate this risk.

- The Oracle Business Intelligence analysis and reporting system was not implemented. This has left some DHBs with reduced reporting capability.
- The Oracle Service-Oriented Architecture (SOA) integration module was not implemented. This would have been used to implement interfaces to other systems and suppliers.
- The ongoing support arrangements still need to be formalised. The current support is being provided by the programme team on an interim basis.
- Ongoing governance for the future of the service is not in place.

The Steering Committee was aware of these issues and believed that they could be resolved after go-live. However, the Cabinet instruction to pause the programme has constrained the programme's ability and the funding required to resolve them.

The resolutions to these key issues are addressed in the business case, while a more detailed integrated plan (outside of this business case) is in place to finalise and enhance the service over the coming months.

4.2 Business case development and structure

The business case was developed through a comprehensive process that engaged the DHBs, Ministry of Health, PHARMAC and central government

This business case was developed on a framework of workshops and on-going engagement with key personnel from DHBs, PHARMAC and central government agencies including the Ministry of Health, Treasury, the Government Chief Digital Officer and the Ministry of Business Innovation and Employment. The options to meet DHBs' finance, procurement and supply chain needs were looked at through fresh eyes while previous work was reused only where practicable. The benefits model, costs, and change management / implementation approaches were redesigned from the ground up.

This business case has been developed using the government standard Better Business Case five-case practices

This business case has been developed using the Better Business Case (BBC) approach and is built on the BBC templates. The core problem statements and benefits were developed using the Investment Logic Mapping (ILM) process.

This business case consists of:

- A Strategic Case presenting the strategic case for change, the specific problems to be resolved, the benefits that can be achieved, and the investment objectives
- An Economic Case presenting the critical success factors, the options considered, an analysis of the options, and a proposed way forward.
- A Commercial Case outlining how the required products and services will be procured
- A Financial Case describing the finances and benefits for the preferred option along with the preferred funding option
- A Management Case describing how the preferred option will be managed and the benefits realised.

This business case has been subject to an Independent Quality Assurance, review of the costing by an independent organisation, review by Central Agencies, a Gateway Review, and includes a Quantitative Risk Assessment

The business case process has been subject to review by central agencies in two Better Business Case clinics. An Independent Quality Assurance has been completed. An accounting firm was commissioned to review the cost model. The financial estimates include a Quantitative Risk Assessment (QRA) to support requirements for time and cost contingencies. The learnings from a "Lessons Learned Report" have been applied to the options analysed. A Gateway Review will also take place, as required by government policy.

5. Strategic case

5.1 Introduction

This section presents the strategic case for change, the specific problems to be resolved, the benefits that can be achieved, and the investment objectives for the business case

This strategic case presents:

- How this business case aligns with wider government strategies and initiatives
- The environmental context in which this business case operates
- The problems that this business case specifically addresses
- The benefits that this business case seeks to achieve
- The scope of the interventions proposed in this business case
- The investment objectives for this business case
- The key constraints and dependencies that must be considered.

A summary of the strategic case is shown in the following diagram.

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Scope of case

Finance, Procurement, Supply Chains systems at DHBs

Alignment with key strategies

Supporting government health priorities	Supporting the living standards framework	Supporting the New Zealand Health Strategy 2016	Supporting the Government ICT strategy	Supporting the Digital Health Strategy	Supporting the New Zealand Health and Disability System Review
• Value from investment • Wellbeing • Equity	• Human capital benefits • Financial benefits	• THEME THREE: Value and high performance • THEME FIVE: Smart system	• Exploiting emerging technologies • Unlocking the value of information	• Sustained change and innovation • Accessible, trusted information	• Respond easily to change" • Provide high quality national data • Control the cost of healthcare

Environmental context

DHBs currently use a variety of finance, procurement, and supply chain systems	Many DHBs are facing immediate IT sustainability issues 10 DHBs covering	Productive investment requires effective use of health systems and data	The sector is well positioned for further system consolidation Current
13 DHBs (84% by PBF) use / about to use Oracle EBS 5 DHBs (11 % by PBF) use / about to use TechnologyOne 2 DHBs (5% by PBF) use JD Edwards	73% by PBF have risk materialising Other DHBs have delayed upgrade decisions and risk will materialise in two to three years	Opportunity to gain value from PHARMAC model with medical devices	Governance and operating models will need to be enhanced

Problems

PRIMARY		SECONDARY	
ONE: System risk and sustainability	**TWO: Ineffective procurement**	**THREE: Product tracking**	**FOUR: Efficient operation**
10 DHBs have immediate system risk issues that will materialise in 2020 – at least four other DHBs have issues that need resolution in two to three years	The lack of a single national catalogue, national data standards, high quality procurement data, and an effective compliance programme are hindering effective procurement	Significant variation across the sector in the ability to track specific products to individuals or events presents clinical risk	Disparate systems and manual processes are driving unnecessary duplication of procurement effort

Benefits

PRIMARY		SECONDARY		
ONE: Sustainable systems at acceptable risk	**TWO: More effective procurement**	**THREE: Better informed decision-making**	**FOUR: Increased efficiency**	**FIVE: Improved supply management**
Finance, procurement, and supply chain systems operating at acceptable risk and supporting change in the future	Increased value from procured good and services through use of a national procurement catalogue and master data along with a compliance regime to support improved contracts	Increased quality and availability of data will support better informed decision-making	Increased operating efficiencies in finance, procurement, and supply chain	Improved supply chain management contributing to reduced clinical risk through standardised products tracked against events and people and improved supplier management

Investment objectives

PRIMARY		SECONDARY		
ONE: Address risks from end-of life systems	**TWO: Achieve savings from procurement**	**THREE: Better informed decision-making**	**FOUR: Efficient operation**	**FIVE: Improved supply management**

Figure 5 Summary of strategic case

5.2 Alignment with key strategies

5.2.1 Supporting government health priorities

Government is investing an additional $8 billion in healthcare over the next four years as part of Budget 2018 to address cost pressures and is seeking wellbeing and equity for all New Zealanders

Government is investing in healthcare and has signalled an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes. It sees the period of 2008 to 2017 as a period of under-investment and has stated that it will invest $8 billion over the next four years to meet cost pressures and deliver new initiatives over the next four years.[7]

Wellbeing

"The heart of this Government's agenda [is] health and wellbeing."[8] "We know if we prioritise wellbeing now, we're laying the foundations for New Zealanders to have better lives for decades to come"[9]. "We are introducing new wellbeing reporting requirements to inform budget decisions and … we are enhancing our evidence base with measures to support decisions promoting wellbeing" [as above].

Equity

Government is strongly focused on systems and solutions that broaden access to services to address equity issues and improve health outcomes for Maori and Pasifika people. "Wellbeing is integral to our work on improving equity in the areas of primary care, mental health and child wellbeing[10]" "Our health system does not deliver equally well for all. We know our Maori and Pacific peoples have worse health outcomes and shorter lives. That is something we cannot accept."[11] "The right to attain the highest possible standard of health is a fundamental right of every New Zealander."[12]

This business case supports government's objectives for the health system and is aligned with key government themes. It seeks increased value from the government's investment in health that will flow through to wellbeing and equity for all New Zealanders.

21

[7] Hon David Clark, *Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19* (May 2018). https://nsfl.health.govt.nz/system/files/documents/pages/auckland_letter_of_expectation_2018.pdf [Accessed 6 November 2018]

[8] Hon David Clark, *Keynote Speech to the Third International Conference on Wellbeing and Public Policy* (6 September 2018). https://www.beehive.govt.nz/speech/keynote-speech-third-international-conference-wellbeing-and-public-policy [Accessed 6 November 2018]

[9] Ibid.

[10] Ibid.

[11] Thomas Coughlan, *'H2' to head public health review* (30 May 2018). [https://www.newsroom.co.nz/2018/05/29/112103/former-clark-staffer-returns-for-health-review [Accessed 6 November 2018]

[12] Hon David Clark, *Speech to the NZ Nurses Organisation AGM* (20 September 2018). https://www.beehive.govt.nz/speech/speech-nz-nurses-organisation-agm [Accessed 6 November 2018]

5.2.2 Supporting the living standards framework

This business case contributes to higher living standards by growing human capital and social capital

The New Zealand Treasury has established a vision focused on higher living standards for New Zealanders. This will require growing the country's human, social, natural and financial / physical capitals. Together these represent New Zealand's overall economic capital.[13] This is illustrated in the following diagram.

Figure 6 Living standards framework[14]

This business case is focused on improving the effectiveness of DHB financial and procurement systems. This will enable:

- *human capital benefits* through improved value from medical device spending in District Health Boards
- *financial benefits* through more effective procurement and more efficient operation.

This business case therefore contributes to higher living standards for New Zealand and seeks to build New Zealand's economic capital.

5.2.3 Supporting the New Zealand Health Strategy 2016

This business case supports the New Zealand Health Strategy – THEME THREE: Value and high performance, THEME FIVE: Smart system

The New Zealand Health Strategy[15] lays out themes for the way the health sector should operate and established a roadmap for change. The themes are summarised in the following diagram.

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[13] See https://treasury.govt.nz/information-and-services/nz-economy/living-standards [Accessed 23 October 2018]

[14] New Zealand Treasury, The Treasury Approach to the Living Standards Framework (Treasury, February 2018), 2.

[15] See Minister of Health, *New Zealand Health Strategy: Future Direction* (Wellington: Ministry of Health, 2016); Minister of Health, *New Zealand Health Strategy: Roadmap of Actions 2016* (Wellington: Ministry of Health, 2016).

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Figure 7 Health sector strategic themes[16]

This business case contributes to the following key themes:

THEME THREE: Value and high performance

> *"… we need to get better and faster at sharing the best new ideas and evidence and putting them to work throughout the system. Such improvements will help us avoid unwarranted variations in the quality, safety and sustainability of services, and will also mean that effort is not wasted when regions or organisations independently develop solutions to common problems. This can be achieved if we take the learnings from successful initiatives and apply them systematically to areas in need of improvement."*[17]

This business case seeks investment in common systems across the sector to enable consistent approaches and processes around procurement and a decreased cost in goods and services procured.

THEME FIVE: Smart system

> *"While technology brings many benefits, both to the system and to individuals, introducing new information technologies and other technologies in a fragmented way would make systems overly complex and expensive. To share new technological innovations, we must have sufficient scale and standardisation to introduce them across our system."*[18]

The sector needs to ensure that technology is implemented in a coordinated manner to bring procurement benefits across the whole system. This business case seeks investment in common

[16] Minister of Health, *New Zealand Health Strategy: Future Direction* (Wellington: Ministry of Health, 2016), 15.

[17] Ibid, 27.

[18] Ibid, 35.

systems connecting DHBs in a coordinated manner to achieve greater effectiveness from finance, procurement, and supply chains systems and processes.

This includes contributing to the following five-year action statements:

- *"The system has a strong analytical capability that meets national standards and is able to transform specific data into the knowledge required to accurately and effectively target services to meet people's needs."*
- *"Data is consistent and accurate. It is accessible across the country, and not needlessly duplicated. Privacy is assured."*[19]

5.2.4 Supporting the Government ICT strategy

This business case supports the outcomes sought by the Government ICT strategy, most notably "Information-driven insights are reshaping services and policies, and adding public and private value"

The Government ICT Strategy is "the New Zealand Government's foundation for digital change".[20] This business case aligns with the Government ICT strategy by:

- [1] Exploiting emerging technologies – this business case explicitly lays out a path to the cloud (as directed by Cabinet in 2012[21])
- [2] Unlocking the value of information – this business case centres around improved quality of information to achieve increased value in the health sector

This business case will support achieving the key outcome of:

- [2] Unlock the value of information, specifically around finance, procurement, and supply chain information.

5.2.5 Supporting the Digital Health Strategy

This business case supports increased use of digital technologies to increase health outcomes

The Ministry of Health is developing a Digital Health Strategy:

> *"… to progress the core digital technologies presented in the New Zealand Health Strategy. It guides the strategic digital investments that are expected to occur across the health and disability sector in the next five years, 2016–2020. It will also align sector investment with value delivery and encourage health organisations to invest with greater clarity and confidence."*[22]

The strategy sets down the Vision for Health Technology, guiding investment in technologies across the health and disability sector. The Vision for Health Technology outlines the pivotal role technology plays in shaping the way New Zealanders "live well, stay well and get well' in 2027. Of

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[19] Minister of Health, *New Zealand Health Strategy: Roadmap of Actions 2016* (Wellington: Ministry of Health, 2016), 21.

[20] See https://www.digital.govt.nz/digital-government/strategy/ [Accessed 23 November 2018]

[21] See https://www.ict.govt.nz/guidance-and-resources/using-cloud-services/additional-background-information/cabinet-decisions/ [Accessed 26 November 2018]

[22] Ministry of Health, *Digital Health 2020*. https://www.health.govt.nz/our-work/ehealth/digital-health-2020 [Accessed 13 November 2018]

the nine themes, sustained change and innovation, and accessible, trusted information are directly aligned to the strategic context of this proposal.

5.2.6 Supporting the New Zealand Health and Disability System Review

This business case supports the flexibility required in core systems to support potential outcomes from the New Zealand Health and Disability System Review

In May 2018, the Minister of Health announced a review of the health and disability services. The review will be wide-ranging and firmly focused on a fairer future. It will look at the way health services are structured, resourced and delivered and seek to make recommendations covering the next decades. The review panel will provide an interim report by July 2019 and a final report by 31 March 2020. The Minister's expectations are that the panel "…will deliver robust and far-reaching recommendations".[23]

This review brings expectations of significant change from 2020. It will be important that the sector has in place systems that will support the flexibility that the outcomes of the review will demand. This will include being able to:

- respond easily to structural and organisational change across the sector
- provide high quality national data that supports effective decision-making
- continue to control the cost of healthcare
- better support the health service in delivering equity for all.

This business case supports the future flexibility and sustainability that will be required while maintaining a strong focus on cost management and use of data to support an equitable health service.

This business case also supports the use of off-ramps and pause points to enable the results of the review to be applied quickly and efficiently.

21

[23] See https://systemreview.health.govt.nz/ [Accessed 17 October 2018]; https://www.beehive.govt.nz/release/details-major-health-review-finalised [Accessed 17 October 2018]

5.3 Environmental context

This business case is presented in the context of immediate IT sustainability issues, effective use of health systems and data, data consistency across the sector, and positioning for further system consolidation

5.3.1 DHBs currently use a variety of finance, procurement, and supply chain systems

DHBs use a variety of finance and procurement systems, with DHBs covering 84% of New Zealand's population using Oracle EBS

10 DHBs covering 73% of the country's population-based funding are using Oracle across three instances. These DHBs comprise approximately 80% of the sector's procurement. A further three DHBs covering 11% of the country's population-based funding are also using Oracle across two instances (Capital & Coast, Hutt Valley, with Wairarapa in the process of moving to the Hutt Valley instance). This leaves seven DHBs covering 17% of the country's population-based funding using non-Oracle systems.

The table on the following page lists the current systems used by DHBs. These are grouped by level of perceived risk to operation (as assessed by the DHBs).

5.3.2 Many DHBs are facing immediate IT sustainability issues

Pausing NOS has left 10 DHBs using Oracle EBS with IT sustainability issues that must be resolved as a matter of urgency – risk will start to materialise in mid-2019 and early 2020

10 DHBs and their associated entities already using Oracle EBS were relying on the continuation of NOS to resolve their immediate IT sustainability issues. Placing NOS on pause has left them with application and/or infrastructure issues.

These DHBs and associated entities are:

- Auckland DHB
- Northland DHB
- Counties Manukau DHB
- Waitemata DHB
- The Three Harbours Health Foundation
- Middlemore Foundation for Health Innovation
- A+ Charitable Trust
- Taranaki DHB
- healthAlliance
- healthAlliance FPSC
- Northern Region Alliance
- NZ Health Partnerships Ltd
- Waikato DHB
- Healthshare
- Bay of Plenty DHB
- Canterbury DHB and
- West Coast DHB
- Southern DHB

NZ HEALTH PARTNERSHIPS

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Table 2 DHB systems

	DHB	PBF (net of IDF)	Current system	Comment
IMPLEM-ENTED	Bay of Plenty	5.0%	Oracle R 12.2.6	Wave One NOS Oracle instance Included in Risk Mitigation Business Case
	Canterbury	11.4%	Oracle R 12.2.6	
	Waikato	9.7%	Oracle R 12.2.6	
	West Coast	0.8%	Oracle R 12.2.6	
		26.9%		
INCLUDED IN RISK MITIGATION BUSINESS CASE	Auckland	14.9%	Oracle R 12.2.1	
	Counties Manukau	9.4%	Oracle R 12.2.1	
	Waitemata	9.3%	Oracle R 12.2.1	healthAlliance Oracle instance
	Northland	4.0%	Oracle R 12.2.1	
	Taranaki	2.4%	Oracle R 12.2.1	
	Southern	6.5%	Oracle R 11.10.xx	Separate Oracle instance
		46.4%		
MEDIUM RISK	Capital Coast	6.8%	Oracle R 11.10.xx	
	Hutt Valley	3.0%	Oracle R 12.2.2	
	Wairarapa	0.8%		Migrating onto Hutt Oracle system
	South Canterbury	1.2%	SunSystems	
		11.8%		
LOW RISK	Mid Central	3.8%	JDE	Shared Mid Central / Whanganui
	Whanganui	1.5%	JDE	
	Nelson Marlborough	3.0%	Tech One	
	Lakes	2.3%	Tech One	
	Tairawhiti	1.1%	Tech One	
	Hawkes Bay	3.4%	Tech One	
		14.9%		

21

For the 2017/18 financial year, the provider arm revenues of the 10 self-identified high-risk DHBs covered amounts to approximately $7 billion. Total Health Sector Provider arm revenues totalled $9.5 billion. These 10 DHBs represent 73% of all Health Sector Provider arm revenue. They employ approximately 47,700 full time equivalents with 85% of all staff employed working in clinical service delivery roles. These DHBs also spend over $1 billion on clinical supplies and a further $1 billion on infrastructure and non-clinical supplies annually. Their procurement comprises 80% of that of the whole sector.

These DHBs and associated entities signalled their risk by agreeing to pursue a collective parallel business case process for risk mitigation whereby they would fund their own risk mitigation by consolidating to a single up-to-date platform and infrastructure. (The Ministry of Health subsequently requested this business case to be folded into the FPIM business case.) They have therefore been ranked as having the highest self-identified risk for the purposes of this business case.

Northern region DHBs and Taranaki DHB are using a version of Oracle that by 2020 will be mostly unsupported on hardware that is already at end of life

The Northern Region (Auckland, Northland, Counties Manukau, Waitemata) and Taranaki DHBs are running a version of Oracle that was released in 2010 and implemented in 2011. Some of the components are completely out-of-support, and/or run in unpatched (and unsecured) environments. By 2020 most aspects of the system will be unsupported. This means that any problems that occur will be far more difficult to resolve as the supplier will only assist on a best-endeavours basis. Any failures will therefore be far more difficult to recover from and recovery will take longer.

The hardware in use in the Northern Region in 2017/18 is already end-of-life. There is no capability to operate from another site in the event of a failure, and in the event of a datacentre disruption (e.g. through a power failure at Middlemore), a service outage will occur. For example, Auckland DHB uses the system for real time supply of the 39 theatres. A supply chain outage for longer than half a working day can result in clinical risk. This system is therefore critical. This situation has come about because of a deliberate decision to minimise investment in existing platforms because of the expectation that NOS would resolve these issues.

Wave One DHBs are using Oracle infrastructure that reaches end of life in December 2019

The Oracle infrastructure used by the Wave NOS DHBs reaches end of life in December 2019. After this point technology updates cease to be available and hardware component replacement becomes limited due to the availability of parts that are supported by the firmware version. This means that any failures could be very difficult to recover from. Wave One DHBs are already experiencing problems obtaining additional disk storage for their system.

The Steering Committee decided to go live with Wave One and resolve some issues after go-live. However, the Cabinet instruction to pause the programme has limited the extent to which these issues can be resolved.

As is the case with the Northern DHBs and Taranaki, a system outage has clinical impact. If the procurement and supply chain functions are not available, the delivery of items critical for (by way of example) operations is impacted, resulting in delayed operations and clinical impact on patients.

Southern DHB's Oracle EBS system has been out of support since 2008 with no maintenance since 2004

Southern DHB's Oracle application and database has been out-of-support since 2008 with no maintenance performed since the system implementation in 2004. The Centos operating system that the application is running on is not certified by Oracle. As a result, any calls to Oracle Support requiring bug fixes or any development would be declined. Southern DHB cannot raise Severity 1 tickets with Oracle Support and can only rely on their database administrators' ability to use existing available knowledge to resolve them, as no new fixes will be created. Furthermore 3rd party systems relied upon for business as usual operation such as Rightfax and ADI (real-time journal interface and reporting with Oracle) are also unsupported.

While current infrastructure is stable, Southern DHB has no disaster recovery (DR) system to fall back on, and no long-term business continuity plan (BCP) that allows for manual business processes to be carried out beyond a few days. The IS department has also specifically discouraged any change requests or functionality improvements to Oracle EBS and its interfaces, to minimise risk of catastrophic failure that even minor changes might bring. As a result, the current financial and procurement functionality is out-dated and there are inefficiencies that more current releases would resolve.

The issues faced by Southern also will have clinical impact should the risk materialise, in a similar manner to the Northern DHBs, Taranaki, and Wave One DHBs.

South Canterbury DHB has delayed upgrading and is left with an unstable system

South Canterbury DHB is operating an older version of the SunSystems finance system. Because an upgrade would deliver little perceived advantage, it has decided not to pursue this option. This has left it with a "very unstable" finance system. South Canterbury has determined that it must upgrade in one to two years to manage this risk with indications that it may use TechnologyOne. South Canterbury notes that its hardware is fit for purpose and no immediate refresh is required.

Smaller DHBs have less resources to manage their systems issues

The smaller DHBs inevitably have reduced resources to operate their finance, procurement, and supply chain systems. This results in system risk when resources are not adequate to keep systems updated and effectively supporting the business. Some smaller DHBs have also delayed enhancements because of the expectations of transitioning to the FPIM.

Any failure in core finance, procurement, and supply chain systems would have consequential impacts on DHBs' ability to manage operations – this would have wide societal impacts.

The core finance, procurement, and supply chain systems have a wide reach into the operations of the DHBs. These DHBs are therefore increasingly at risk of systems failures or outages which will have severe consequences, including impacting on hospital operations. A failure of this kind would have wide societal impacts.

5.3.3 Productive investment requires effective use of health systems and data

Government is investing $8 billion in healthcare over the next four years to meet costs pressures and is seeking wellbeing and equity for all New Zealanders – it wants value from this investment

It is obvious that any investment made by Government must be productive and effectively support equity of access and equity of outcomes. This is especially so considering continuing local cost pressures from changes in demographics, prices, and patterns of illness.

New Zealand cost pressures are part of a global phenomenon as worldwide expenditure on health is projected to grow at 4.3% Compound Annual Growth Rate (CAGR) for 2015–2020. Healthcare in Asia and Australasia is projected to grow at 5% CAGR for the same period.[24]

While the sector has a long history of joined-up procurement initiatives, it has become more difficult for DHBs to continue to increase procurement value and manage costs

DHBs recognise the potential of joined-up, strategic procurement to improve value and address cost pressures. Recently this is evidenced through the development of the sector's first ever DHB Procurement Strategy (April 2016) and first ever Procurement Operating Model (March 2017), both facilitated by NZ Health Partnerships, and both approved by all 20 DHBs. These were developed as a result of DHBs seeking guidelines around how they approached procurement. The strategy and operating model will form the basis of new procurement initiatives and the principles and approaches are reflected in this business case.

However, savings from national procurement benefits have been minimal for most DHBs since 2014/15. This is because national procurement was established with the expectation that the national FPIM system would be built, implemented and providing nationally consistent data.

DHBs have opportunities to further increase procurement value through the PHARMAC model applied to medical devices covering $640 million pa

The previous government sought to increase procurement value by extending the PHARMAC model from pharmaceuticals into medical devices. In 2012 the government agreed to a phased plan for PHARMAC to progressively take on managing hospital medical devices. The aim of PHARMAC's role in this area is to create national consistency in access to treatment, improve and increase transparency of decision making, and improve the cost-effectiveness of public spending to generate savings.

PHARMAC has already achieved major savings in pharmaceuticals expenditure. This is illustrated in the following chart of actual versus estimated Combined Pharmaceutical Budget (CPB) expenditure at 2007 subsidies.

[24] Deloitte, *2018 Global health care outlook: The evolution of smart health care* (Deloitte, 2018), 7.

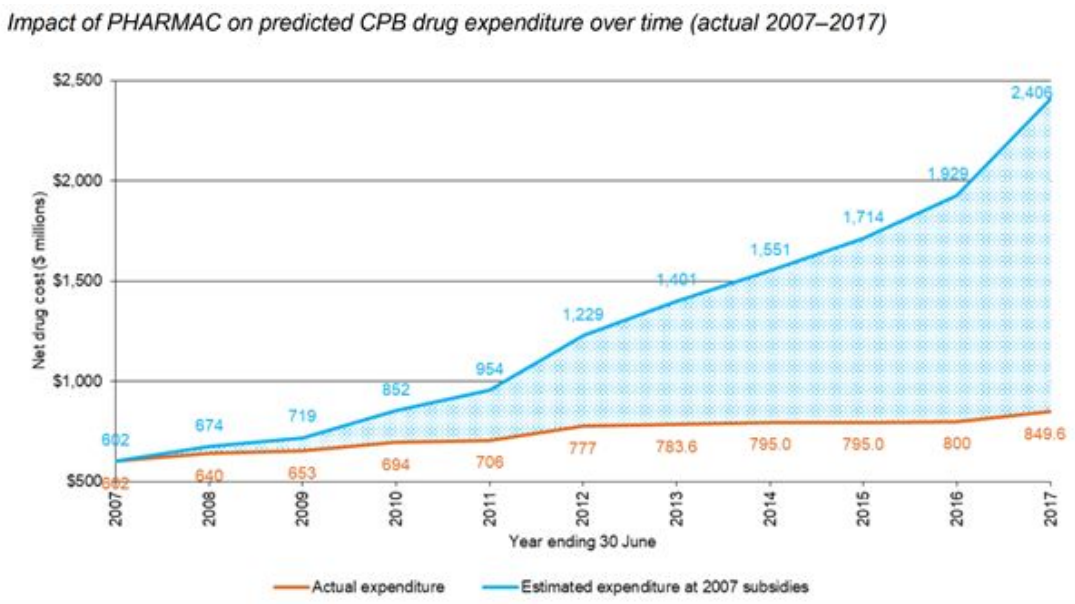

Figure 8 Impact of PHARMAC on Combined Pharmaceutical Budget[25]

PHARMAC stated in its 2017 annual report:

> *"Between 2007 and 2017, we [PHARMAC] saved DHBs a cumulative total of around $5.93 billion, including $ 1.56 billion in 2016/17. At the same time, the number of new medicines and people receiving them has increased."* [26]

As can be seen from the graph the PHARMAC approach has flattened the cost growth curve for pharmaceuticals. Over the 10-year period from 2007 to 2017, average annual expenditure was projected to grow at an average of 15% per annum. PHARMAC has been able to reduce this to 3.6%, one quarter of the projected year-on-year growth rate.

PHARMAC's work has expanded to include medical devices used in DHB hospitals.[27] It plans to have the major of medical device categories under management by the end of 2019.[28] This comprises an annual expenditure of approximately $640 million across 388 suppliers. Contracts will be renegotiated and improved as PHARMAC gains better information about the market and is able to negotiate improved conditions.

Gaining value from the PHARMAC contracts will require a national catalogue, data consistency, a national data repository, and compliance against contracts for all DHBs – and would achieve $32 million benefits pa

PHARMAC estimates that national contracts on a national catalogue would achieve savings of approximately 2% on total medical device costs. This is essentially the discount that suppliers offer based on saved time to individually deal with each DHB. However, if a national catalogue, consistent

[25] PHARMAC, Annual Report of Pharmaceutical Management Agency for the year ended 30 June 2017 (Wellington: PHARMAC, 2017), 30.

[26] Ibid, 30.

[27] See https://www.pharmac.govt.nz/hospital-devices/ [Accessed 9 October 2018]

[28] PHARMAC, Annual Report of Pharmaceutical Management Agency for the year ended 30 June 2017 (Wellington: PHARMAC, 2017), 5.

data, and compliance arrangements are in place, it estimates that this saving could rise to 7%.[29] This is based on experience with wound care products, whereby suppliers are guaranteed a share of the DHB spend.[30]

Medical device spending is currently approximately $640 million per annum. A 2% saving therefore translates into $13 million cost avoidance per annum. A 7% saving translates into $45 million per annum. Implementing a national catalogue, data standards, a national data repository, and compliance against national contracts at the time of purchase could therefore support cost avoidance in medical devices of 5%, or $32 million per annum.

For the model to operate and achieve benefits, all DHBs need to be using the national contracts with compliance against these contracts enforced at the time of purchase. PHARMAC maintains that after the fact monitoring of compliance is not sufficient for the savings to be achieved.

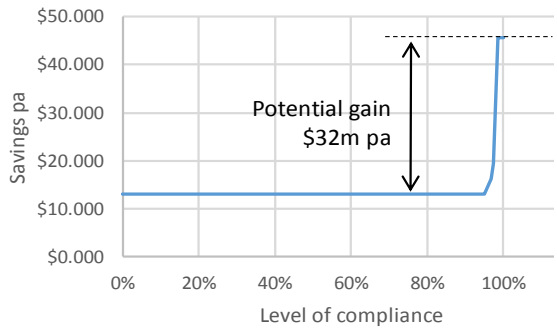

Figure 9 Illustration of potential savings for PHARMAC related medical devices with compliance across sector

There is at least another $102 million pa of true national procurement (identified by NZ Health Partnerships) where equivalent savings could be found in indirect products and services (i.e. non-medical) and capital procurement. When this is added in, the cost avoidance reaches $37.1 million pa (based on $640 million medical devices and $102 million other pa, a total of $742 million pa with savings at 5%).

This demonstrates a significant need to enhance existing DHB procurement systems and processes to provide the national catalogue, data consistency, and compliance management that PHARMAC requires to enable these major savings in medical devices.

Standardisation of financial, supply, and procurement master data could enable further efficiencies, most especially around cost savings from use of EDI to communicate with suppliers

Healthcare organisations worldwide have achieved some impressive efficiencies through standardised procurement data and the use of technologies such as barcodes and Electronic Document Interchange (EDI) for transmitting purchase orders, shipping notices, and invoices between suppliers and customers. Some examples are:

- In the UK NHS, "Scan4Safety" has been implemented at six Demonstrator Site trusts. This system uses global data standards for identification of products and inventory locations. Each

[29] Based on information provided directly to the business case team by PHARMAC.

[30] See PHARMAC, Annual Report of Pharmaceutical Management Agency for the year ended 30 June 2017 (Wellington: PHARMAC, 2017), 5.

Scan4Safety trust is on track to realise a 4:1 benefits ratio over a seven-year period. The benefits noted include releasing nursing time, reducing inventory, and ongoing operational efficiencies.[31]

- A health sector region in Denmark reduced its time spent ordering and ensuring the correct order submission of medical devices by 75% on average when it moved from manual processes to the scanning of barcodes for their inventory management processes.[32] Mercy ROi in the USA achieved a 73% reduction in purchaser order discrepancies by moving to a barcode enabled automated process.[33] (Barcoding relies upon standardised product coding.)
- Ramsay Healthcare in Australia reduced procure-to-pay processing costs by 95% through implementing full Electronic Data Interchange (EDI) with its suppliers. The cost to process a document via EDI (such as a purchase order or an invoice) dropped from approximately AU$35 per document to approximately AU$2.[34] (EDI relies upon standardised product coding.)

A future opportunity for benefits across the sector will come from using the governments planned e-invoicing initiative. In 2017 DHBs processed approximately 1.3 million invoices from suppliers. Information provided by MBIE indicates that for users of online software invoices cost $23.01 each to process. MBIE estimates that e-invoicing (whereby true electronic invoices are managed through central clearing houses and enter customer systems directly rather than by being keyed) could save 67% from this total.[35] This could translate to efficiency savings across DHBs of $20 million pa.

These examples point the way to how New Zealand can increase the value it receives from the government's investment in the health sector through procurement efficiencies.

5.3.4 The sector is well positioned for further system clustering

The sector has consolidated Finance, Procurement, and Supply Chain systems through regional clusters – this can continue

13 DHBs covering 83% of the country's population-based funding are using Oracle across five instances (Wave One NOS, Northern DHBs and Taranaki, Southern, Capital & Coast, Hutt/Wairarapa). This was the basis for the original decision to choose Oracle as the common platform for a consolidated finance, procurement, and supply chain system.

DHBs have long seen the benefit of consolidation and sharing of core finance, procurement, and supply chain systems. Significant consolidation has already occurred through local initiatives:

- Northern DHBs and Taranaki are operating on a shared Oracle system – Auckland, Counties Manukau, Northern, Taranaki, Waitemata. These DHBs are also operating shared services using this platform.

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[31] See https://www.scan4safety.nhs.uk/in-action/the-demonstrator-sites/ [Accessed 17 Sept 2018]

[32] Sine Carlsson, *GS1 barcodes on medical devices reduces stock and enhances patient safety* (GS1 Healthcare Reference Book 2016-2017). https://www.gs1.dk/media/1557/case-regsyd.pdf [Accessed 17 Sept 2018]

[33] See Dennis Black, Alex Zimmerman, *Perfect Order and Beyond* (BD and Mercy /ROI, 2012). https://www.medsc.org/pdfs/Mercy-ROi-BDCaseStudy-PerfectOrderandBeyondJan2012.pdf [Accessed 17 Sept 2018]

[34] Andrew Potter, *Ramsay Health Care getting the benefits of using GS1 standards* (GS1 Healthcare Reference Book 2016-2017). https://www.gs1ca.org/pages/n/sectors/hc/Case_Studies/2016-2017/Australia-The_benefits_of_using_GS1_standards.pdf [Accessed 17 Sept 2018]

[35] Information provided from MBIE by email on 23 November 2018.

- The Wave One DHBs are using a single Oracle instance – Bay of Plenty, Canterbury, Waikato, West Coast.
- MidCentral and Whanganui are sharing a single JD Edwards (JDE) system.
- Capital and Coast, Hutt Valley, and Wairarapa are sharing IT services.

It is expected that outside of any centralised initiatives to consolidate systems, local requirements will continue to drive tactical consolidation. For example, there is an opportunity for the four DHBs using TechnologyOne to consolidate on to a single instance hosted on-premises or in the cloud.

Current governance and operating models will be enhanced to achieve the benefits from increased consolidation

This business case is by its very nature focused on common good benefits, most notably in PHARMAC procurement of medical devices. All DHBs are autonomous but must cooperate to achieve these common good benefits. Achieving the benefits from shared systems and practices requires strong governance across all DHBs. This will be especially difficult when different DHBs see different levels of benefit (or disadvantage) from any shared initiatives.

Further, it is unclear how benefits achieved through applying the PHARMAC model will be shared with DHBs. There is little incentive under existing arrangements for DHBs to adopt a common good approach to procurement systems if the benefits are not shared with DHBs. If this is not resolved, it will naturally drive continued fragmentation of systems and common good procurement savings will not be achieved. This must be resolved through active engagement with PHARMAC in any governance of sector wide procurement systems.

Operating shared systems on behalf of all DHBs will require a neutral organisation to operate the service on behalf of all DHBs with agreed governance, shared processes and Service Level Agreements. If one DHB (or a group of DHBs) operates on behalf of others, service levels will inevitably be skewed (or will be perceived to be skewed) to the operator of the service.

5.4 Scope of this business case

The scope of this business case is: the finance, procurement, and supply chain systems at all 20 DHBs, the infrastructure required to operate these systems, and the governance and benefits realisation management

Cabinet has requested "… a new programme business case" for FPIM.[36] The scope of this business case is therefore confined to those products, services, and benefits contemplated under the Finance, Procurement, and Supply Chain programme as defined in the last change control report for the NOS programme.[37] This is summarised in the following table.

Table 3 Scope of business for this business case

Included in scope	Excluded from scope
Systems and processes	
Finance, procurement, and supply chain systems and their supporting processes	Clinical systems Patient management systems
Interfaces to and from other DHB systems and the finance, procurement, and supply chain systems	
Infrastructure required to operate finance, procurement, and supply chain systems whether hosted, cloud, or a combination	Infrastructure for other DHB systems
Enablers for shared services	Implementation of shared supply chain services Implementation of shared financial services
Operation	
Support of finance, procurement, and supply chain systems	Other systems
Management of a common national catalogue for procurement of good and services managed under national, regional, and local contracts	
Data governance of finance, procurement, and supply chain data	Data outside these systems
Benefits realisation management	
Implementation	
Immediate addressing of issues regarding Wave One NOS DHBs and self-identified high risk DHBs	Immediate addressing of risk regarding other DHBs who have not selected to be part of the group of 10 self-identified high risk DHBs

[36] "Cabinet requires NZ Health Partnerships to develop a new programme business case". See Letter from DG Health to Megan Main, CE NZ Health Partnerships, 28 June 2018, 2.

[37] NZ Health Partnerships, *NOS Revised Business Case – Change Control Report* (NZ Health Partnerships, 2017).

Included in scope	Excluded from scope
Implementation of all systems, processes and change required to operate and manage systems and processes	
Change management for DHBs changing systems or upgrading as a result of preferred option	
Central programme costs and DHB implementation costs	

References to data in this business case, unless otherwise noted, refer to finance, procurement, and supply chain data.

5.5 Problems faced

The critical problems faced by the DHBs covered in this business case are systems risk and sustainability, and procurement value for money – supply risk, and efficient operation are also subsidiary issues that need to be addressed

Two Investment Logic Mapping (ILM) workshops were held with key stakeholders (principally DHB CFOs and CIOs) in September and October 2018. These confirmed the problems and benefits to be addressed in this business case and the contribution of each. The problems identified are summarised below. The problems and benefits were subsequently adjusted to reflect input from DHB Chief Executives at a workshop on 7 November 2018 and the Steering Committee on 3 December 2018.

5.5.1 PROBLEM ONE: System risk and sustainability

10 DHBs have immediate system risk issues that will materialise in 2020 – at least four other DHBs have issues that need resolution in two to three years

The Wave One DHBs, the Northern DHBs including Taranaki, and Southern DHB have immediate sustainability issues. The Wave One and Northern infrastructure requires remediation by the end of 2019 if operation is to continue at acceptable risk. Southern DHB is running on an older version of Oracle and has key person dependencies around support.

South Canterbury's current system is unstable and requires remediation in the next one to two years. Capital & Coast, Hutt Valley, and Wairarapa are running older versions of Oracle that will need upgrading at some point to mitigate risk, possibly in the next two to three years.

Mid-Central and Whanganui are operating JDE 9.1. This comes out of support in March 2020. An upgrade is planned to mitigate this risk.

The smaller DHBs inevitably have reduced resources to operate their finance, procurement, and supply chain systems. This results in system risk when resources are not available to keep systems updated and effectively supporting the business.

There is increasing reliance on the finance, procurement, and supply chain systems and increased impact on DHBs when they fail

A Deep Dive Risk and Impact assessment workshop was held with key subject matter experts from healthAlliance and Auckland DHB to better understand the issue and impact of finance, procurement, and supply chain systems. The workshop modelled a range of scenarios across supply chain, procurement, finance and clinical, looking at variables such as timing and duration of outages, to better understand business continuity procedures and identify when the delivery of health service could be critically impacted. These issues will be common across all DHBs facing the impacts of older systems.

The following was noted at the workshop:

- Continuing operational drivers to reduce headcount, reduce inventory held days (from 100 to 30) and receive just in time deliveries increase the requirement for systems to be available at all times.
- In the case of a major systems failure, business continuity procedures are invoked. However, because business continuity plans require (typically) a reversion to manual processes, their operation requires more resource and takes longer.
- Successful operation of business continuity relies upon prioritisation to match resource to workload. This prioritisation itself takes time and effort, adding more pressure. After the second

day of an outage a centralised team would need to be established to manage the delegated authorities and decision making.

- Impact would be felt most in areas where stock turnover is high. Specialist ordering was expected to be less impacted due to the nature of the relationships with suppliers and greater clinical knowledge of the items.
- Reliance on the system to know supplier and product details would create issues for manual ordering.
- Suppliers are often not equipped to receive email or phone orders because of their own automated systems.
- Reconciliation after the systems have been restored would be difficult and very open to error, especially in accounts payable and accounts receivable.
- System processes such as vendor inventory management require the data to be corrected and updated before automated ordering processes can begin to function again. Consequently, operations can be expected to be impacted for many days after the system is back up and running.

System outages therefore have significant impacts beyond just the system is unavailable.

Any failure in core finance, procurement, and supply chain systems would have consequential impacts on DHBs' ability to manage operations – this would have wide societal impacts.

The core finance, procurement, and supply chain systems have a wide reach into the operations of the DHBs. These DHBs are therefore increasingly at risk of systems failures or outages which will have severe consequences, including impacting on hospital operations. A failure of this kind would have wide societal impacts.

Failure to address immediate sustainability issues creates associated problems – cyber security vulnerabilities, performance issues, difficulty in retaining staff, increased support costs, and reduced ability to undertake new work

While there are immediate risks with not upgrading existing systems, there are also associated issues.

- Older versions of Oracle software are more likely to have potential cyber risk vulnerabilities.
- Older versions of Oracle software are subject to speed and performance issues.
- Any halt in project work to resolve the issues would see potential loss of the staff competency and system development capability that has been built up. The programme team and their collective capability, insight and understanding would be increasingly lost to other projects.
- The current operational capability will become increasingly likely to reduce as staff move on to new platforms and look to evolve their knowledge, employability, and marketability elsewhere. This will in turn raise the risk of systems issues/failure and reduce the capability to for the organisation(s) to be able to respond.
- Support costs will climb as more fixes are required on ageing systems and/or infrastructure, and as staff leave those remaining will demand high remuneration and/or support will be outsourced to higher cost parties.
- There will also be a reduction of support from Oracle. This will lead to higher costs as other support capability is bought in. It also increases risk as less experienced or offshore parties are used.

- DHBs will be unable to progress savings and innovations anticipated from the continuation of the FPIM programme.
- The capacity of the current arrangements will hit constraints. This will limit DHBs from taking on new suppliers or for key larger northern DHBs act as back up for smaller DHBs.

Processes and systems cannot be easily and consistently adapted to meet changing health sector needs

DHB systems are currently split across:

- The Wave One FPIM DHBs sharing a single Oracle instance
- The Northern DHBs plus Taranaki and Southern, who will join the Wave One Oracle DHBs on a single instance
- Hutt Valley (and Wairarapa from mid-2019) operating on a single instance of Oracle
- MidCentral and Whanganui sharing a JDE system
- The remaining DHBs each running their own systems – Technology One and SunSystems.

It is difficult to make global changes for all DHBs as these need to be implemented in multiple DHBs using differing systems. One example would be changes in bank accounts. More complex requirements (e.g. use of common EDI formats) become even more difficult.

5.5.2 PROBLEM TWO: Ineffective procurement

The lack of a single national catalogue, national data standards, high quality procurement data, and an effective compliance programme are hindering effective procurement across the health sector

The DHBs need to increase the value for money from procurement if escalating costs are to be managed. This requires DHBs to improve the value gained from the contracts with suppliers. In general, this means reducing the number of suppliers and items bought, enabling the sector to offer greater volume for suppliers, thereby enabling lower prices and increased value from contracts. This requires the DHBs to work together to achieve better value for the whole sector.

To achieve this the sector needs:

- National contracts for high value / high spend items so that suppliers can achieve greater volume and thereby offer lower prices and better value
- A single national catalogue so that DHBs consistently purchase the specified items against these contracts and so gain the benefits that have been negotiated
- High quality procurement data compliant with national data standards so that the sector can retain its negotiating power with suppliers and monitor compliance of the DHBs against these contracts
- Ability to ensure that DHBs use the contracts and do not buy equivalent items from non-approved suppliers.

Currently there is $640 million pa spent on medical devices across 388 suppliers and subject to PHARMAC management. NZ Health Partnerships has identified at least another $102 million pa that could be managed under national contracts.

PHARMAC has gathered significant experience with the procurement of medical devices. PHARMAC's advice (based on experience with wound care products) is that:

- A national catalogue by itself can achieve 2% savings across the whole medical device catalogue.
- The ability to ensure compliance of purchasers – i.e. they can only purchase items from these contracts and cannot purchase equivalent items from other suppliers – will raise this cost saving to 7%.

When this 5% uplift is applied across the total spend this translates to potential cost avoidance of $37.1 million per annum (based on $640 million medical devices and $102 million other pa, a total of $742 million pa with savings at 5%).

Currently there is no single national procurement catalogue. Each DHB or cluster of DHBs manages its own catalogues and uses differing data standards for these catalogues. There are significant data inconsistencies across the sector. NZ Health Partnerships operates a data hub that consolidates procurement data from the DHBs. The following data issues have been observed in the 2017/18 financial year:

- Missing data files from DHBs – 11 monthly return files were not received from DHBs in the 2017/18 financial year
- Duplicated data causing artificially inflated spending figures – e.g. an amount for $555,728 for one DHB was duplicated 18 times
- Inconsistencies in the number of data fields sent from DHBs – the total number of data fields sent by DHBs varies from 10 up to 45, skewing the overall picture provided by the data across DHBs
- The types of data fields sent by DHBs differ significantly, depending upon the systems used by the DHBs, how these were implemented and how they are used – this again skews the overall picture provided by the data across all DHBs
- Mandatory fields are often left blank – of the 17 mandatory fields for data collection some DHBs provided as few as 10
- Unit of measure inconsistencies across DHBs leading to incorrect data and pricing – this is often because of the different underlying processes and levels of procurement process maturity across DHBs
- Mismatches between quantities procured, quantities received, and the actual price paid for items – also a sign of different underlying processes and levels of maturity across DHBs
- Incomplete data fields so the spend cannot be allocated against overall categories for analysis – e.g. missing supplier codes, item codes, supplier time references, etc.

These issues mean that the consolidated data is of relatively low usefulness. In the 2017/18 financial year, $3.7 billion of spending out of a total of $5 billion could not be allocated to an item code or a category.

DHBs have been moving towards a common chart of accounts for many years. However, analysis shows that all DHBs have departed from the standards in their own systems. Variations range from 10 to 100%, with an average 30% across the sector, and this is with only a few hundred codes that change infrequently.

The Health Information Standards Organisation (HISO) has recently released data standards for medical device terminology and identification. This will require implementation across the whole

sector with all devices matched to the HISO coding system. The current data quality issues with each DHB managing its own catalogues will make accurate coding very difficult if not impractical.

From the limited, poor quality data we have today we know DHBs are paying significantly different prices for a vast range of products and services. Peritoneal Dialysis Fluids are a good example:

- For one type of fluid three DHBs are currently paying $10.81 per bag; three others are paying $14.01.
- There are only four DHBs that purchase another type of PDF fluid. Three of these DHBs are paying $18.56 per bag, while the fourth is paying $29.43 for the same product.

Today, without visibility of the underlying data, the New Zealand health system is at a disadvantage. Pacemakers are but one example:

- In Victoria, Australia the average price paid for a single chamber ICD is NZD$9,858. In New Zealand the volume weighted average price is nearly 30% higher at NZD$13,832.
- Double chamber ICDs cost NZD$11,707 in Victoria. In New Zealand we pay NZD$15,548.

Two subsidiary problems were also identified – product tracking against people and events, and efficient operation

5.5.3 PROBLEM THREE: Product tracking

Significant variation across the sector in the ability to track specific products to individuals or events presents clinical risk

Each DHB has varying ability to track procured items against clinical events (e.g. operations) or people (e.g. patients and staff). The data held on procured items is not recorded consistently across the sector.

If there are problems with specific medical devices – for example, in the case of recalls – while some DHBs can provide the information, it is difficult to gain an accurate national picture of the problem and therefore mount a national response.

The lack of a national catalogue and consistent data limits the extent of national responses to supplier issues. For example, in the case of suppliers not being able to supply specific items, it is difficult to coordinate a national response to ensure that clinical risk is managed across all DHBs.

Anecdotal feedback is that DHBs have so far been able to manage product risk without a public crisis. However, the responses to issues faced have been hindered by lack of good data, and these outcomes have been achieved only by good fortune. It is only a matter of time before a product issue occurs that cannot be effectively managed at the national level.

5.5.4 PROBLEM FOUR: Efficient operations

Disparate systems and manual processes are driving unnecessary duplication of procurement effort

DHBs are at different levels of maturity in terms of their procurement implementation. Some DHBs require purchase orders for all invoices and can support automated matching, whereas other DHBs are running more traditional accounts payable centred processes for paying invoices. There are no current mechanisms whereby best practices can be easily propagated across all DHBs.

Each DHB manages its own procurement and its own product and services catalogue (although several do not have a catalogue). Items procured under national contracts therefore need to be

loaded into local catalogues by individual DHBs and managed by these DHBs. There is no current opportunity for this to be implemented once for the whole sector.

One significant opportunity for efficiencies is the use of Electronic Document Interfaces (EDI) for transmitting purchase orders, shipping notices, and invoices. Currently each DHB or cluster of DHBs must negotiate interface standards with its suppliers and implement its own gateways. Even if DHBs share gateway infrastructure, they still need to ensure that common data standards are met with the supplier so that the EDI can work effectively.

5.6 Benefits that can be achieved

If these problems are solved, key benefits can be achieved in sustainable systems at acceptable risk, and more effective procurement – better informed decision-making, and improved supply risk management will also result

The second of the two Investment Logic Mapping (ILM) workshops focused on the potential benefits that could be achieved if the problems were resolved. These benefits are outlined below. Note that they have been adjusted to explicitly address system sustainability and procurement to reflect input from DHB Chief Executives at a workshop on 7 November 2018 and the programme Steering Committee on 3 December 2018.

5.6.1 BENEFIT ONE: Sustainable systems at acceptable risk

Finance, procurement, and supply chain systems operating at acceptable risk and supporting change in the future

The benefits related to sustainable systems at acceptable risk are:

- Reduction in probability of finance, procurement, and supply chain outages
- Improved time to recover from outages
- Stable and predictable infrastructure and systems
- Fit-for purpose protection against cyber-security attacks and confidential data breaches
- Reduction in key person and DHB systems intellectual property risk – for example, recent healthAlliance engagement surveys have shown that technical team engagement scores have declined, and comments made attribute this to uncertainty and satisfaction; Southern DHB is dependent on one critical IT staff member to maintain its systems
- Ability to respond to environment and sector changes in the future.

These can be measured by:

- Systems availability
- Time to recover
- Achievement of performance service levels
- Level of corporate IT risks reported to Board.

This benefit directly reflects what can result from addressing the key problem of system risk and sustainability.

5.6.2 BENEFIT TWO: Effective procurement

Increased value from procured goods and services through use of a national procurement catalogue and master data along with a compliance regime to support improved contracts

All DHBs have opportunity to obtain greater value from its external spend. We estimate that value improvement could be achieved across approximately $742 million procurement pa across all DHBs. This comprises $640 million pa in medical devices across 388 suppliers and (at least) a potential further $102 million pa of goods that could be procured through national contracts.

The key areas of value that can be achieved are:

- Reduced short term cost – as noted above PHARMAC advice is that consistent compliance with and reporting on national contracts could achieve additional savings of 5% per annum across the targeted expenditure of $742 million pa ($640 million pa medical devices plus $102 million pa other). This equates to potential cost avoidance of $37.1 million per annum across all DHBs.
- Reduced supply risk – national contracts in conjunction with consistent national data can be used to ensure continuity of supply and therefore continuity of care.
- Improved asset management – wider and deeper data on assets purchased across DHBs and their ongoing costs will help improve asset management, especially regarding minimising total costs of ownership through better visibility of ongoing operating costs and whole of life costs.
- Reduced total cost of ownership – the combination of improved procurement, improved data, and improved supply chain management can be used to reduce the overall total cost of ownership of procurement and supply chain. This includes such areas as improved delivery approaches to reduce freight costs, improved management of inventory and use of working capital, improved transfer of risk to supply chain partners (e.g. Onelink), reduced number of write-offs because of excess purchases or poorly managed change, more economic order sizes, more efficient management of procurement and supply chain, more efficient use of funds from order to payment.
- Improved management of innovation – consistent, accurate national data enables a national view to be taken on innovation. This is critical for PHARMAC to succeed with medical devices in the same way it has with pharmaceuticals. This will significantly increase the value of the health dollar spent across the sector.
- Improved management of suppliers through improved availability of high-quality procurement and supplier data.
- Improved supplier confidence in dealing with government – the recent government procurement survey notes that there are still significant areas where improvements can be made.[38]

There is a wide difference between what supply management leaders can achieve in value versus what all others achieve. Because of the paucity of data available across DHBs it is not possible to benchmark health sector supply management performance. However, given the variety of systems

[38] See Ministry of Business, Innovation & Employment, *New Zealand Government Procurement Business Survey 2018* (NZ Government, 2018). https://www.procurement.govt.nz/assets/procurement-property/documents/2018-business-survey-report-government-procurement.pdf [Accessed 3 December 2018]

and lack of true national procurement, it is likely that the sector could achieve major savings if it had consistent systems and processes.

A study by A.T. Kearney[39] noted the following:

> "Leaders achieve nearly three times higher return on their supply management assets score versus other companies, and they also deliver a broader array of value. Leaders are two and a half times more likely to deliver a high impact on managing supply risk, four times more likely on reducing structural total cost of ownership (TCO), seven times more likely on driving innovation, and 13 times more likely on positioning their supply management organization to be a talent source for the rest of the enterprise." [40]

This is illustrated in the following graph.

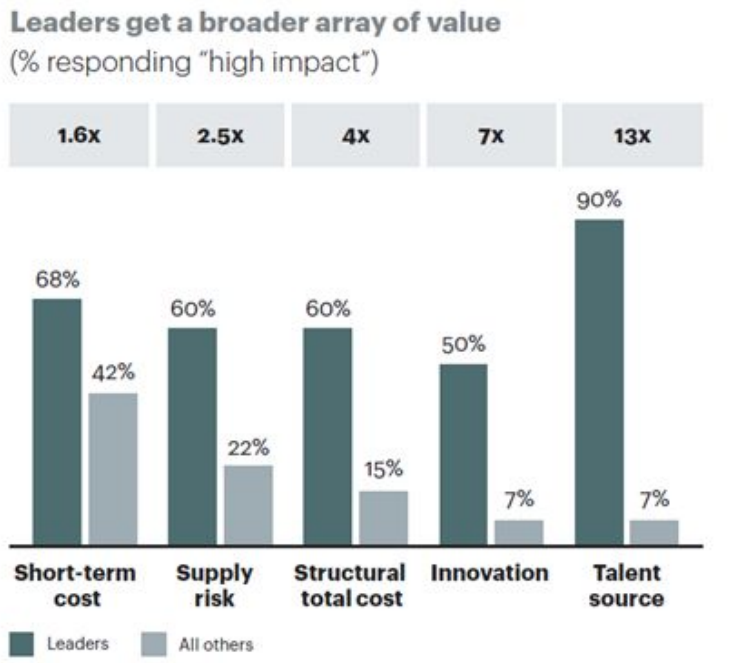

Figure 10 Ability of leaders to achieve value improvements from supply management[41]

The report from which this graph is taken notes that 73% of this value is generated by category excellence, with the remaining 27% coming from supplier excellence. Increased value comes through applying tailored methods based on a category's supply and demand power balance. It also requires taking a longer-term view of categories,[42] an approach that PHARMAC is already taking.

Achieving this level of uplift in value in the health sector requires a national view and approach across all DHBs.

Improved procurement cost can be measured by the following:

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[39] Mike Hales, Sonali Agarwal, John Blascovich, Alex Thoreson, *Mobilising for excellence in supply management* (A.T. Kearney, 2017).

[40] Ibid, 2.

[41] Ibid, 2.

[42] Ibid, 4.

- Standard cost tracking against items to determine the purchase price variance – this measures how costs have tracked for specific items from pre-national contract to actual prices paid (including freight)
- Comparison of the forecast volume and volume-related costs versus the actual – this measures the integrity of order forecasting and how well the negotiated deals have been achieved.

Improved supply chain management can be indicated by:

- Reduction in average age of stock – this measures improvements in the management of stock against usage and how well supply chain partners are being used
- Reductions in write-offs of stock – this measures improvements in how well stock is managed in terms of expiry dates and changes
- Reductions in working capital – this measures the overall level of inventory and how this is tracking
- Reductions in freight cost per item – this measures how well shipping is managed for individual stock items
- Reduction in purchase order discrepancies through failure of automatic matching of order, receipt, and invoice – this measures the accuracy of the procurement-to-payment process
- Reduction in cost to process procurement transactions – this measures efficiency of the procurement-to-payment cycle.

Compliance with national procurement approaches can be indicated by:

- Improved national catalogue utilisation and reduced off-catalogue spending – this measures compliance with the use of national catalogue items and therefore the ability to support more effective national procurement
- Reduced duplication of catalogue items – this measures the effectiveness of national procurement to achieve single contracts covering the same supplier/product item and the effectiveness of managing the information that can be gathered from procurement of these items
- Reduced local DHB catalogue entries in categories targeted for national procurement – measures coverage of national procurement arrangements and usage of current national procurement arrangements.

Other potential benefits include better informed decision-making, increased efficiency, and improved supply management – these are lower priority benefits

5.6.3 BENEFIT THREE: Better informed decision-making

Increased quality and availability of data will support better informed decision-making

High data quality is a pre-requisite to using data to gain insights. It is a truism that low-quality data cannot lead to accurate analysis. As noted in the Deloitte 2018 health care outlook, "Health data is the new health care currency as organisations increasingly use advanced digital and cognitive technologies to mine vast amounts of data to produce clinical and operational insights."[43]

The current consolidated finance, procurement, and supply chain data is of relatively low value. It suffers from duplicated data, missing data, inconsistencies between DHBs as to how data fields are used, and missing mandatory fields. These issues reach right back into how each DHB manages its own business and how it ensures it has the data required.

High data quality will lead to:

- Increased value of insights through having complete and accurate data
- Increased timeliness of insights through the use of up-to-date data that does not need retrospective cleansing or triangulation with other data to ensure analysis is accurate
- Increased statistical value of insights because of an increase in the range of data that can be analysed and relied upon to support the insights.

These can be measured by the following:

- Increase in proportion of data fields that can be matched across DHBs against the national procurement catalogue – this measures consistency of procurement data held across DHBs
- Increase in proportion of national procurement spend that can be mapped to a product category – this measures consistency of catalogue category information across DHBs
- Reduced missing key data fields in core data tables – this measures the completeness of the data held in core procurement tables.

5.6.4 BENEFIT FOUR: Increased efficiency

Increased operating efficiencies can occur in finance, procurement, and supply chain

The use of common systems, processes, and data standards across DHBs provides great opportunity for increased efficiencies. The most obvious candidate is that of shared services. The use of a common platform across DHBs enables staff to use the same system for common processes across DHBs. For example, Northern DHBs already run shared services through their use of a common Oracle system. Shared services in the more mechanical areas of the finance business enable more effective use of staff across DHBs and throughout the monthly and annual business cycles.

The use of common systems, processes, and operating models enables best practices to be propagated across all DHBs. This enables learnings at one DHB to be incorporated across the whole sector. Reports developed for one DHB can be used by all DHBs. Functions developed for one DHB can be used by all DHBs.

[43] Deloitte, *2018 Global health care outlook: The evolution of smart health care* (Deloitte, 2018), 19.

Common systems sharing common data enable one set of data input to be made on behalf of all DHBs. This will become especially important in the case of a national catalogue, whereby one person can enter a contract (in all its complexity, sometimes requiring more than a thousand lines to be entered) and the entry can then be made available to all DHBs. The alternative is for DHBs to all enter their own. In many cases, smaller DHBs may not enter the item, thereby impacting PHARMAC's negotiated contract, as well as the DHB not benefitting from the negotiated price.

Shared EDI infrastructure will enable all DHBs to dramatically reduce their operational effort regarding processing procurement-to-payment transactions.

If DHBs share a single system (one of the potential solutions), technical support can be undertaken through a common shared service rather than each DHB individually investing in staff with the high level of technical skill required. A single system means that software upgrades can be undertaken once for all DHBs, rather than each DHB going through the upgrade process individually.

Some of the smaller DHBs have less ability to manage system change and their staff have many roles to fulfil. Shared systems and services have the potential to provide them with the systems they need while relying on a larger resource pool than they themselves can fund. This has been one of the factors driving system consolidation in the sector.

A future opportunity for benefits across the sector will come from using the government's planned e-invoicing initiative. In 2017 DHBs processed approximately 1.3 million invoices from suppliers. Information provided by MBIE indicates that for users of online software invoices cost $23.01 each to process. MBIE estimates that e-invoicing (whereby true electronic invoices are managed through central clearing houses and enter customer systems directly rather than by being keyed) could save 67% from this total.[44] This could translate to efficiency savings across DHBs of $20 million pa.

5.6.5 BENEFIT FIVE: Improved supply management

Improved supply chain management contributing to reduced clinical risk through standardised products tracked against events and people and improved supplier management

The benefits related to improved supply management are as follows:

- Standardisation of medical devices, equipment, and processes to ensure all health services, regardless of size and location, have access to the same equipment at the same price
- Standardisation of medical devices, equipment, and processes to support better auditing as a quality improvement process to improve patient care
- Improved visibility of stock levels and traceability through the supply chain to help ensure the right tools, get to the right hands, at the right time
- Best practices from supply chain management applied across all DHBs to ensure right items available at right time at right cost
- Reduction of "preference-based decisions" whereby items are purchased through familiarity rather than because of demonstrable clinical outcomes – this will support improved clinical outcomes
- Standardisation of processes to ensure that clinicians working across multiple DHBs are more likely to be familiar with the equipment used at all sites, resulting in improved safety and clinical outcomes.

[44] Information provided from MBIE by email on 23 November 2018.

These can be measured by the following:

- Reduced time to identify patients who have received a specific product across all DHBs – this measures the ability to identify who might be impacted by issues with a specific medical device
- Reduced time to identify alternate supplies of products or services in the case of a supplier failure – this measures the ability to ensure continuity of supply when there are supplier issues.

5.7 Primary investment objectives

Two critical investment objectives have been identified: address risks from end-of-life systems and achieve savings from procurement

These investment objectives are used in the Economic Case to compare the options.

Table 4 Summary of the critical investment objectives

Investment Objective One	Address risks from end-of-life systems
Statement	Finance, procurement, and supply chain systems will operate at acceptable risk and be able to adapt to future change
Key requirements	• Operation of infrastructure and application systems at acceptable risk • Ability to adapt to change with and across the sector • Ability to take advantage of new technologies • Ability to use industry best practices
Current arrangements	• Varying DHB corporate risks regarding Finance, Procurement, and Supply Chain systems including supportability of systems and/or infrastructure, business continuity support • 10 DHBs have immediate risk that must be addressed from mid-2019 to early 2020
Potential measures	• Time to recover following primary systems failure • Number of IT related risks on corporate risk registers above medium level for each DHB • Number of systems and platforms no longer eligible for premium support from suppliers weighted by criticality to delivery of service

Investment Objective Two	Achieve savings from procurement
Statement	Improved procurement value through effective use of national data and procurement arrangements and processes
Key requirements	• National management of medical device contracts via PHARMAC • National management of contracts for other candidate national procurement categories e.g. capital and indirect products and services • A single national procurement catalogue • Data standards for procurement in place and adhered to • Consistent procurement data across all DHBs • Management of compliance against the agreed national catalogue items • National monitoring and management of procurement value for money
Current arrangements	• No national catalogue in place • Recorded procurement data is inconsistent within and across DHBs • No ability to manage and monitor compliance against national procurement

	contracts
Potential measures	• Standard cost tracking against items to determine the purchase price variance • Comparison of the forecast versus actual volume and volume-related costs • Reduction in average age of stock • Reductions in write-offs of stock • Reductions in working capital • Reductions in freight cost per item • Improved national catalogue utilisation and reduced off-catalogue spending • Reduced duplication of catalogue items • Reduced average category costs • Reduced on-cost for an inventory item or delivery of an ordered item to where it is required • Reduction in purchase order discrepancies • Reduction in cost to process procurement-to- payment transactions

5.8 Secondary investment objectives

Three supporting investment objectives have been identified: informed decision-making, efficient operation, improved supply management

Table 5 Summary of the supporting investment objectives

Investment Objective Three	Better informed decision-making
Statement	Better informed decision-making through higher quality, higher value, and more timely data
Key requirements	• Common data standards in place across all DHBs • Essential data gathered and stored • Data collections to be complete and consistent • Data accessible for national analysis and reporting • Ongoing monitoring and management to ensure compliance against data standards
Current arrangements	• Each DHB has its own data standards with varying levels of compliance • Variable levels of data quality within DHBs • Low ability to analyse across DHBs because of varying data standards and quality across DHBs
Potential measures	• Increase in proportion of data fields that can be matched across all DHBs against the national procurement catalogue • Increase in proportion of national procurement spend that can be mapped to a product category • Reduction in missing key data fields in core data tables

Investment Objective Four	Efficient operation
Statement	Finance, procurement, and supply chain systems will operate efficiently
Key requirements	• Efficient finance, procurement, and supply chain processes • Efficient utilisation of inventory • Cost effective delivery of inventory items to point of use
Current arrangements	• Varying levels of efficiency across Finance, Procurement, and Supply Chain in DHBs • Limited ability to propagate best practices across DHBs
Key measures	• Reduced on-cost for an inventory item or delivery of an ordered item to where it is required • Reduced team size to process equivalent level of transactions

Investment Objective Five	Improved supply management
Statement	Improved supply management contributing to reduced clinical risk through effective access to, and use of, procurement and supply chain data
Key requirements	• Adherence to common data standards • Consistent national data, especially regarding medical devices • Access to and use of national data to manage clinical risk relating to procured items (e.g. recalls, supply chain issues)
Current arrangements	• Limited ability to track medical devices to people or events • Limited ability to mount national responses to supply problems as each DHB manages its own stocks and it is difficult to match specific items across all DHBs
Potential measures	• Reduced time to identify patients who have received a specific product (across all DHBs) • Reduced time to identify alternate supplies of products or services in the case of a supplier failure

5.9 Key Constraints and Interdependencies

It is urgent that work start quickly to resolve infrastructure issues, and FPIM requires some work to be completed and functioning well for Wave One

This business case has some key constraints and dependencies. These are described below.

- Current proposals for mitigation of infrastructure risk at the Northern DHBs and Taranaki DHB require the building of core infrastructure to start in early 2019. Cabinet has instructed a pause for the programme; therefore, this work potentially cannot start until the programme has been "un-paused". The urgency of starting work could potentially drive DHBs away from a collective risk mitigation approach using shared infrastructure to a DHB by DHB approach that addresses their own issues, but prevents benefits from increased sharing of systems.

- Wave One DHBs need to make an investment decision to upgrade their existing Oracle Database Appliance (ODA) infrastructure by the end of March 2019. If there is no certainty whether and when the National Technology build will commence this too may lead to individual actions being taken that preclude the collective risk mitigation approach (although this would still align with the clustered option). Delays will result in "regrettable spending" to enable the existing environments to be temporarily extended to manage risk.

- The existing NOS system requires further work before additional DHBs can be migrated on to this system. This includes implementation of Oracle middleware to enable the use of such facilities as EDI, and software to enable DHBs to access the reporting they need.

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6. Economic case

This section presents the critical success factors, outlines the options considered, analyses the options, and proposes a preferred option for investment

6.1 Introduction

This section presents the economic case for investment in a preferred option. It:

- Presents the critical success factors for the options to be considered
- Develops a list of options for comparison based on stakeholder input, including the potential impact of cloud technologies
- Compares the options against the investment objectives, critical success factors, costs, and financial benefits
- Draws overall conclusions and recommends a preferred option for investment.

6.2 Critical success factors

The options need to be assessed against the factors critical for success of the programme – these cover strategic fit, value for money, capacity and capability, affordability, and achievability

There are several factors that must be satisfied to achieve a successful outcome for any of the options. The following table lists the critical success factors that will be used – along with the investment objectives – to assess the options. These were developed from the standard factors identified by Treasury as part of the BBC guidance.

Table 6 Critical Success Factors

Generic Critical Success Factors	Broad Description	Proposal-Specific Critical Success Factors
NON-FINANCIAL		
Strategic fit and business needs	How well the option meets the related business needs and service requirements, and integrates with other strategies, programmes and projects. Note: Excludes fit to investment objectives.	Fits with wider government policy Fits with wider health policy (including ICT, funding, workforce) Complies with privacy and security requirements (including private data held under NZ legislation)
Supplier capacity and capability	How well the option matches the ability of potential suppliers to deliver the required services and is likely to result in a sustainable arrangement that optimises value for money.	Recognises the scale of change required Addresses all parts of supplier capability required Enables risk to be shared with suppliers
DHB capacity and capability	How well the option matches the ability of the DHBs to deliver the required services and is likely to result in a sustainable arrangement that optimises value for money.	Recognises sector capability Recognises the scale of change required Addresses DHB capability required
Achievability	How well the option is likely to be delivered given the various organisations' abilities to respond to the changes required and provide the level of available skills required for successful delivery.	Recognises sector capability, culture, and governance Managed change impact on sector Provides required level of support for DHBs Can be achieved within acceptable risk levels
FINANCIAL		
Potential value for money	How well the option optimises value for money (i.e., the optimal mix of potential benefits, costs and risks). Informed by financial analysis This has been evaluated through the cost benefit analysis undertaken for each option	Central costs DHB-specific costs Financial benefits Cost avoidance Efficiency gains
Affordability	How well the option can be met from likely available funding and matches other funding constraints.	DHBs will support funding required Capex is available Opex is available

Generic Critical Success Factors	Broad Description	Proposal-Specific Critical Success Factors
	This has been evaluated through the cost benefit analysis undertaken for each option	

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6.3 Options

6.3.1 Summary

A shortlist of six key options was developed by stakeholders – a "clean sheet of paper" approach was taken to ensure a wide range of options was developed and assessed

A workshop was held with key stakeholders (principally DHB CFOs and CIOs) on 18 October to develop the options to be considered for this business case. The options were then further refined after a workshop with DHB Chief Executives on 7 November and discussions with the Steering Committee on 3 December 2018.

The options development exercise was seen as an opportunity to re-examine possible options "on a clean sheet of paper". The approach was to determine all the potential dimensions of options that could be identified without presupposing any outcome. The logic used to develop the options can be found in APPENDIX A: Development of options.

The options are aligned around the two key investment objectives: #1 Address risks from end of life systems, #2 Achieve savings from procurement

The options for assessment are aligned around the FPIM programme's five investment objectives, with the focus being on the two primary objectives: #1 Address risks from end of life systems, #2 Achieve savings from procurement.

Six options have been identified to address the investment objectives – a status quo option with the costs of shutting down FPIM has been included for baseline comparison

The following diagram summarises the options that have been identified.

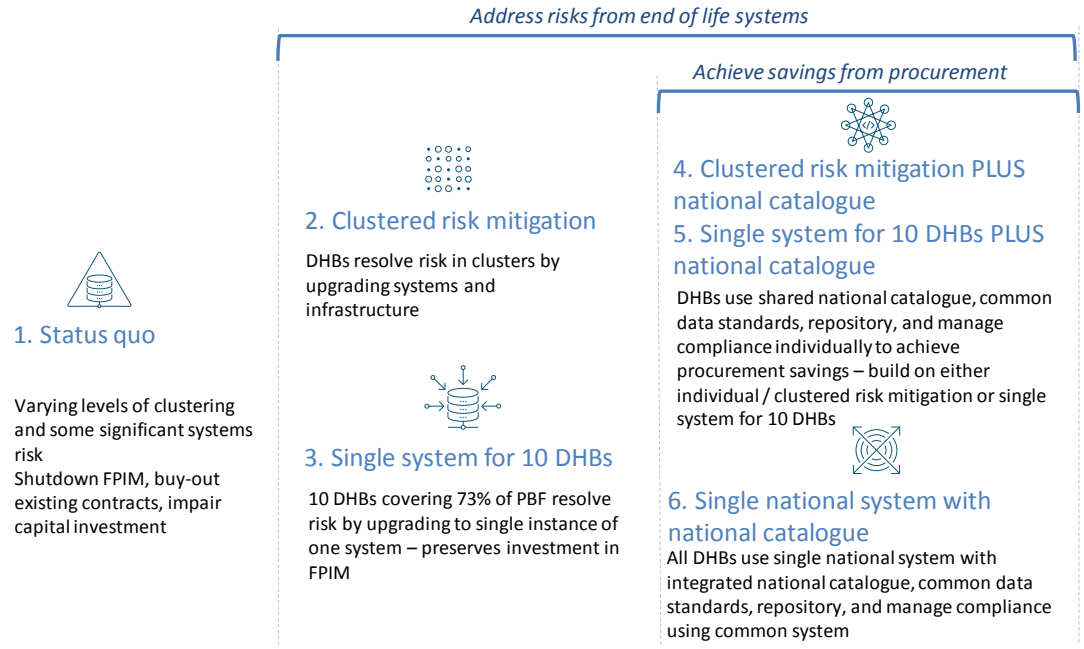

Figure 11 Summary of options identified

These options provide a pathway forward for the sector whereby end-of-life systems risk can be addressed followed by achieving savings from procurement

The options provide an incremental approach to addressing the risk from end of life systems and achieving savings from procurement. Options 2, 3, 4, and 5 all allow an incremental pathway to a single national system using an integrated national catalogue.

This is illustrated in the following diagram.

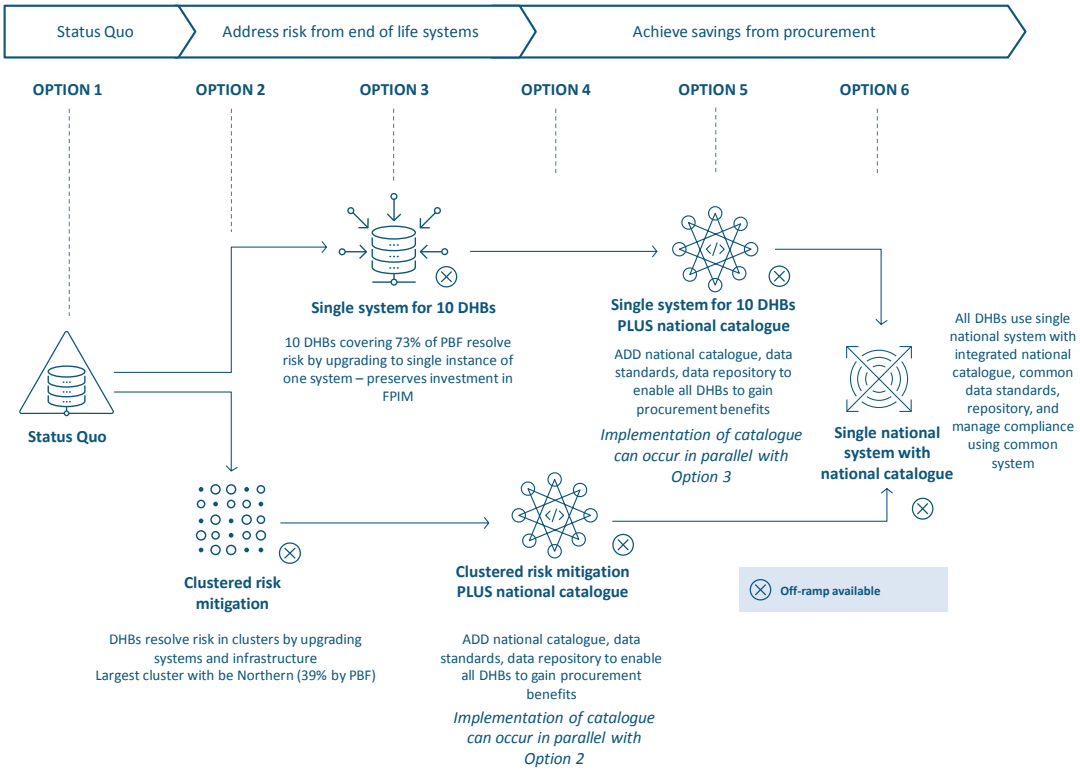

Figure 12 Options pathway

For example, Option 3 can be implemented to immediately resolve the systems and /or infrastructure risk faced by the 10 DHBs. This also will move these 10 DHBs to a shared catalogue. Once this remediation is complete a national catalogue (along with data standards, a data repository, and compliance at point of procurement) can be implemented connecting all DHBs into a single catalogue though Option 5. Other DHBs can join the shared system, providing for a gradual migration to Option 6.

Options two to six all have significant change management

Options two to six all involve data cleansing, process change, training, and change management for effective use of upgraded systems and the shared national catalogue. Options 4 to 6 also have active benefits realisation to ensure that the procurement benefits are achieved.

By their very nature, each option will have a different scope, as each option addresses issues in a different way, and affects DHBs differently

The following table summarises the scope of the options considered and the costs and benefit implications for each DHB.

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Table 7 Scope of options, costs, and benefits

OPTIONS	1. Status Quo / shutdown FPIM	2. Individual / clustered risk mitigation	3. Single system for 10 DHBs	4. Individual / clustered risk mitigation + catalogue	5. Single system for 10 DHBs + catalogue	6.National system & integrated catalogue
OVERALL SHAPE						
Summary	Shutdown FPIM, buy-out existing contracts, impair capital investment, allocate exit costs	10 self-identified high-risk DHBs resolve risk in clusters by upgrading systems and infrastructure – includes all data cleansing, process change, training, and change management for effective use of upgraded systems	10 self-identified high-risk DHBs resolve risk by upgrading to single instance of one system – includes all data cleansing, process change, training, and change management for effective use of upgraded systems	10 self-identified high-risk DHBs resolve risk in clusters by upgrading systems and infrastructure DHBs use shared national catalogue, common data standards, repository, and manage compliance Data cleansing, process change, training, and change management for effective use of upgraded systems and catalogue Benefits realisation management	10 self-identified high-risk DHBs resolve risk by upgrading to single instance of one system DHBs use shared national catalogue, common data standards, repository, and manage compliance Data cleansing, process change, training, and change management for effective use of upgraded systems and catalogue Benefits realisation management	All DHBs use single national system with integrated national catalogue, common data standards, repository, and manage compliance using common system (As contemplated in original NOS) Data cleansing, process change, training, and change management for effective use of upgraded systems and catalogue Benefits realisation management
FPIM Programme	Programme is shut down, infrastructure licensing support cancelled from November 2019, existing contracts bought out, and programme recovers as many costs as possible	Programme is shut down, infrastructure licensing support cancelled from November 2019, existing contracts bought out, and programme recovers as many costs as possible	Programme continues for the 10 self-identified DHBs – utilises existing investment	Programme is shut down, infrastructure licensing support cancelled from November 2019, existing contracts bought out, and programme recovers as many costs as possible	Programme continues for the 10 self-identified DHBs – utilises existing investment	Programme continues for all self-identified DHBs
Current Oracle licences	Current Oracle application licences spread across 12 DHBs using Oracle rather than all 20 DHBs	Current Oracle application licences spread across 12 DHBs using Oracle rather than all 20 DHBs	Current Oracle application licences spread across 12 DHBs using Oracle rather than all 20 DHBs	Current Oracle application licences spread across 12 DHBs using Oracle rather than all 20 DHBs	Current Oracle application licences spread across 12 DHBs using Oracle rather than all 20 DHBs	All DHBs use the Oracle licences
DHB Exit costs	Exit costs defined and all DHBs incur this	Exit costs defined and all DHBs incur this	None	Exit costs defined and all DHBs incur this	None	None
Risk	All DHBs make own plans to address risk (including Wave One DHBs)	Wave One remediates risk Northern and Taranaki create cluster Southern continues on own Other DHBs make own plans	Wave One moves to national technology solution Northern, Taranaki, Southern all move on to Wave One instance Other DHBs make own plans	Wave One remediates risk Northern and Taranaki create cluster Southern continues on own Other DHBs make own plans	Wave One moves to national technology solution Northern, Taranaki, Southern all move on to Wave One instance Other DHBs make own plans	Wave One moves to national technology solution All other DHBs move to Wave One instance

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OPTIONS	1. Status Quo / shutdown FPIM	2. Individual / clustered risk mitigation	3. Single system for 10 DHBs	4. Individual / clustered risk mitigation + catalogue	5. Single system for 10 DHBs + catalogue	6.National system & integrated catalogue
Catalogue	No national catalogue	No national catalogue	No national catalogue	National shared catalogue Programme established to implement, operating structure established to manage	National shared catalogue Programme established to implement, operating structure established to manage	National catalogue integrated in FPIM Operation of catalogue include in FPIM operation
HOW BENEFITS ACHIEVED						
Addresses risks by:	✘	10 DHBs with self-identified high systems risk upgrade in existing clusters or independently	10 DHBs with self-identified high systems risk move to single instance of Oracle FPIM on common infrastructure with common support	10 DHBs with self-identified high systems risk upgrade in existing clusters or independently	10 DHBs with self-identified high systems risk move to single instance of Oracle FPIM on common infrastructure with common support	All DHBs on single Oracle FPIM instance
Achieves savings by:	✘	✘	✘	National catalogue, data standards, data repository, compliance at point of procurement	National catalogue, data standards, data repository, compliance at point of procurement	National catalogue integrated into national FPIM, data standards, data repository, compliance at point of procurement
SCOPE OF COSTS: 10 AT RISK DHBS						
INCLUDED in costs for 10 at risk DHBs	Costs to buy-out existing FPIM contracts (exit costs)	Costs to buy-out existing FPIM contracts (exit costs) Upgrade / transition systems in clusters or individually Licences Infrastructure Operate systems Provide central support	Upgrade / transition systems to single FPIM instance Licences Infrastructure Operate systems Provide central support Build of NTS infrastructure	*Option 2 PLUS:* National catalogue Data repository Interfaces to/from DHBs Data standards and data cleansing at DHBs DHB compliance mechanisms Ongoing operation of catalogue & systems Central benefits management	*Option 3 PLUS:* National catalogue Data repository Interfaces to/from DHBs Data standards and data cleansing at DHBs DHB compliance mechanisms Ongoing operation of catalogue systems Central benefits management Build of NTS infrastructure	Upgrade / transition systems to single FPIM instance Licences Infrastructure Operate systems Provide central support Central benefits management Build of NTS infrastructure
EXCLUDED from costs for 10 at risk DHBs	Operation of finance, procurement, supply chain systems Mitigation of systems risk Any investment to achieve procurement benefits	Existing end user support	Existing end user support	Existing end user support Southern DHB support costs Secondary procurement activities to achieve benefits	Existing end user support Secondary procurement activities to achieve benefits	Existing end user support Secondary procurement activities to achieve benefits

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OPTIONS	1. Status Quo / shutdown FPIM	2. Individual / clustered risk mitigation	3. Single system for 10 DHBs	4. Individual / clustered risk mitigation + catalogue	5. Single system for 10 DHBs + catalogue	6.National system & integrated catalogue
SCOPE OF COSTS: OTHER DHBS						
INCLUDED in costs for other DHBs	Costs to buy-out existing FPIM contracts	Costs to buy-out existing FPIM contracts	None	Costs to buy-out existing FPIM contracts National catalogue Data repository Interfaces to/from DHBs Data standards and data cleansing at DHBs DHB compliance mechanisms Ongoing operation of catalogue & systems Central benefits management	National catalogue Data repository Interfaces to/from DHBs Data standards and data cleansing at DHBs DHB compliance mechanisms Ongoing operation of catalogue systems Central benefits management	Upgrade / transition systems to single FPIM instance Licences Infrastructure Operate systems Provide central support Central benefits management
EXCLUDED from costs for other DHBs	Operation of finance, procurement, supply chain systems Mitigation of systems risk Any investment to achieve procurement benefits	Mitigation of systems risk Operation of systems Any investment to achieve procurement benefits	Mitigation of systems risk Operation of systems Any investment to achieve procurement benefits	Mitigation of systems risk Operation of systems Secondary procurement activities to achieve benefits	Mitigation of systems risk Operation of systems Secondary procurement activities to achieve benefits	Existing end user support Secondary procurement activities to achieve benefits
SCOPE OF BENEFITS						
INCLUDED in benefits	None	healthAlliance identified savings (benefits to Northern region)	healthAlliance identified savings (benefits to Northern region)	Medical devices savings Other national procurement savings	healthAlliance identified saving Medical devices savings Other national procurement savings	healthAlliance identified saving Medical devices savings Other national procurement savings
EXCLUDED from benefits	N/A	Current operating costs at the 10 DHBs Current core support costs Any savings from shutdown of exiting finance, procurement, and supply chain systems	Current operating costs at the 10 DHBs Current core support costs Any savings from shutdown of exiting finance, procurement, and supply chain systems	Current operating costs at the 10 DHBs Current core support costs Any savings from shutdown of exiting finance, procurement, and supply chain systems	Current operating costs at the 10 DHBs Current core support costs Any savings from shutdown of exiting finance, procurement, and supply chain systems	Current operating costs at all DHBs Current core support costs at all DHBs Any savings from shutdown of exiting finance, procurement, and supply chain systems
BALANCE SHEET IMPLICATIONS						
Impairment of FPIM asset	All DHBs impair FPIM asset completely	Wave One DHBs (using FPIM) impair partially to reflect value received DHBs not using FPIM impair completely	10 DHBs using FPIM impair partially to reflect value received DHBs not using FPIM impair completely	Wave One DHBs (using FPIM) impair partially to reflect value received DHBs not using FPIM impair completely	10 DHBs using FPIM impair partially to reflect value received DHBs not using FPIM impair completely	No impairment

6.3.2 Option 1 Status Quo

A status quo option that shuts down the existing investment in FPIM has been defined as the baseline for comparison

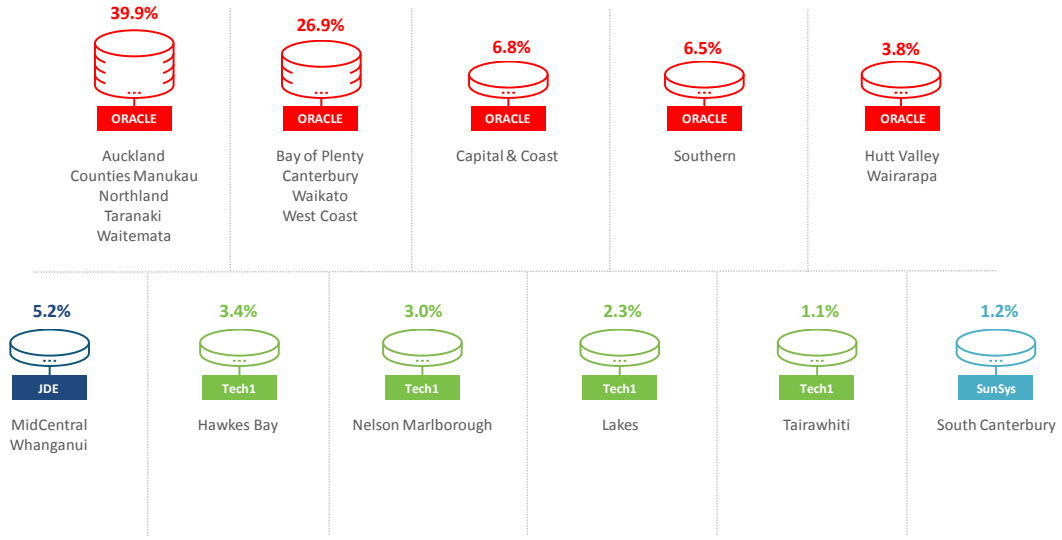

Figure 13 Option 1 Status Quo / shutdown FPIM summary

This option retains the status quo while shutting down the existing FPIM programme. It meets none of the investment objectives.

- The current arrangements for the Northern DHBs continue – Auckland, Counties Manukau, Northland, Waitemata continue using a single Oracle instance.
- The arrangements for Wave One DHBs continue – Bay of Plenty, Canterbury, Waikato, West Coast on a single Oracle instance.
- The remaining DHBs continue with their own arrangements.
- Evolutionary change continues in the sector. Further consolidation occurs on a tactical basis and would be initiated by DHBs or groups of DHBs.
- National, collaborative, and local procurement continues under existing arrangements.
- The FPIM programme is shut down and the programme recovers as much as possible of the Oracle licencing costs and investment to date in infrastructure. Infrastructure licensing support is cancelled from 30 November 2019.
- The Oracle licensing costs are split across all the current DHBs using Oracle, i.e. 12 instead of all 20 DHBs.
- The 16 DHBs not using the FPIM Oracle EBS systems impair the assets up to $56 million, the existing lease arrangements are terminated, and the early termination penalties paid out. (Details of the potential impairment can be found in the Financial Case.)

There are no initiatives to address current DHB systems or infrastructure risk (outside those underway in individual DHBs). These risks will start to materialise for the 10 highest risk DHBs using Oracle EBS at the end of 2019. This will result in a heightened probability of systems failure for the Wave One DHBs from early 2020 onwards. The Northern DHBs are also likely to have failures in the same timeframe.

There are no initiatives to establish a national catalogue, common data standards, a procurement compliance regime, or any national governance arrangements to achieve national procurement benefits.

The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

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Solution components	Intermediate impacts	Benefits	
NO BENEFITS IDENTIFIED		1. Address risks from end-of life systems	None
		2. Achieve savings from procurement	None
		3. Better informed decision-making	None
		4. Efficient operation	None
		5. Improved supply management	None

Figure 14 Benefits drivers for Option 1 Status Quo / shutdown FPIM

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Table 8 Option 1 Status Quo ($million) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
Costs										
	Operating									
	IaaS Hosting & Support	2.379	0.595						2.974	2.974
	Oracle Infrastructure	1.057	3.349						4.406	4.406
	Oracle Licensing	3.409							3.409	3.409
	Third Party Support Fees	0.148							0.148	0.148
	Application support	3.178							3.178	3.178
	DHB implementation									
	Total Operating Costs	10.171	3.943						14.115	14.115
	Indicative impairment	56.000								

These costs relate to the running out of the existing contracts that the sector is already committed to regarding FPIM.

21

6.3.3 Option 2 Clustered risk mitigation

A modified status quo option with the 10 DHBs using Oracle EBS with high systems risk mitigating their own risk independently or in clusters

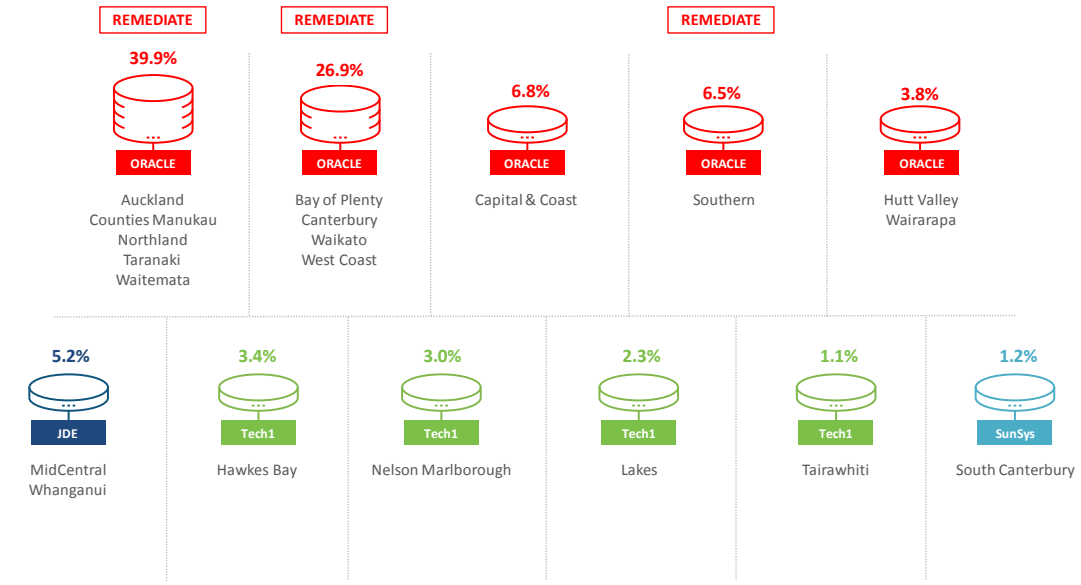

Figure 15 Option 2 Clustered risk mitigation summary

This option focuses on the 10 DHBs with high risk infrastructure addressing their own risk in clusters. It therefore only contributes to investment objective one: sustainable operation at acceptable risk.

This option assumes that Northern, Wave One, and Southern DHBs work individually and independently to develop their own respective finance, procurement, and supply chain systems for their region only. This could involve:

- A new finance, procurement, and supply chain application for Southern DHB
- An upgraded system and infrastructure for the Northern region and Taranaki
- Infrastructure replacement for the Wave One NOS DHBs.

DHBs will individually or in their existing clusters manage their own process change, training, and change management.

Hybrid cloud solutions will be used on a tactical basis as part of the individual or clustered solutions where they make sense. Non-Oracle DHBs may continue their own clustering of systems (e.g. as in the case of MidCentral and Whanganui on JDE software).

The FPIM programme is shut down and the programme recovers as much as possible of the Oracle licencing costs and investment to date in infrastructure. Infrastructure licensing support is cancelled from 30 November 2019.

The Oracle licensing costs are split across all the current DHBs using Oracle, i.e. 12 instead of all 20 DHBs.

Data cleansing, process change, training, and change management occurs to enable effective use of the upgraded systems.

There are no initiatives to establish a national catalogue, common data standards, a procurement compliance regime, or any national governance arrangements. DHBs individually manage the benefit from their individual investment. There is no cross-sector benefits management.

Note that the scope of this option is confined to the 10 DHBs with self-identified risk.

The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

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OPTION 2 – CLUSTERED RISK MITIGATION

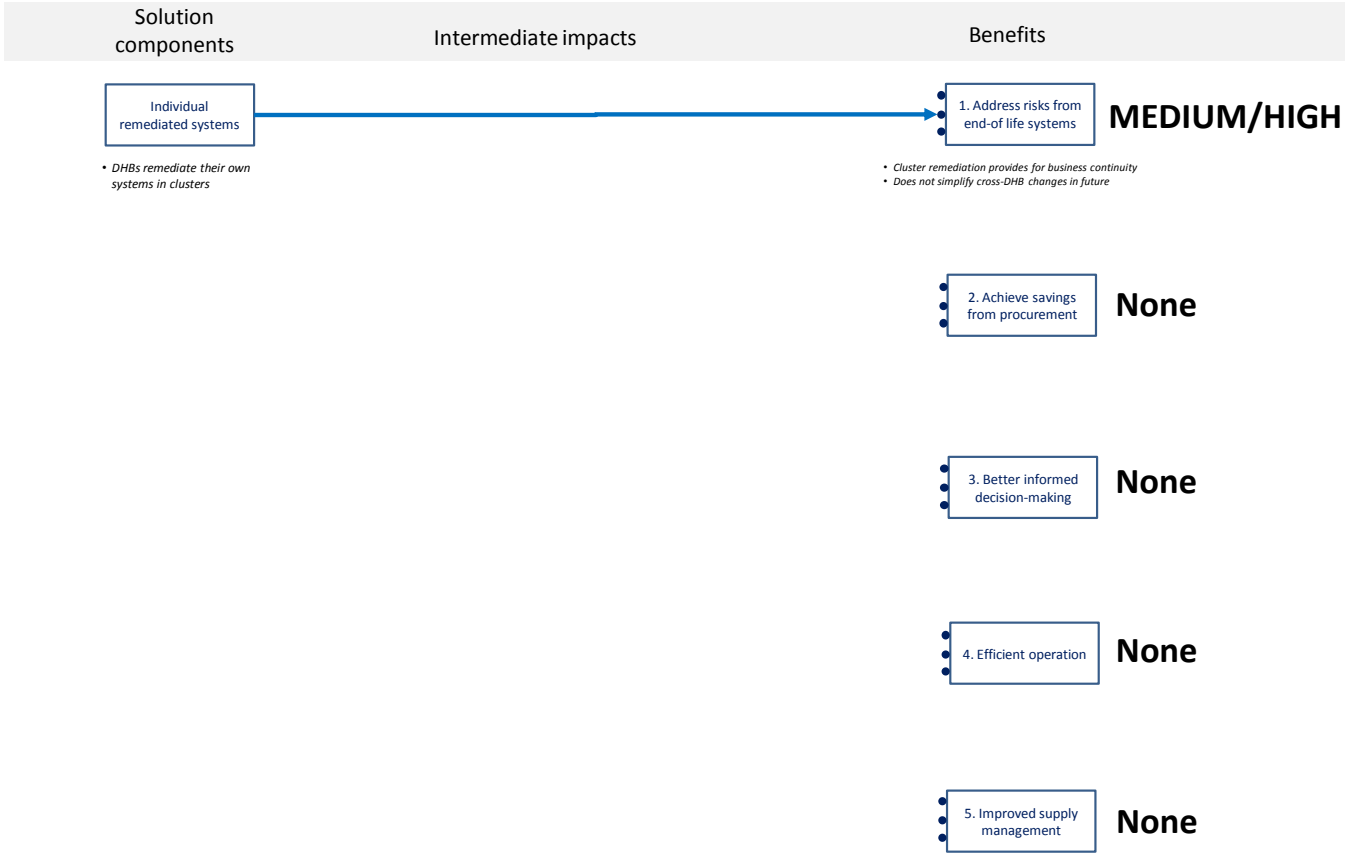

Figure 16 Benefits drivers for Option 2 Clustered risk mitigation

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Table 9 Option 2 Clustered risk mitigation costs and benefits ($million) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits					2.000	2.000	2.000	2.000	8.000	14.000
					2.000	2.000	2.000	2.000	8.000	14.000
Costs										
	Operating									
	IaaS Hosting & Support	1.259	0.315						1.574	1.574
	Oracle Infrastructure	3.436	3.943						7.380	7.380
	Infrastructure support	2.706	2.706	2.706	2.706	2.706	2.706	2.706	18.942	27.060
	Oracle Licensing	3.409	3.409	3.409	3.409	3.409	3.409	3.409	23.864	34.091
	Third Party Support Fees	0.148	0.353	0.353	0.353	0.353	0.353	0.353	2.264	3.322
	Application support	3.428	3.428	3.428	3.428	3.428	3.428	3.428	23.994	34.277
	DHB implementation	1.222	1.222						2.444	2.444
	Total Operating Costs	15.608	15.376	9.895	9.895	9.895	9.895	9.895	80.461	110.147
	Capital									
	Core Build	4.561	4.561						9.121	9.121
	DHB Implementation	10.388	10.388						20.777	20.777
	Total Capital	14.949	14.949						29.898	29.898
	Total Cash Out	30.557	30.325	9.895	9.895	9.895	9.895	9.895	110.359	140.045
	Net Cash	(30.557)	(30.325)	(9.895)	(7.895)	(7.895)	(7.895)	(7.895)	(102.359)	(126.045)
	Indicative impairment	56.000								

These costs have been developed based on the scenario of: northern DHBs upgrading their own system and infrastructure collectively, Wave One DHBs upgrading their own infrastructure collectively, and Southern DHB upgrading its Oracle EBS application.

21

6.3.4 Option 3 Single system for 10 DHBs

The 10 DHBs with high system risk collectively mitigate their risk by migrating to a single Oracle EBS instance operating on shared infrastructure

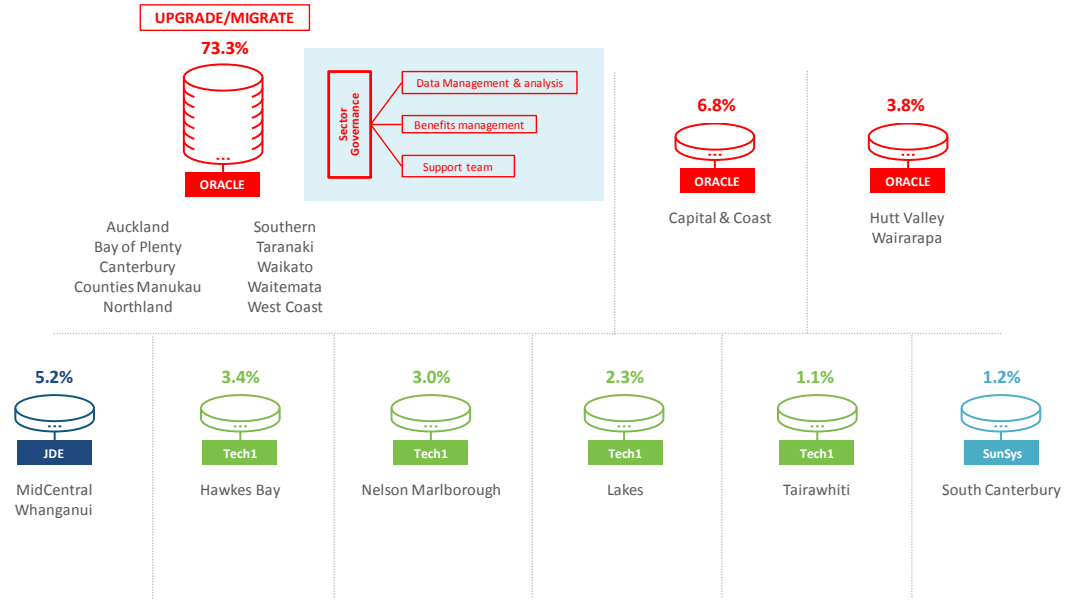

Figure 17 Option 3 Single system for 10 DHBs summary

10 DHBs using Oracle EBS agree that they have immediate system and infrastructure issues that cannot wait to be resolved. They therefore have agreed to pursue a business case process to mitigate their risk.

This option focuses on addressing the risk of these 10 DHBs. While there are other DHBs with older systems and risk issues, these have not been included in this option. We have used the "self-selecting" nature of the original risk mitigation business case as the measure of the highest risk DHBs.

This option focuses on addressing their needs collectively through a common solution. While it focuses on investment objective one: sustainable operation at acceptable risk, the nature of the solution also contributes to the other investment objectives and provides a pathway to further consolidation if required in the longer term.

The solution operates as follows.

- The 10 DHBs all operate on a single instance of Oracle EBS running on shared infrastructure.
- The remaining 10 DHBs continue with their own arrangements. Alternatively, some additional DHBs may choose to join these ten DHBs to resolve their own risk issues.
- Evolutionary change continues in the sector. Further consolidation occurs on a tactical basis and would be initiated by DHBs or groups of DHBs which decide to solve their immediate risk by joining.
- National, collaborative, and local procurement continues under existing arrangements.

- A permanent support team independent of any single DHB is established and manages the ongoing operation of the system. This would include staff seconded from DHBs and located within DHBs.
- Data cleansing, process change, training, and change management occurs to enable effective use of the upgraded systems.

This option is implemented as follows:

- The National Technology Solution (NTS) as originally contemplated for NOS will be completed. The design is already complete, has been peer reviewed by PWC Australia, and the hardware is already in place.
- The four Wave One DHBs will be migrated on to the NTS. This will be a "lift and shift" process with no upgrade to the Oracle EBS system.
- A common operating model will be implemented to operate across all DHBs.
- The Northern DHBs, Taranaki, and Southern DHB will be upgraded on to the Wave One instance. This will occur in multiple waves and will involve data cleansing, process changes, training, and change management. Some interfaces to other systems will need to be upgraded as well.

This implementation will also resolve the outstanding issues for the Wave One DHBs, namely access to the Oracle Business Intelligence system, implementation of Oracle SOA to enable interfaces to other systems, and establishment of a business as usual operating model.

Financial benefits

healthAlliance has identified $2m of operational cost savings for Northern Region if the upgrade to FPIM and the move to the new infrastructure takes place.

There are no initiatives to establish a national catalogue, common data standards, a procurement compliance programme, or any national governance arrangements. There are therefore no significant procurement benefits.

The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

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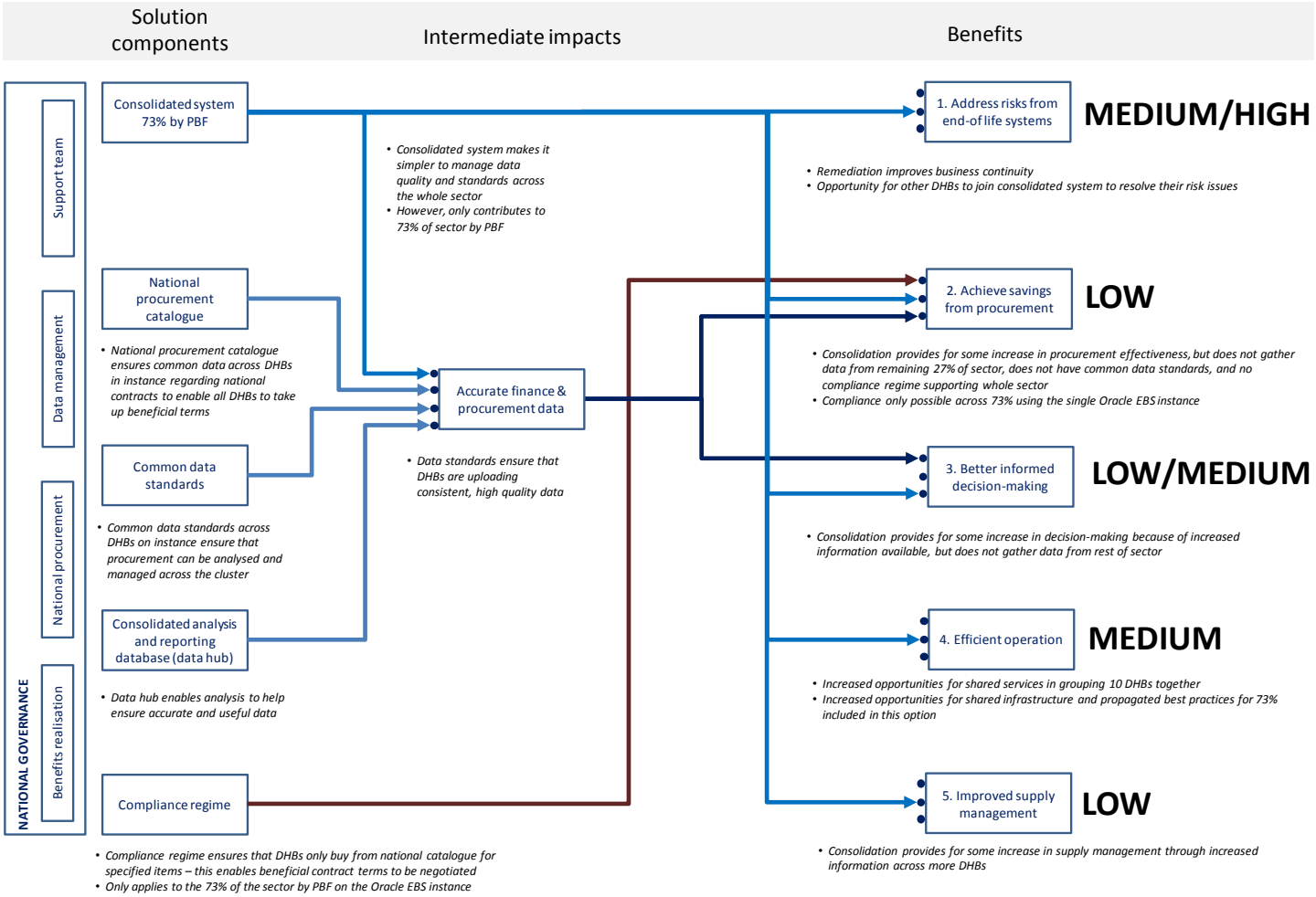

Figure 18 Benefits drivers for Option 3 Single system for 10 DHBs

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Table 10 Option 3 Single system for 10 DHBs costs and benefits ($million) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
	Operating savings Northern region				2.000	2.000	2.000	2.000	8.000	14.000
	Total Benefit				2.000	2.000	2.000	2.000	8.000	14.000
Costs										
	Operating									
	IaaS Hosting & Support	2.379	2.379	2.379	2.379	2.397	2.397	2.397	16.706	23.897
	Oracle Infrastructure	1.057	1.057	1.057	0.864	0.671	0.671	0.671	6.049	8.061
	Oracle Licensing	3.409	3.409	3.409	3.409	3.409	3.409	3.409	23.864	34.091
	Third Party Support Fees	0.148	0.353	0.353	0.353	0.353	0.353	0.353	2.264	3.322
	Application support	5.548	5.548	5.548	5.548	5.548	4.833	4.833	37.406	51.905
	DHB implementation	0.002	1.557	1.064					2.623	2.623
	Central Programme implementation		0.308	0.137					0.445	0.445
	Quality Assurance		0.525	0.375					0.900	0.900
	Total Operating Costs	12.544	15.136	14.322	12.553	12.378	11.663	11.663	90.257	125.244
	Capital									
	Core Build	9.694	4.775						14.468	14.468
	DHB implementation	0.010	5.048	1.392					6.450	6.450
	Central Programme implementation	0.023	7.401	3.448					10.872	10.872
	Hardware Refresh									2.100
	Total Capital	9.727	17.224	4.840					31.791	33.891
	Total Cash Out	22.270	32.360	19.162	12.553	12.378	11.663	11.663	122.047	159.135
	Net Cash	(22.270)	(32.360)	(19.162)	(10.553)	(10.378)	(9.663)	(9.663)	(114.047)	(145.135)
	Indicative impairment	22.000								

21

6.3.5 Option 4 Clustered risk mitigation PLUS national catalogue

This option seeks to achieve national procurement benefits – it is essentially Option 2 plus a central national catalogue and data hub to achieve data synchronisation across all DHBs along with sector governance to achieve benefits

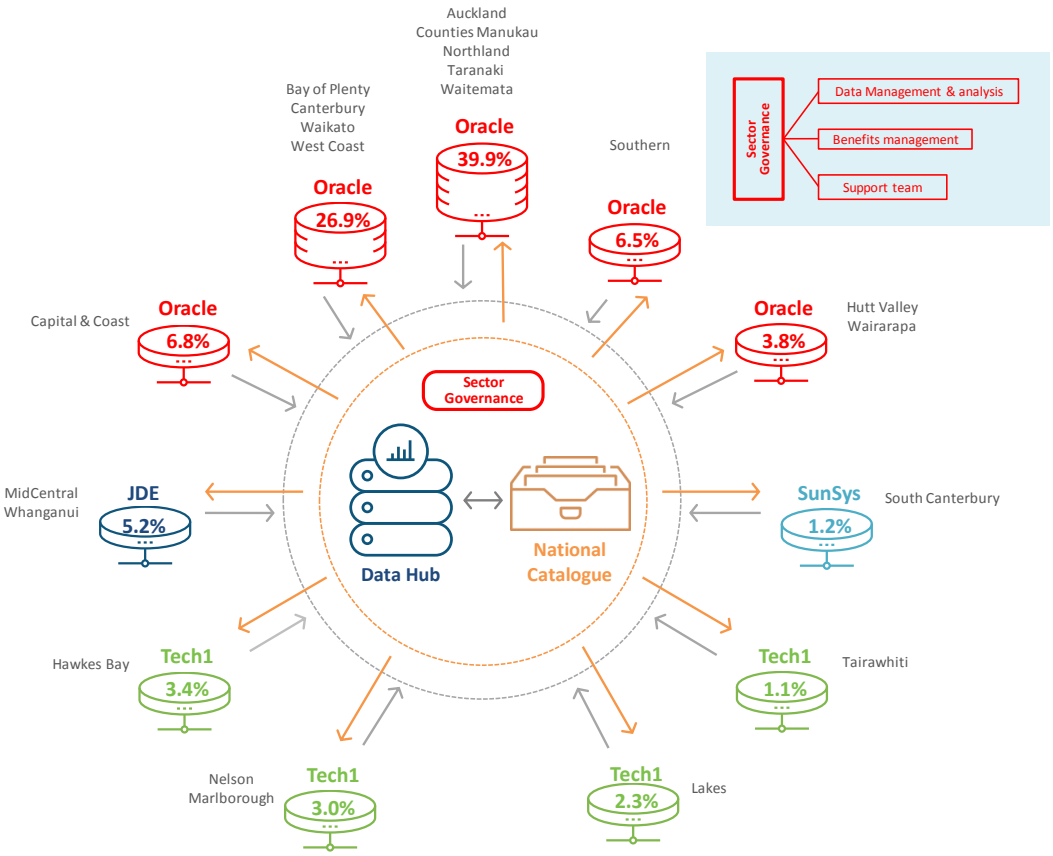

Figure 19 Option 4 Clustered risk mitigation PLUS national catalogue summary

This option builds on Option 2 Clustered risk mitigation by adding the following components to achieve the national procurement benefits.

- Common data standards are in place across the sector. A procurement compliance regime is in place to enable value to be gained from the national contracts.
- A separate national catalogue is maintained for distribution to all DHBs. This catalogue contains contract and benefits realisation information for all nationally managed goods and services.
- Each DHB takes a copy of this national catalogue and applies it to their own Finance, Procurement, and Supply Chain system. They then purchase goods and services against these national contracts.
- Historical and stock level information is gathered from each DHB and collated in a single central database – a national data hub. This will include off-catalogue purchases.
- The national data hub is then used for overall benefits realisation management and monitoring of compliance. (It should be noted that achieving compliance against the national catalogue will

be challenging when compliance cannot be easily enforced centrally but relies on distributed behaviour around the sector.)

- National sector governance is in place to ensure that the procurement benefits are achieved, to manage national contracts outside of medical devices, and to manage data analysis.
- A permanent support team independent of any single DHB is established and manages the ongoing operation of the central hub and data reporting. This would include staff seconded from DHBs and located within DHBs.
- Change management across the sector is coordinated from a central implementation team. DHBs will be responsible for the change in business processes required to achieve the procurement benefits.
- Data cleansing, process change, training, and change management occurs to enable effective use of the upgraded systems and the use of the shared national catalogue.

Financial benefits occur as follows:

- Once all DHBs have the national catalogue, data standards, reporting, and compliance in place, an uplift of 5% can be achieved in cost avoidance on PHARMAC managed medical devices ($640 million pa across 388 suppliers) and potential other national contracts ($102 million pa) – this produces cost avoidance benefits of $37.1 million pa on a total of $742 million pa.

The key drivers for the costs of the national catalogue are summarised in the table below. The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

Table 11 Drivers for cost estimates for implementation of national catalogue

SETUP	
• Develop requirements for catalogue, catalogue management, data to be distributed, data standards at DHBs, data collection, and procurement compliance. • Develop data standards. • Define catalogue data to be managed. • Re-platform the existing NZ Health Partnerships data hub for use as the central data repository. (Team lead, data engineer, data analyst, tester, report developer.) Oracle database requirements, Oracle training (1-year online subscription), Oracle implementation services, Revera implementation services, Solution design, Project management.	• Software licences for the Oracle Data Quality Management software. Implement the Oracle Data Quality Management software. • Design the national catalogue web service to enable data to be transferred around the sector. • Implement the web service between all 20 DHBs. • Implement a data warehouse for the legacy DHB procurement data. Define catalogue management and data management procedures.
DHB IMPLEMENTATION	
• Develop fit-gap for each DHB to achieve benefits from national catalogue. • Develop procedure changes to enable benefits to be achieved from compliance. • Extract and cleanse data. Load cleansed data.	• Develop systems changes required (e.g. for enforcing compliance at point of procurement). • Develop training materials. Train staff. • Manage change.
ONGOING	
• Oracle cloud analytics software licences. • Database licence support and maintenance. • Database monitoring and issue resolution.	• Revera IaaS and ITMS support. • Ongoing support for systems and DHBs (team lead, data engineer, senior data analyst, report developer).

The cost and benefit realisation risk depend on the final configuration of this option. The larger the individual clusters are and the fewer of these clusters there are, in general, the easier it will be to manage the national shared catalogue, data standards, the central data repository, and compliance across the sector.

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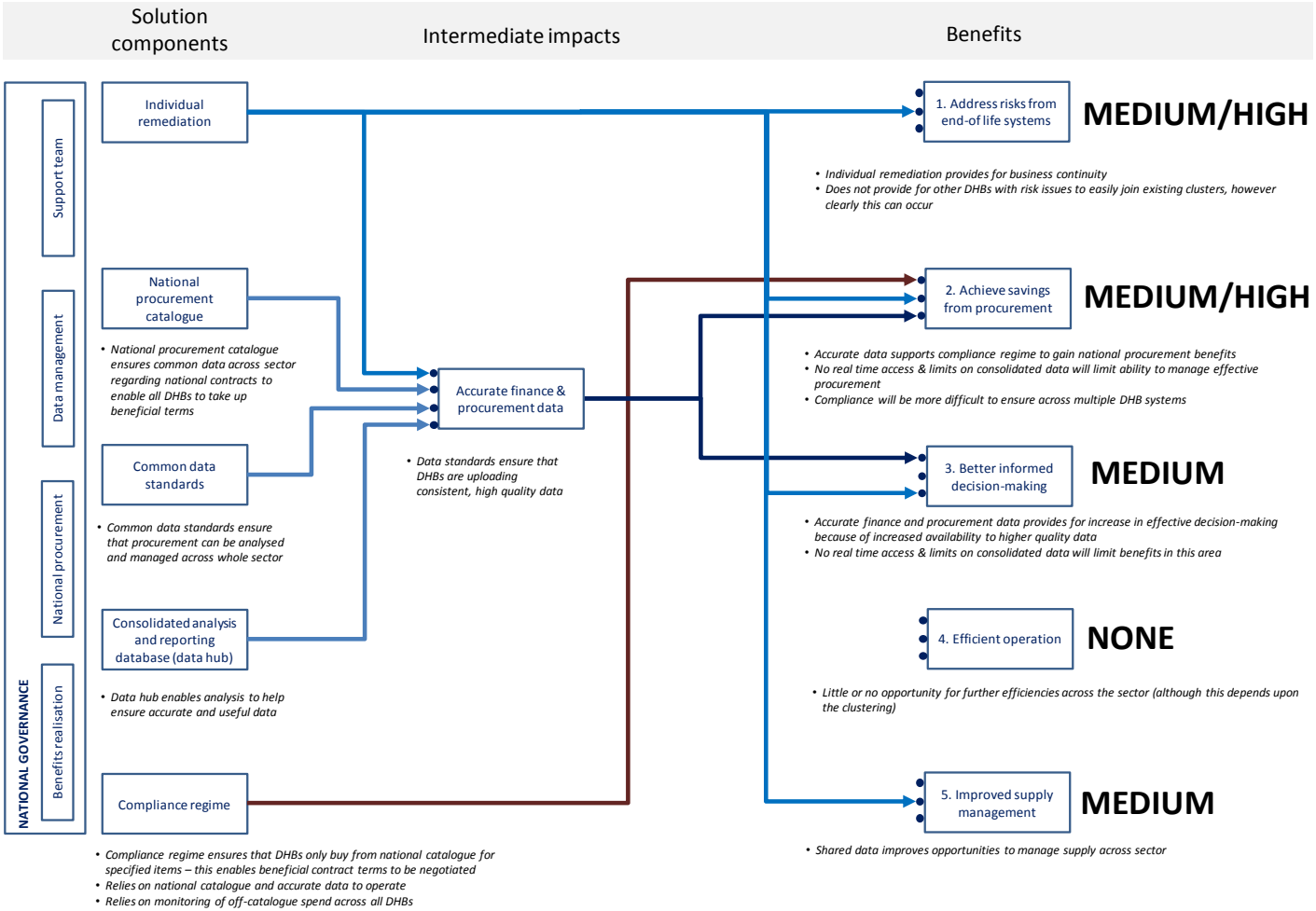

Figure 20 Benefits drivers for Option 4 Clustered risk mitigation PLUS national catalogue

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Table 12 Option 4 Clustered risk mitigation PLUS national catalogue costs and benefits ($million) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
	PHARMAC benefit					32.100	32.100	32.100	96.300	192.600
	National Procurement					5.100	5.100	5.100	15.300	30.600
						37.200	37.200	37.200	111.600	223.200
Costs										
	Operating									
	Option 2	15.608	15.376	9.895	9.895	9.895	9.895	9.895	80.461	110.147
	Catalogue support				3.516	3.516	3.516	3.516	14.064	24.611
	Catalogue DHB implementation			0.147	0.768	0.489			1.405	1.405
	Benefits management				0.230	0.460	0.460	0.460	1.610	2.990
	Quality Assurance				0.525				0.525	0.525
	Total Operating Costs	15.608	15.376	10.043	14.934	14.361	13.871	13.871	98.064	139.678
	Capital									
	Option 2	14.949	14.949						29.898	29.898
	Catalogue design, analysis	0.200	1.000						1.200	1.200
	Catalogue build			8.261					8.261	8.261
	Catalogue DHB implementation			0.438	1.716	0.272			2.427	2.427
	Data management			2.803	11.160	3.033			16.996	16.996
	Total Capital	15.149	15.949	11.503	12.876	3.305			58.782	58.782
	Total Cash Out	30.757	31.325	21.545	27.811	17.665	13.871	13.871	156.846	198.460
	Net Cash	(30.757)	(31.325)	(21.545)	(27.811)	19.535	23.329	23.329	(45.246)	24.740
	Indicative impairment	56.000								

6.3.6 Option 5 Single system for 10 DHBs PLUS national catalogue

This option seeks to achieve national procurement benefits – it is essentially Option 3 plus a central national catalogue and data hub to achieve data synchronisation across all DHBs along with sector governance to achieve benefits

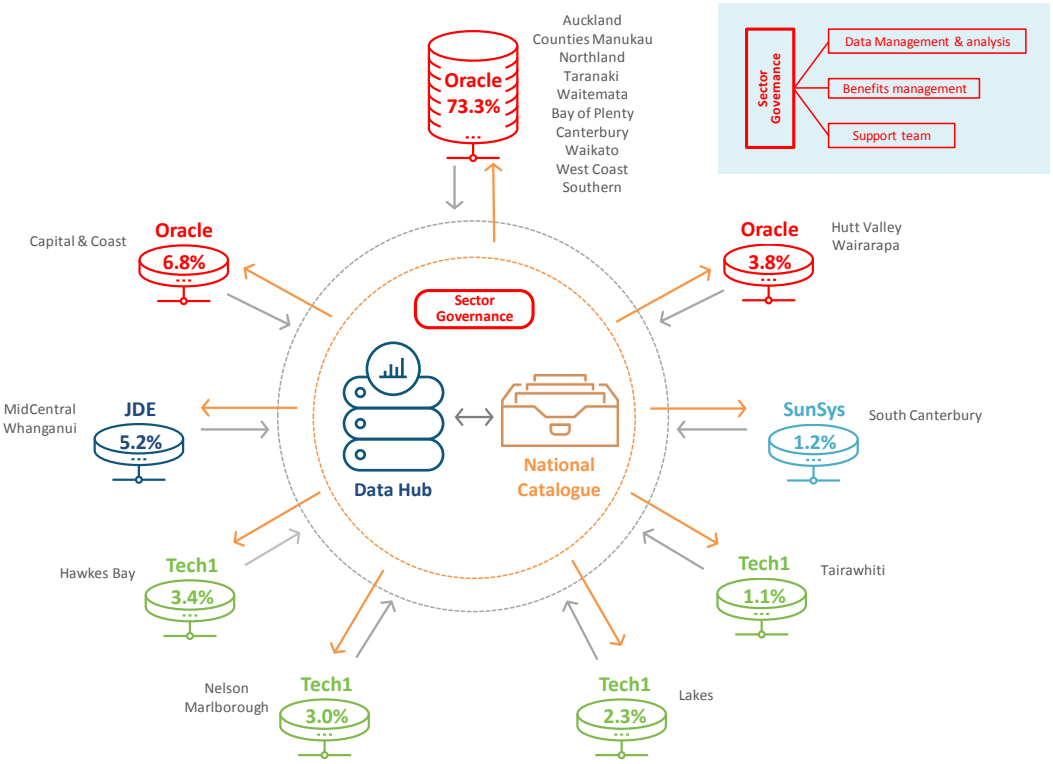

Figure 21 Option 5 Single system for 10 DHBs PLUS national catalogue summary

This option builds on Option 3 Single system for 10 DHBs by adding the following components to achieve the procurement benefits. The 10 DHBs comprise approximately 80% of the procurement spend.

- Common data standards are in place across the sector. A procurement compliance regime is in place to enable value to be gained from the national contracts.
- The largest cluster of DHBs operating on a single Oracle instance provides and manages a national catalogue for distribution to all other DHBs. This catalogue contains contract and benefits realisation information for all nationally managed goods and services.
- Each DHB takes a copy of this national catalogue and applies it to their own Finance, Procurement, and Supply Chain system. They then purchase goods and services against these national contracts.
- Historical and stock level information is gathered from each DHB and collated in a single central database – a national data hub. This will include off-catalogue purchases.
- The national data hub is then used for overall benefits realisation management and monitoring of compliance. (It should be noted that achieving compliance against the national catalogue will be challenging when compliance cannot be easily enforced centrally but relies on distributed behaviour around the sector.)

- National sector governance is in place to ensure that the benefits are achieved, to manage national contracts outside of medical devices, and to manage data analysis.
- A permanent support team independent of any single DHB is established and manages the ongoing operation of the system. This would include staff seconded from DHBs and located within DHBs.
- Change management across the sector is coordinated from a central implementation team. DHBs will be responsible for the change in business processes required to achieve the procurement benefits.
- Data cleansing, process change, training, and change management occurs to enable effective use of the upgraded systems and the use of the shared national catalogue.
- A benefits realisation regime is put in place across all DHBs to manage the collective benefits.

Financial benefits occur as follows:

- healthAlliance has identified $2 million of operational cost savings for Northern Region if the upgrade to FPIM and the move to the new infrastructure takes place.
- Once all DHBs have the national catalogue, data standards, reporting, and compliance in place, an uplift of 5% can be achieved in cost avoidance on PHARMAC managed medical devices ($640 million pa across 388 suppliers) and potential other national contracts ($102 million pa) – this produces cost avoidance benefits on $742 million pa of $37.1 million pa.

The key drivers for the costs of the national catalogue are summarised in the table below. The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

Table 13 Drivers for cost estimates for implementation of national catalogue

SETUP	
• Develop requirements for catalogue, catalogue management, data to be distributed, data standards at DHBs, data collection, and procurement compliance. • Develop data standards. • Define catalogue data to be managed. • Re-platform the existing NZ Health Partnerships data hub for use as the central data repository. (Team lead, data engineer, data analyst, tester, report developer.) Oracle database requirements, Oracle training (1-year online subscription), Oracle implementation services, Revera implementation services, Solution design, Project management.	• Software licences for the Oracle Data Quality Management software. Implement the Oracle Data Quality Management software. • Design the national catalogue web service to enable data to be transferred around the sector. • Implement the web service between all 20 DHBs. • Implement a data warehouse for the legacy DHB procurement data. Define catalogue management and data management procedures.
DHB IMPLEMENTATION	
• Develop fit-gap for each DHB to achieve benefits from national catalogue. • Develop procedure changes to enable benefits to be achieved from compliance. • Extract and cleanse data. Load cleansed data.	• Develop systems changes required (e.g. for enforcing compliance at point of procurement). • Develop training materials. Train staff. • Manage change.
ONGOING	
• Oracle cloud analytics software licences. • Database licence support and maintenance. • Database monitoring and issue resolution.	• Revera IaaS and ITMS support. • Ongoing support for systems and DHBs (team lead, data engineer, senior data analyst, report developer).

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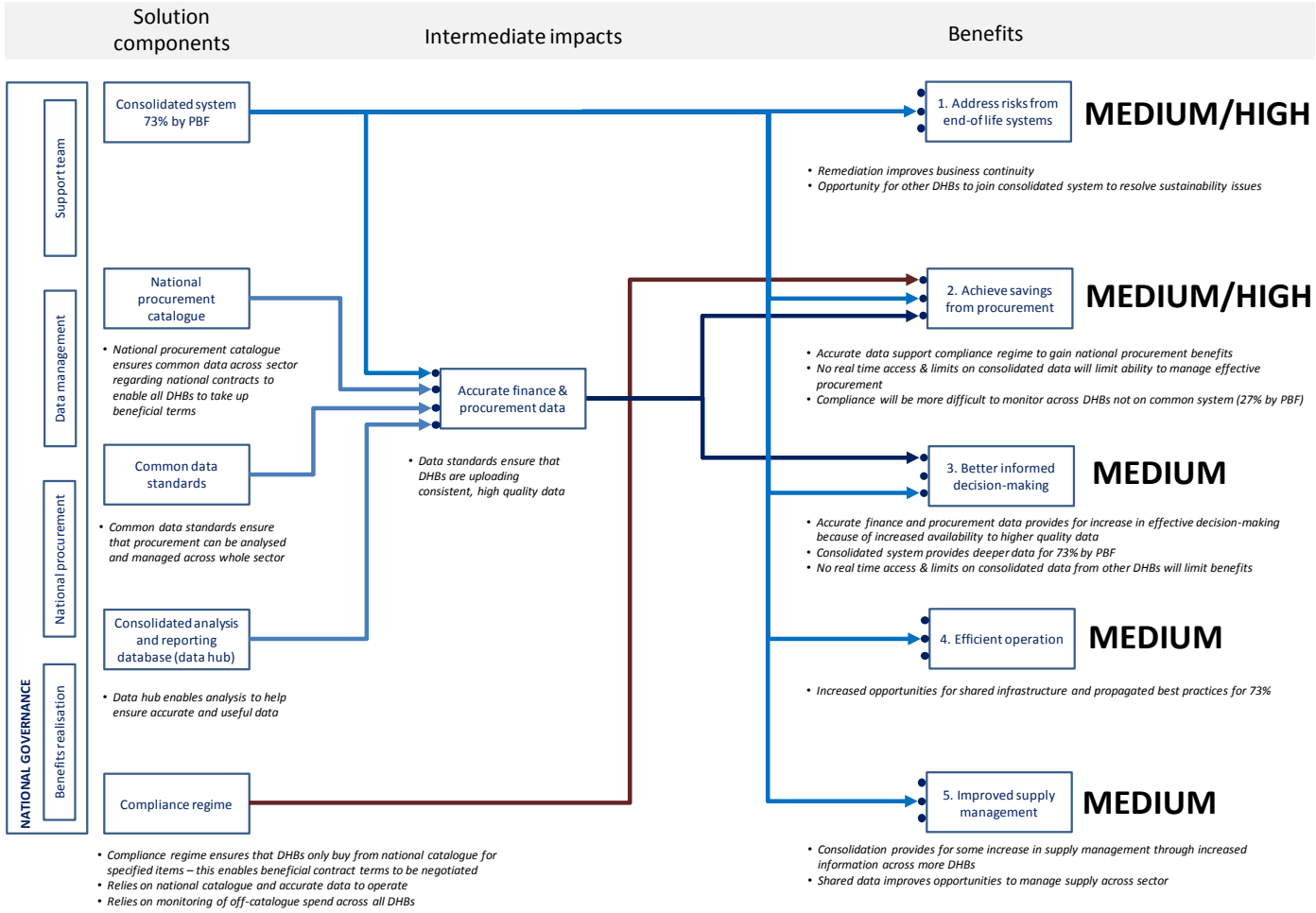

Figure 22 Benefits drivers for Option 5 Single system for 10 DHBs PLUS national catalogue

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Table 14 Option 5 Single system for 10 DHBs PLUS national catalogue costs and benefits ($millions) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
	PHARMAC benefit					32.100	32.100	32.100	96.300	192.600
	National Procurement					5.100	5.100	5.100	15.300	30.600
	Operating savings Northern region				2.000	2.000	2.000	2.000	8.000	14.000
					2.000	39.200	39.200	39.200	119.600	237.200
Costs										
	Operating									
	Option 3	12.544	15.136	14.322	12.553	12.378	11.663	11.663	90.257	125.244
	Catalogue DHB implementation			0.098	0.512	0.326			0.936	0.936
	Catalogue Support			0.960	0.960	0.960	0.960	0.960	4.802	7.683
	Benefits management		0.230	0.460	0.460	0.460	0.460	0.460	2.530	3.910
	Total Operating Costs	12.544	15.366	15.840	14.485	14.124	13.083	13.083	98.525	137.774
	Capital									
	Option 3	9.727	17.224	4.840					31.791	33.891
	Catalogue Design & Analysis	0.100	0.500						0.600	0.600
	Catalogue Build			4.131					4.131	4.131
	Catalogue Programme implementation			1.869	5.653	2.022			9.544	9.544
	DHB implementation of catalogue			0.292	1.144	0.181			1.618	1.618
	Total Capital	9.827	17.724	11.131	6.798	2.203			47.683	49.783
	Total Cash Out	22.370	33.090	26.972	21.283	16.327	13.083	13.083	146.208	187.557
	Net Cash	(22.370)	(33.090)	(26.972)	(19.283)	22.873	26.117	26.117	(26.608)	49.643
	Indicative impairment	22.000								

6.3.7 Option 6 Single national system

A national consolidated Finance, Procurement, and Supply Chain system with a national catalogue

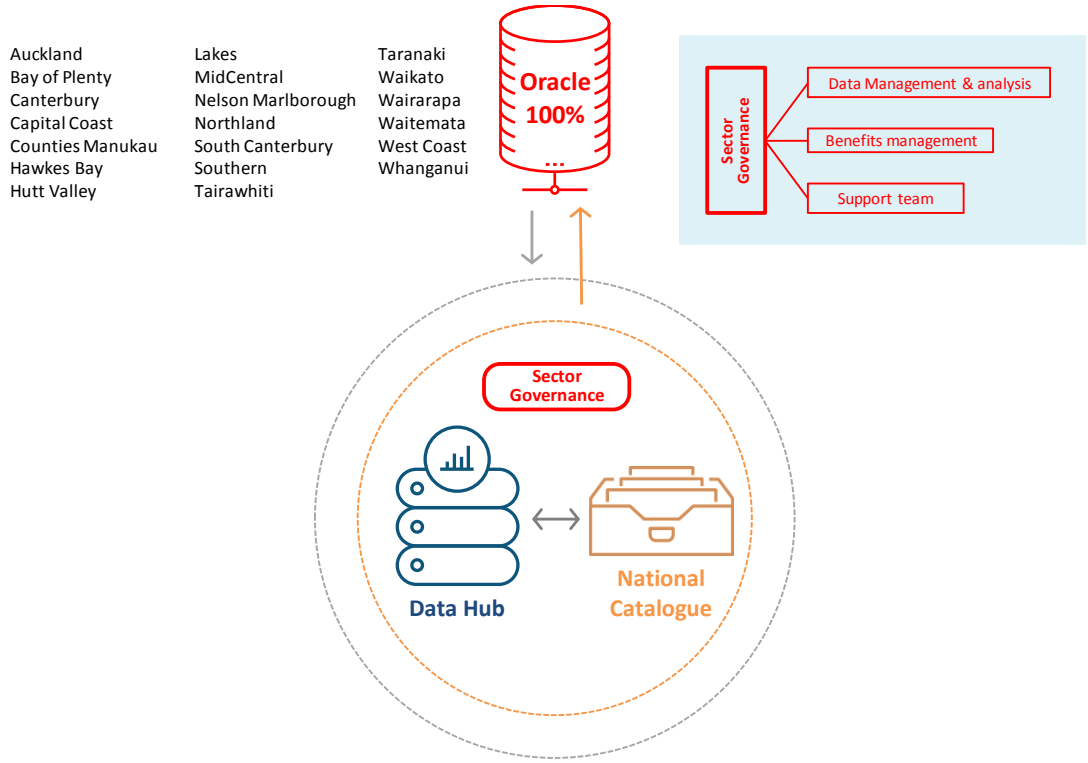

Figure 23 Option 6 Single national system summary

This option seeks to achieve the procurement benefits contemplated by PHARMAC for medical devices (as well as other national procurement activity). It also seeks to provide a common platform to support increased efficiencies and improved data management. This option follows the original NOS vision of creating one finance, supply chain, and procurement system for the whole sector.

This option operates as follows:

- All DHBs operate from a single instance of Oracle EBS.
- All DHBs use common data standards and operate from a single national procurement catalogue.
- Reporting occurs across the whole Oracle database to enable the monitoring of compliance, potentially in real-time.
- As all DHBs are operating on a single system, it will be simpler to enforce compliance across catalogue items on the national catalogue than it would be with a distributed system as contemplated under Options 4 or 5.
- A single support organisation enables the system to operate and meet the needs of all DHBs.
- DHBs are free to pursue further shared services arrangements to increase efficiency.

This option is implemented as follows:

- The National Technology Solution (NTS) as originally contemplated for NOS will be completed. The design is already complete, has been peer reviewed by PWC Australia, and the hardware is already in place.
- The four Wave One DHBs will be migrated on to the NTS. This will be a "lift and shift" process with no upgrade to the Oracle EBS system.
- A common operating model will be implemented to operate across all DHBs.
- The Northern DHBs, Taranaki, and Southern DHB will be upgraded on to the Wave One instance. This will occur in multiple waves and will involve data cleansing, process changes, training, and change management. Some interfaces to other systems will need to be upgraded as well.
- The remaining 10 DHBs will be migrated on to the central system in subsequent waves.
- National, collaborative, and local procurement continues under existing arrangements.
- A benefits realisation regime is put in place across all DHBs to manage the collective benefits.
- Change management across the sector is coordinated from a central implementation team. DHBs will be responsible for the change in business processes required to achieve the procurement benefits.
- Data cleansing, process change, training, and change management occurs to enable effective use of the upgraded systems and the use of the shared national catalogue.

Financial benefits occur as follows:

- healthAlliance has identified $2 million of operational cost savings for Northern Region if the upgrade to FPIM and the move to the new infrastructure takes place.
- Once all DHBs have the national catalogue, data standards, reporting, and compliance in place, an uplift of 5% can be achieved in cost avoidance on PHARMAC managed medical devices ($640 million pa across 388 suppliers) and potential other national contracts ($102 million pa) – this produces cost avoidance benefits on $742 million pa of $37.1 million pa.

The benefits drivers are summarised on the following page. Estimated costs are summarised on the subsequent page.

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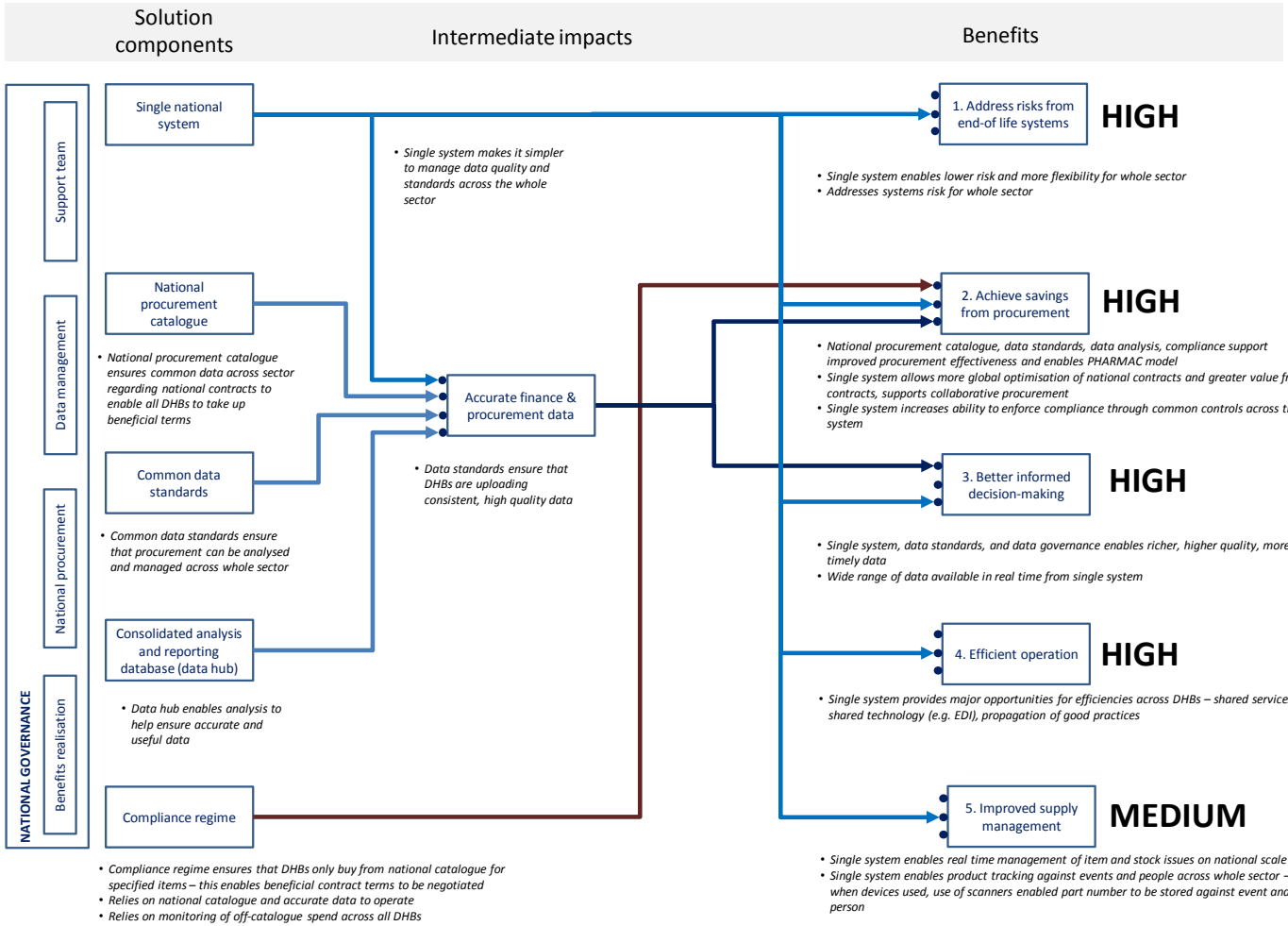

Figure 24 Benefits drivers for Option 6 Single national system

NZ HEALTH PARTNERSHIPS

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Table 15 Option 6 Single national system costs and benefits ($million) – EXCLUDING ANY CONTINGENCY

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
	PHARMAC benefit					32.100	32.100	32.100	96.300	192.600
	National Procurement					5.100	5.100	5.100	15.300	30.600
	Operating savings Northern region				2.000	2.000	2.000	2.000	8.000	14.000
					2.000	39.200	39.200	39.200	119.600	237.200
Costs										
	Operating									
	Option 3	12.544	15.136	14.322	12.553	12.378	11.663	11.663	90.257	125.244
	PLUS Additional Oracle licencing			0.579	0.869	0.869	0.869	0.869	4.055	6.662
	PLUS Remaining DHB implementation			0.178	1.026	0.383			1.587	1.587
	PLUS Quality Assurance		0.525	0.375					0.900	0.900
	PLUS Benefits Management			0.230	0.460	0.460	0.460	0.460	2.070	3.450
	Total Operating Costs	12.544	15.661	15.684	14.908	14.089	12.991	12.991	98.869	137.843
	Capital									
	Option 3	9.727	17.224	4.840					31.791	31.791
	PLUS Remaining DHB implementation		4.502	10.553	0.384				15.438	15.438
	PLUS Central Programme		3.803	10.162	1.784				15.748	15.748
	PLUS Hardware refresh									2.100
	Total Capital	9.727	25.529	25.554	2.168				62.977	65.077
	Total Cash Out	22.270	41.190	41.238	17.075	14.089	12.991	12.991	161.846	202.920
	Net Cash	(22.270)	(41.190)	(41.238)	(15.075)	25.111	26.209	26.209	(42.246)	34.280
	Indicative impairment	None								

21

6.3.8 Pathway to the public cloud

Cloud services will be an inevitable part of future systems for DHBs

Cloud services are becoming more and more ubiquitous. Businesses across New Zealand are increasingly using cloud systems for their day to day work. The spread of Xero among New Zealand business and public sector organisations (e.g. schools) is a case in point. With the increased investment of vendors in their cloud offerings it is inevitable that on-premises systems will decline.

Cloud services typically provide the following benefits:

- Reduced cost to implement the infrastructure environment (e.g. when compared with the implementation of the EXA environment for the National Technology Solution for Options 3 and 5).
- Reduced cost of application maintenance through centralised provision of service.
- Reduced cost of upgrade through centralised upgrades occurring across all customers.
- More user-friendly systems designed as web systems from the ground up.
- The flexibility to scale up and scale down without requiring investment in infrastructure capital.
- Disaster recovery is (typically) built into the solution.
- More secure systems than can be consistently achieved through locally managed on-premises systems.
- Reduced requirement for capital as the services are pay-as-you-go.

All major systems suppliers are increasingly focusing their investment on cloud-based products and are seeking to transition their existing customers to their cloud-based offerings. This means that the cloud-based offerings are becoming increasingly functional and that in the future, investment will inevitably reduce for their traditional on-premises hosted products. DHBs must therefore expect to move to the cloud and plan for it.

In 2012 Cabinet directed government agencies to adopt public cloud as first preference

The New Zealand government has had a policy of public sector agencies using public cloud as a first preference since August 2012.[45]

The sector therefore must be considering how it uses the cloud, with the knowledge that it is likely that a transition to full cloud for finance, procurement, and supply chain systems will occur at some time in the future.

Cloud services typically separate into IaaS, PaaS, and SaaS

There are typically three types of cloud services:

- IaaS (Infrastructure as a Service) – this provides infrastructure services across the internet. Customers rent a managed service providing an equivalent service to a data centre, namely computing hardware, storage, and networking.
- PaaS (Platform as a Service) – this provides the underlying infrastructure as in IaaS, but also providing the core systems software such as the database and the middleware software

[45] See https://www.ict.govt.nz/guidance-and-resources/using-cloud-services/additional-background-information/cabinet-decisions/ [Accessed 26 November 2018]

required for an application such as Oracle EBS to operate. Customers rent this service and the components are kept up to date by the cloud services provider.

- SaaS (Software as a Service) – this provides the application itself for access across the internet. The customers pay a regular fee for the service.

Hybrid cloud options that mix on-premises systems and cloud are available today and can provide value

Hybrid cloud uses a mixture of on-premises systems and cloud services with interfaces between the two. It enables workload to be moved between on-premises services and the cloud as suits the particular costs and workload.

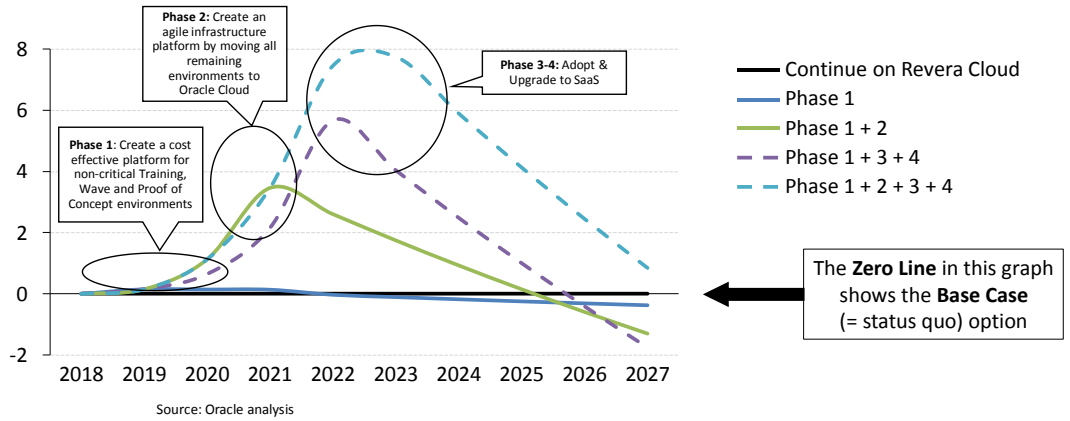
By way of example, one potential opportunity is the use of Oracle cloud to run less frequently used development and test environments for those DHBs with Oracle EBS. In this example a training environment could be hosted using IaaS. A full version of Oracle EBS for training purposes would be hosted on a cloud services. It would only be used (and paid for) when required for training purposes. When training was completed, its database could be refreshed with clean training data. Another example would be a hybrid cloud environment used to provide reporting and analysis services. These examples could also be replicated with non-Oracle service providers.

Most DHBs are not ready for an immediate move to SaaS

Moving to a full SaaS service is not a trivial undertaking. In many cases it may be as complex as a major upgrade or a transition to a new system. Significant data cleansing, process change, training, and change management is required. DHBs with existing investments in infrastructure or lease agreements will need to determine the most economic time to make any transition.

Oracle has undertaken some initial analysis around moving the existing FPIM Oracle EBS to cloud. The analysis only took into account the Oracle costs but provides an indicative basis for assessing the payback period. This is summarised in the following diagram. It plots Total Cost of Ownership (TCO) in millions as this increases while transition costs to SaaS are incurred and then reduces as savings occur.

Accumulated *Additional* TCO per year vs Status Quo, per Cloud Roadmap option, NZD million $



Source: Oracle analysis

Figure 25 Potential financial payback for cloud technologies

This graph shows that on the basis of initial analysis, the move to Oracle cloud technologies pays for itself in eight to ten years. While the ongoing costs will be lower than hosted and locally managed systems, there is a significant cost to transition. Moving from Oracle EBS to cloud is the equivalent of

migrating between major Oracle releases. The financial drivers will therefore not be the primary drivers for change.

A phased approach to the cloud can be taken

DHBs can individually or collectively take a phased approach to the cloud as makes sense for each DHB or cluster of DHBs. We note that different DHBs are at different parts of their life-cycle and therefore will be driven by different issues.

One approach is a four-phase transition plan to move to full cloud services. This approach could be used for individual DHBs, clusters of DHBs, or for all DHBs.

Phase One: Hybrid cloud IaaS

Hybrid cloud IaaS can be used as a cost-effective platform for non-critical environments. This provides for reduced demand on the hosted environment as well has enabling a low risk proof-of-concept. This could be used for non-production environments or for archiving in the case of legacy systems no longer used on a daily basis.

By way of example, Oracle has advised that a hybrid cloud proof of concept could be implemented in one to two months for Oracle EBS.

Phase Two: Full hosting of finance, procurement, supply chain system on IaaS or PaaS

This phase (for DHBs or clusters of DHBs using Oracle) would involve full hosting of Oracle EBS on Oracle Cloud using PaaS. This would increase the ability of the DHBs to respond to changes in load, reduce the administration effort, and enable new capabilities available through Oracle PaaS to be used. DHBs would pay for what they used. There would be no requirement for capital to buy infrastructure (or enter into a finance lease). This option would also be available for DHBs not using Oracle EBS.

The sector is currently committed to leasing infrastructure from Revera until January 2022 as part of the original FPIM commitments. This would be a logical point to consider implementing phase two cloud for those Oracle EBS DHBs planning to use this infrastructure. Other DHBs could clearly choose to implement this cloud phase earlier depending on their own circumstances.

Phase Three: Selective use of SaaS

This phase could operate in parallel with phase two. It would involve the trial of key pieces of software providing high value to DHBs. This could be planning, budgeting, and forecasting. This provides a low risk entry into SaaS and could be started anytime.

Phase Four: Full use of SaaS

This would involve moving a DHB or cluster of DHBs completely on to the cloud. This would bring the benefits of a modern user experience, automatic provision of upgrades, and reduced administration effort (as this is part of the cloud service).

Opportunities to interface Oracle cloud and Oracle EBS

Oracle EBS / Oracle cloud has the capability of what it terms "tier two ERP". In this scenario, Oracle EBS organisations can be linked together with Oracle EBS organisations, with all the key master data coming from Oracle cloud. This enables the management of common data standards, common master data (including catalogue information), and consolidated analysis and reporting across the Oracle EBS instances and the Oracle cloud instances. This is typically used in a transitionary manner in the case when (for example) a multi-national organisation is making a transition from Oracle EBS to cloud on a country by country basis.

This approach could enable DHBs using Oracle EBS on the Revera infrastructure to share data with Oracle cloud DHBs. This provides further nuanced options for the transition to a common cloud platform for those DHBs using Oracle EBS.

Potential use to replace existing national technology solution

An example "optimistic" timeline for the phases is shown below. This example shows how Oracle cloud services could be used to replace the national technology solution as contemplated by the original FPIM programme. Currently the sector is committed to leases with Revera until January 2022. This would then be the earliest practical time that a full migration to cloud could occur.

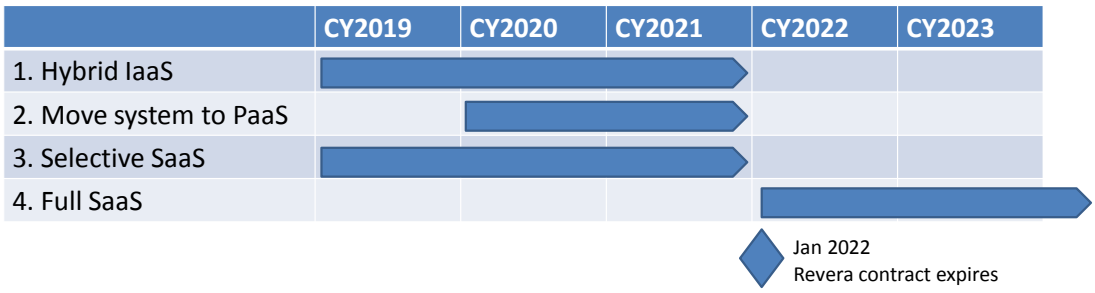


Figure 26 Potential "optimistic" timeline for replacement of national technology solution

No separate cloud-based option has been defined for this business case – cloud will be a potential part of all options

Cloud technologies will form part of any solution that is used by the sector. IaaS, PaaS, and SaaS provide flexibility to "mix-and-match" with existing technology solutions.

The transition to SaaS is a significant undertaking and is the equivalent of a major upgrade or transition to a new system. It should not be undertaken lightly, however, point SaaS solutions will be useful. The drivers for the move to cloud services will be different for different DHBs.

A single cloud-based system is fundamentally no different to a single on-premises system with a national catalogue (as for option six). An additional cloud-based option has therefore not been included in this analysis. However, it is expected that cloud options will form part of the future evolution of the solutions, whether this is for Oracle EBS or other systems. Any proposal for move to cloud SaaS would clearly need to be a standalone business case providing value in its own right.

6.4 Key financial assumptions for options

6.4.1 Costs included

The following table lists the key costs that have been included.

Table 16 Costs included in the options

Cost	How determined	Comments
Oracle licence fee	NZ Health Partnerships owns some licences, fees determined from contract Additional licences will need to be purchased	
Third party software licence fees	NZ Health Partnerships already owns some licences, fees determined from contracts Additional licences will need to be purchased	
Ongoing costs of Oracle Exadata / Exalogic platforms	From existing contracts	
Infrastructure as a service	From contracts agreed with Revera	
Oracle Administration Team (OAT) ongoing support	Based on estimated team size	Estimated on basis of salaried staff
Programme implementation	Based on estimated programme team size overlaid against the planned implementation schedule	Estimated on basis of a mix between salaried staff and external resources.
DHB implementation	Based on estimated team size Modelled for small, medium, and large DHBs	Estimated on basis of mix of contract and backfilled DHB subject matter experts

6.4.2 Costs excluded

The following table lists the costs have been excluded from the cost model.

Table 17 Costs not quantified

Cost	Description	Why excluded
Oracle EBS upgrades	Oracle EBS will require ongoing upgrades – typically once every five years	DHBs currently fund their own upgrades Under clustering options additional costs for Oracle upgrade will be more than offset by existing upgrade costs
Migration to cloud services	Migration of the privately hosted Oracle EBS to cloud based services	This will be managed as a standalone business case when cloud services demonstrate the necessary maturity

6.4.3 Benefits included

The following table lists the key benefits that have been accounted for.

Table 18 Financial benefits considered

Financial Benefit	How recognised	Comments
Operational Savings	Operational savings on account of having the whole of Northern Region on a single common catalogue resulting in operational savings of $2 million within the shared service procurement and supply chain function at healthAlliance Available in Options 2,3,4,5,6	Estimated by the healthAlliance FPSC team.
Procurement savings	Procurement savings have been estimated on the basis of 5% reductions for $640 million pa for medical devices plus $102 million pa for other procurement that could be managed nationally Total of $37.1 million pa Available in options 4,5,6	Based on PHARMAC provided information and analysis undertaken by NZ Health Partnerships

6.4.4 Benefits excluded

The following table lists the benefits have been excluded from the cost model.

Table 19 Benefits not quantified

Financial Benefit	How recognised	Comments
Reduction in DHB licence fees	Reduction in DHB licence fees in case of new central system Not quantified	Will depend on DHB circumstances and meeting requirements for archiving
Reduction in DHB upgrade costs	Reduction of system upgrade costs in case of new central system. System upgrades will occur once as opposed to DHB by DHB Assumed to be cost neutral in worst case (i.e. cost of central upgrade will be equal to or less than combined DHB upgrades required)	Upgrades not costed in business case as DHBs already need to budget for upgrade costs
Procurement efficiencies	Reduced cost of operating procurement Benefits from collaborative and local procurement Qualitative only	Expected to take place from EDI and other initiatives Not quantified
Master data management	Reduced DHB cost of managing master data	Reduced DHB costs displaced by increase in central data management costs Costs not included in preferred option costs.
System upgrade costs	Reduced requirement for system upgrades	Reduced DHB system upgrade costs as upgrades only occur centrally

6.5 Impact of Quantitative Risk Assessment

The Quantitative Risk Assessment (QRA) of the key costs and benefits makes no change to the financial ranking of the options, albeit finding that the base costs are "optimistic" and additional contingency will be required

6.5.1 Introduction

A Quantitative Risk Assessment (QRA) was conducted on the cost and benefits model to identify the likely funding ranges required for the business case and what aspects of the programme will most impact costs. This section discusses the impact on the preferred option, namely Option 3.

6.5.2 Process

A series of risk workshops were held with key staff to identify the uncertainty factors driving the costs and benefits. These workshops were facilitated by Broadleaf Capital International who are expected in QRA.

The following table summarises the probability curves assigned to the most material factors in the cost/benefit model as a result of these workshops. The table shows:

- the optimistic cost
- the most likely cost
- the pessimistic cost
- the mean cost ("simulated mean) based on the optimistic, most likely, and pessimistic values.

Note that these are the factors that apply to the preferred option – Option 3 – only (the full list can be found in the section on QRA in the Economic Case). Note that only factors considered material to the overall costs were considered and modelled.

Table 20 Probability curve parameters for key inputs to cost/benefit model

Factors that can vary	Optimistic	Most likely	Pessimistic	Simulated Mean
CAPITAL				
Option 2 Capex Implementation	-5%	5%	20%	7.1%
Licencing shortfall	5%	12.5%	20%	12.5%
Detail build	0%	15%	50%	23.6%
Establish support model, infrastructure and systems	15%	25%	75%	42.3%
End-to-end testing	20%	33%	80%	47.7%
Business Intelligence report development	5%	10%	15%	10.0%
Other 3rd party & solution providers	0%	100%	200%	100%
SDHB resourcing – duration delay cost	25%	25%	50%	36.1%
Northern DHBs – duration delay cost	0%	0%	25%	11.1%
Central Programme Implementation – duration delay cost	25%	50%	75%	50.0%
Quality Assurance	-20%	0%	20%	0.0%
Capital general – Option 3	-5%	5%	20%	7.1%
Interface catalogue – Option 4	6%	4%	3%	4.4%

Factors that can vary	Optimistic	Most likely	Pessimistic	Simulated Mean
New catalogue web service – Option 4	0%	20%	50%	24.3%
National catalogue operational costs	-10%	0%	15%	2.1%
Option 5 resourcing	25%	50%	75%	50.0%
Option 6 resourcing	25%	25%	50%	36.1%
OPERATING				
OAT support	-5%	0%	15%	4.3%
BENEFITS				
PHARMAC & National Procurement Benefits Option 4	3%	2%	1%	2.0%
PHARMAC & National Procurement Benefits Option 5,6	6%	4%	3%	4.4%
Time lag to achieve full benefits	0%	-50%	-100%	-50.0%

6.5.3 Impact on financial comparison of options

The probabilities for the key inputs were modelled through the cost/benefit spreadsheet to determine the ranges of funding required over the business case period and the impact on NPV. The following graph summarises the results.

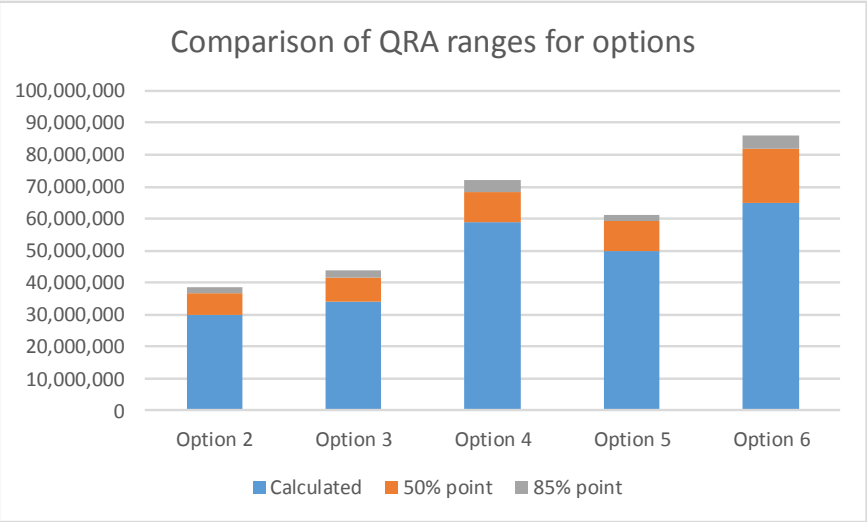


Figure 27 QRA impact on capital for options

The following should be noted:

- Option 2 has only had high level cost analysis. We have therefore applied the same level of uncertainty spread as for Option 3, where most of the financial analysis has taken place. We believe that this better represents the level of uncertainty in this option.
- All the options have optimistic costs in the base estimates. This is shown by the fact that the 50% costs are higher than the base estimate.
- The benefits totals for all options using a national catalogue – options 4, 5 & 6 – have a high range of uncertainty. This translates into higher risk of realising the benefits. This level of benefits realisation will need to be reduced.
- Capital uncertainty reduces for Options 4 and 5 from Option 3. This is because Option 4 and Option 5 have less optimistic costings for the national catalogue.

When the ranges are compared, they make little difference to the financial ranking of the options. While Option 2 looks superficially attractive from a capital perspective, it should be remembered that it provides a pathway to Option 4, whereas Option 3 provides a pathway to Option 5, a lower cost option.

The key value for the QRA is in the analysis of the preferred option and the identification of the key risks. This is described in the Financial Case below.

6.6 Comparison of options

6.6.1 Summary

The short list options were compared against how well they met the investment objectives and critical success factors. Their costs and financial benefits were also compared

The opposite table compares the aspects of the options. It shows the fit against investment objectives as laid out in the option description above as well as the critical success factors, risk, and costs and benefits.

6.6.2 Investment objectives

When considered against the investment objectives, Option 6 National system and integrated catalogue will deliver the highest value, but Options 4 and 5 which both use a national catalogue should also be considered

Each of the options has been ranked against the investment objectives. The implications of the rankings by investment objective are discussed below.

1. *Address risks from end of life systems:*
    a. Option 6 National system and integrated catalogue addresses this requirement the best. It addresses the risks at all 20 DHBs and ensures that all 20 DHBs are operating an up to date system.
    b. Option 3 Single system for 10 DHBs and Option 5 Single system for 10 DHBs plus national catalogue both ensure that 10 DHBs covering 73% of the sector by PBF (and 80% of the procurement spending) have up to date systems. These are the DHBs that have self-identified their critical issues. However, these two options do not address the risk faced by the other DHBs outside of the 73%.
    c. Option 2 Clustered risk mitigation and Option 4 Clustered risk mitigation plus national catalogue enable the same 10 DHBs covering 73% of the sector by PBF to address their critical issues, albeit in a different way, by operating individually or in existing clusters. (More information is required from the participating DHBs.)
2. *Savings from procurement:*
    a. Option 4 Clustered risk mitigation plus national catalogue, Option 5 Single system for 10 DHBs plus national catalogue, and Option 6 National system and integrated catalogue, all provide for a national catalogue, common standards, sector-wider analysis, and compliance against national contracts. These are the key prerequisites for delivering the procurement savings.
    b. Option 6 National system and integrated catalogue may provide improved procurement effectiveness because of the greater ease in managing the quality of data and the level of compliance through a single central system. It may be more difficult to manage data quality and compliance across diverse systems managed by different DHBs as in options 3 and 4. However, this requires further investigation.

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Table 21 Comparison of options ($million)

OPTIONS	1. Status Quo / shutdown FPIM	2. Clustered risk mitigation	3. Single system for 10 DHBs	4. Clustered risk mitigation + catalogue	5. Single system for 10 DHBs + catalogue	6.National system & integrated catalogue
CRITICAL VALUE						
#1 Address risks from end of life systems	○	◔	◔	◔	◔	●
#2 Savings from procurement	○	○	○	◔	◔	●
SUPPORTING VALUE						
3. Better informed decision-making	○	○	◔	◑	◔	●
4. Efficient operation	○	○	◑	○	◑	●
5. Improved supply management	○	○	○	◑	◑	◑
CRITICAL SUCCESS FACTORS						
Strategic fit and business needs	○	○	◑	◔	◔	●
Supplier capacity and capability	○	●	●	●	●	◑
DHB capacity and capability	○	●	●	◑	◑	◑
Achievability	○	◔	◔	◔	◑	◑
RISK						
Implementation risk	n/a	◔	◔	◔	◔	●
Operational risk	●	◔	◔	◔	◔	◔
Benefits realisation risk	n/a	○	○	◔ [1]	◑ [2]	◔
COSTS & FINANCIAL BENEFITS (EXCLUDING CONTINGENCY)						
Cash comparison (10 year)						
Capital		(29.989)	(33.891)	(58.782)	(49.783)	(65.077)
Operating	(14.115)	(110.147)	(125.244)	(139.678)	(137.774)	(137.843)
Total	**(14.115)**	**(140.045)**	**(159.135)**	**(198.460)**	**(187.557)**	**(202.920)**
Benefits		14.000	14.000	223.200	237.200	237.200
Net	**(14.115)**	**(126.045)**	**(145.135)**	**24.740**	**49.643**	**34.280**
NPV (at 7%)	(12.950)	(84.953)	(109.639)	(12.783)	4.899	(8.575)
Cash plus impairment comparison (10 year)						
Net cash	(14.115)	(126.045)	(145.135)	24.740	49.643	34.280
Potential impairment	(56.000)	(56.000)	(22.000)	(56.000)	(22.000)	-
Net impact	**(68.115)**	**(182.045)**	**(167.135)**	**(31.240)**	**27.484**	**34.280**

Notes
1. Benefits realisation risk medium/high because of difficulties in achieving data consistencies and compliance across disparate systems
2. Benefits realisation risk lower when compared with option 4 as 80% of medical device procurement will be on a single Oracle FPIM system

Low	Low/Medium	Medium	Medium/High	High
○	◔	◑	◔	●

3. *Better informed decision-making:*
    a. The options progressively provide better data to support decision-making as DHBs become more connected through options 2 to 6.
    b. Option 6 National system and integrated catalogue will provide the best support for decision-making as all sector data will be available in real-time in one database for analysis.
    c. Option 5 Single system for 10 DHBs plus national catalogue ensures that data covering 10 DHBs and 73% of the country by PBF (and 80% of the procurement spending for the sector) is available real-time in a single database. Lower levels of data will be available for sector wide analysis for the remaining 27%.
    d. Option 4 Clustered risk mitigation plus national catalogue will enable the sharing of significant amounts of data across the sector, thereby supporting more effective decision-making. However, it will not provide the breadth and depth of data provided by Option 5 which has 10 DHBs with 80% of the procurement spending in a single system and database or Option 6 which has all 20 DHBs on a single system and single database.
4. *Efficient operation:*
    a. The use of a single system across the sector as proposed by Option 6 National system and integrated catalogue provides the best opportunity to create sector wide efficiencies through shared services, shared infrastructure such as Electronic Document Interchange (EDI) with suppliers, and propagation of best practice across all DHBs.
    b. Option 3 Single system for 10 DHBs and Option 5 Single system for 10 DHBs plus national catalogue provide increased efficiencies for the DHBs all on the same system (73% by PBF). $2 million pa of supply chain savings have been identified for these options.
5. *Improved supply management:*
    a. Options 4, 5, and 6 all provide centralised data and provide similar benefits regarding supply management. They will all enable global management across all DHBs of supply issues and the tracking of individual medical devices against events and/or persons.

6. *CONCLUSIONS*
    a. In terms of the investment objectives, Option 6 National system and integrated catalogue provides the best value in both the categories of critical value and supporting value.
    b. The options providing for a national catalogue interfaced to existing systems – Option 4 Clustered risk mitigation plus national catalogue and Option 5 Single system for 10 DHBs plus national catalogue – provide a medium/high level of value for the critical value areas.
    c. Option 5 Single system for 10 DHBs plus national catalogue where there is a single system covering 73% of the country by PBF provides better supporting value because of the level of data quality that can be achieved by having 73% of the country's data on a single system and database comprising 80% of the procurement spending.
    d. Option 4 Clustered risk mitigation can potentially support high data quality if there are a small number of large clusters.

e. Options 4, 5, and 6 should therefore all be considered on the basis of the value they can bring through risk mitigation and savings from procurement through the national catalogue.

f. The implementation of a common system across the sector means that some DHBs may lose existing functionality. However, this could be addressed through early analysis and confirmation of requirements.

6.6.3 Critical success factors

Option 3 Single system for 10 DHBs and Option 5 Single system for 10 DHBs plus national catalogue have the best fit to the critical success factors

1. *Strategic fit and business need*

    a. Option 6 National system and integrated catalogue has the best fit to future strategy. It enables global changes to be undertaken without the need to address DHB systems boundaries and complex interfaces between disparate systems.

    b. Option 6 provides for consistency across all DHBs while providing for future flexibility regarding any global changes across the sector.

2. *Supplier capacity and capability*

    a. Option 6 National system and integrated catalogue requires the largest degree of change and complexity as it affects all DHBs. The scale of this option will inevitably reduce the number of suppliers who can address the issues. This option also requires more reliance on a single supplier, most notably Oracle. This could leave some DHBs with higher implementation and operating risk.

3. *DHB capacity and capability*

    a. The more change that occurs across the sector, the more difficult it will be for DHBs to manage the level of change.

    b. All options require significant change. Moving to a single system (in the case of Option 6 National system and integrated catalogue) requires the greatest level of change.

    c. However, DHBs working together to implement a national catalogue, common data standards, a national data repository, and procurement compliance, also requires significant change across the sector, especially as they implement changes in procurement processes for items and services in the national catalogue.

4. *Achievability*

    a. All options are equally technically achievable.

    b. Option 6 has the highest implementation risk and will be the most difficult option to implement.

    c. Achieving the benefits from the PHARMAC medical device contracts will require high levels of data quality and compliance against use of the national catalogue at all DHBs.

5. CONCLUSIONS

    a. Option 6 National system and integrated catalogue will provide the best strategic fit through the future flexibility provided by the solution. However, because of the complexity of the solution, it is ranked lower on the other areas, namely supplier capacity and capability, DHB capacity and capability, and achievability.

b. Both Option 5 Single system for 10 DHBs plus national catalogue and Option 6 National system and integrated catalogue should be considered on the basis of their evaluation against the critical success factors.

6.6.4 Risk

Option 6 National system and integrated catalogue has the highest implementation risk, but the lowest risk regarding achieving the benefits; Option 5 Single system for 10 DHBs plus national catalogue and Option 4 Clustered risk mitigation should be considered as they will have a lower implementation risk

1. *Implementation risk*
    a. This relates to the risk of implementing the solution required for the option.
    b. Implementation risk will be highest for those options requiring the greatest technical and people change. Option 6 National system and integrated catalogue has therefore been rated as having high implementation risk.
    c. There is also be increased risk when larger numbers of DHBs need to work together to implement a system. In these cases, the change management risk is also higher.
    d. Options 2, 3, and 4 are all complex implementations. They have therefore been rated as having medium/high risk.
2. *Operational risk*
    a. This relates to the risk of operating the solution required for the option.
    b. With the exception of option 1 status quo, all options can be made to operate at acceptable risk.
    c. There is an argument that having all DHBS on one system in fact raises the risk. While this is partially true, the scale that can be achieved allows this risk to be better mitigated.
    d. There is an argument that having all DHBs using a single supplier (e.g. Oracle in the case of Option 6) creates operational risk and reduces the possibility of innovation. The counter-factual to this argument is that Oracle has low supplier risk as it is one of the two biggest market players and that its future solutions have far more access to innovation due to its market reach and the investment it can make.
3. *Benefits realisation risk*
    a. This relates to the risk of achieving the benefits as estimated for the option.
    b. The highest *potential* benefits realisation risk will be that of Option 4 Clustered risk mitigation plus national catalogue. This is because it relies upon DHBs working together to manage a national catalogue, common data standards, a data repository, and compliance. The distributed nature of the systems and decision-making will make achieving compliance particularly challenging.
    c. Option 5 Single system for 10 DHBs plus catalogue has a lower level of benefits realisation risk than option 4 because 73% of the country by PBF will be operating on a single system and database covering 80% of the procurement spend. This will enable data standards, a data repository, and procurement compliance to be more easily manage for 80% of the sector's spending.
    d. The benefits realisation risk of Option 4 Clustered risk mitigation plus national catalogue can be reduced depending upon the final configuration chosen by participating DHBs.

E.g. a small number of large clusters will have a lower benefits realisation risk than a large number of small clusters or individual DHB systems.

4. CONCLUSIONS

a. Option 6 National system and integrated catalogue has the highest implementation risk, but the lowest risk regarding achieving the benefits.

b. Option 5 Single system for 10 DHBs plus national catalogue should be considered for investigation regarding achieving the benefits as its implementation risk is lower than option 6.

6.6.5 Financial

Option 4 Clustered risk mitigation plus national catalogue and Option 5 Single system for 10 DHBs plus national catalogue – those implementing the catalogue interfaced to existing systems – and Option 6 National system with integrated catalogue, have comparable estimated costs, with options 5 and 6 having lower impairment of the existing FPIM assets

Option 2 Clustered risk mitigation was developed originally as the counter-factual to Option 3 Single system for 10 DHBs. Option 2 appears to have a lower cost. Some of this can be attributed to the significantly more analysis that has been undertaken for Option 3. It should also be remembered that Option 2 provides the pathway to Option 4, which is more expensive that the pathway provided by Option 3, namely Option 5.

Option 4 Clustered risk mitigation plus national catalogue and Option 5 Single system for 10 DHBs plus national catalogue can be directly compared as they address the same critical value drivers.

Option 6 National system and integrated catalogue cannot be directly compared with the other options on a cost basis s it implements new systems for the remaining10 DHBs not covered in options 3 and 5.

Option 6 National system and integrated catalogue has the lowest asset impairment as it uses all the FPIM investment to date.

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6.7 Choosing the best pathway

The following can be concluded from this comparison.

Option 1 Status quo / shutdown FPIM	Does not address the immediate risk of operational failure faced by the 10 DHBs using Oracle EBS who have self-identified as having high risk. Does not provide any procurement savings.	→	Reject
Option 2 Clustered risk mitigation	Resolves the risk for the 10 DHBs with immediate issues. While it appears attractive cost-wise, these costs are based on high level estimates only. If it is adopted its pathway is to a higher cost option when the catalogue is added, that of Option 4.	→	Reject on the basis that no alternative cluster has been identified by sector
Option 3 Single system for 10 DHBs	Resolves the risk for the 10 DHBs with immediate issues. Moves 80% of sector procurement to single platform, thereby simplifying data standards and procurement compliance. It consolidates the sector along a path towards a single national system (at some point in the future) and is aligned to a shared national catalogue. The National Technology (infrastructure) has already been designed, peer reviewed by PWC Australia, and the hardware is already in place.	→	Implement as matter of urgency
Option 4 Clustered risk mitigation plus national catalogue	Provides a means for Option 2 to have a national catalogue and common chart of accounts and so provide savings in procurement. It may be more challenging to implement and achieve the benefits than Option 5 Single system for 10 DHBs plus national catalogue.	→	Reject on the basis that no alternative cluster has been identified by sector
Option 5 Single system for 10 DHBs plus national catalogue	Provides the most promising solution to achieving the PHARMAC level savings without implementing a single national system. The national catalogue, data standards, data repository, and compliance can be implemented in parallel with Option 3. It enables the sector to build off the cluster of 73% by PBF / 80% of procurement spending on a single Oracle EBS instance without requiring other DHBs to change their preferred systems.	→	Implement Option 3 and in parallel start design of shared national catalogue and chart of accounts

21

Option 6 National system and integrated catalogue	At this stage Option 6 appears to have the strongest case financially. However, it has a high implementation risk, higher risk of cost escalation, requires the short-term replacement of systems at seven DHBs, and will require the largest level of change management in DHBs. It should be preserved as a future pathway if possible, to keep the path open to future consolidation of systems across the sector and is most likely to be a cloud solution.	→	Preserve pathway to this state

6.8 Conclusions

On the basis of the analysis and conclusions, the following is recommended:

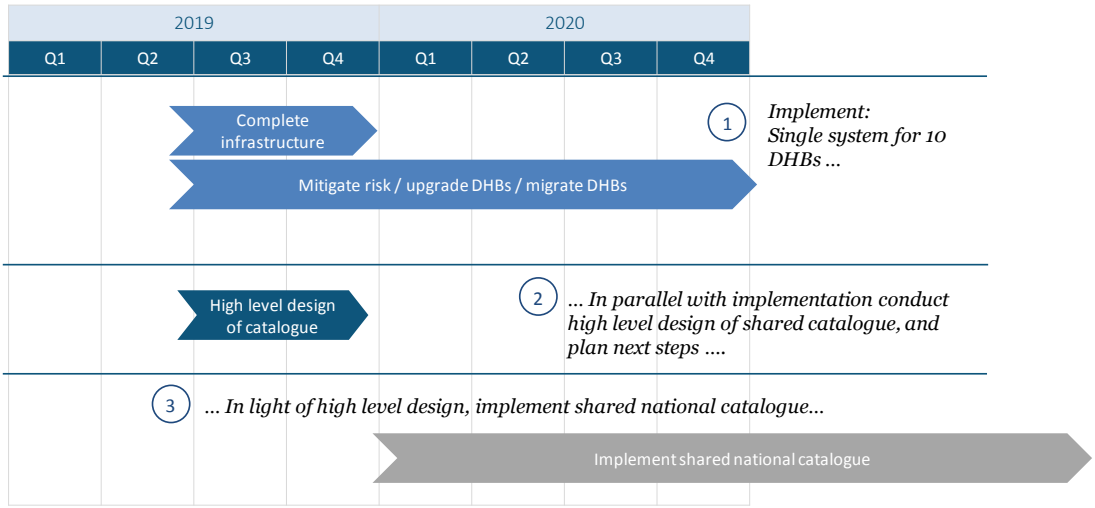

Figure 28 Decision-making plan

1. Option 3 Single system for 10 DHBs should start as soon as possible to mitigate the systems risk of 10 DHBs using Oracle EBS. This addresses immediate risks from end of life systems and preserves all future options.
2. A 6-month high level design should be conducted on shared national catalogue to determine how it should be implemented and how the PHARMAC level benefits could be achieved.
    a. The scope of the high-level design will include technology (interfacing to multiple different systems), data standards, data analysis and reporting, common Chart of Accounts, significant data cleansing, changes in procurement processes, and governance
    b. It will also include working with PHARMAC to ensure that their benefits realisation model provides incentives for DHBs to support it.
3. Implementation of the catalogue would start from late 2019 once analysis had been completed and agreement gained to move forward.

See 9. Management case for details on plan for implementation of preferred option.

See APPENDIX E: Shared national catalogue high level design project brief for description of the high-level design work.

See 8. Financial case for details on costing and cost allocation to DHBs.

7. Commercial case

7.1 Introduction

This commercial case describes how the components of the preferred option will be procured. It describes:

- The overall procurement strategy
- The commercial components that must be procured
- Individual procurement plans for each of these components.

Note that it does not describe why the overall option is best value for money – this is covered in the Economic Case.

7.2 High-level procurement strategy

Procurement will occur through leveraging existing arrangements, existing internal resource (DHBs, NZ Health Partnerships, and associated entities), or project level procurement

7.2.1 Background

The NOS programme was operating up until Cabinet requested a "pause". This means that most commercial contracts are already in place for the provision of the infrastructure and services required. The preferred option (Option 3) is the continuation of the programme for 10 DHBs. It therefore relies upon existing contracts for:

- Infrastructure – Revera
- Infrastructure build – Oracle.

The programme relies upon the use of expert staff already in place in DHBs. In many cases, staff are seconded and then backfilled by temporary contract staff. Skilled staff are also available from healthAlliance, an organisation owned by the northern DHBs.

This current situation along with the requirements for the programme drives the following commercial strategy:

1. Leverage existing commercial arrangements where these are in place and appropriate
2. Use existing internal resources where these skills are required, and the staff are available
3. Programme level procurement for additional services and products required

The following should be noted:

- No additional national technology solution hardware is required. This has already purchased and under lease.
- Any future IaaS contracts can be covered under All of Government contracts.

7.2.2 Services and products required

We have identified the products and services to be procured and developed a high-level approach to their procurement

The following diagram summarises the commercial components that must be procured. How these packages will be procured are described in the following sections.

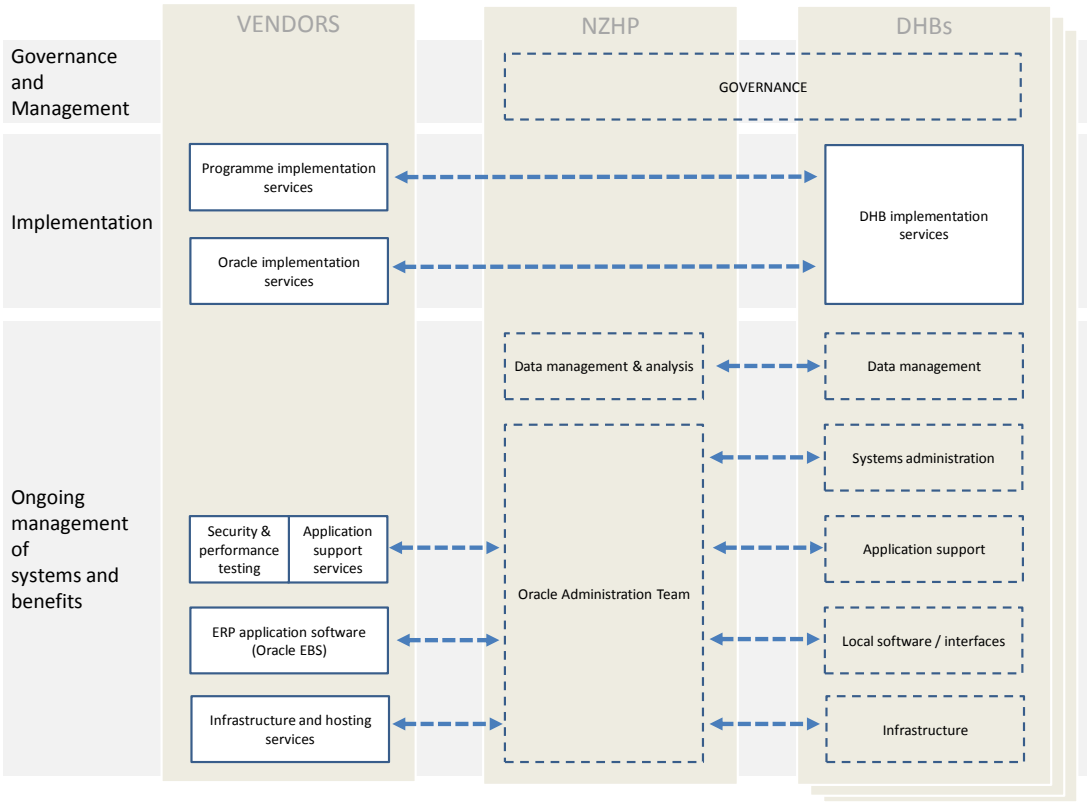

Figure 29 Commercial components

The following areas are excluded from this Commercial Case:

- *DHB ongoing management* – (DHB benefits management, system administration, application support, local software / interfaces, infrastructure). Individual DHBs will manage the procurement of the services required for their continued operation in conjunction with the services provided by NZ Health Partnerships and the suppliers.
- *NZ Health Partnerships ongoing management* – (data management and analysis, national procurement, Oracle administration team) – these functions will be delivered as business as usual fully staffed positions. (Further detail is provided in the Management Case).

The procurement of the key supplier and DHB implementation services are described in the following sections.

7.2.3 High-level procurement strategy

The following diagram summarises the high-level procurement strategy. This comprises:

- Leveraging existing procurement arrangements
- Internal resourcing
- Programme level procurement.

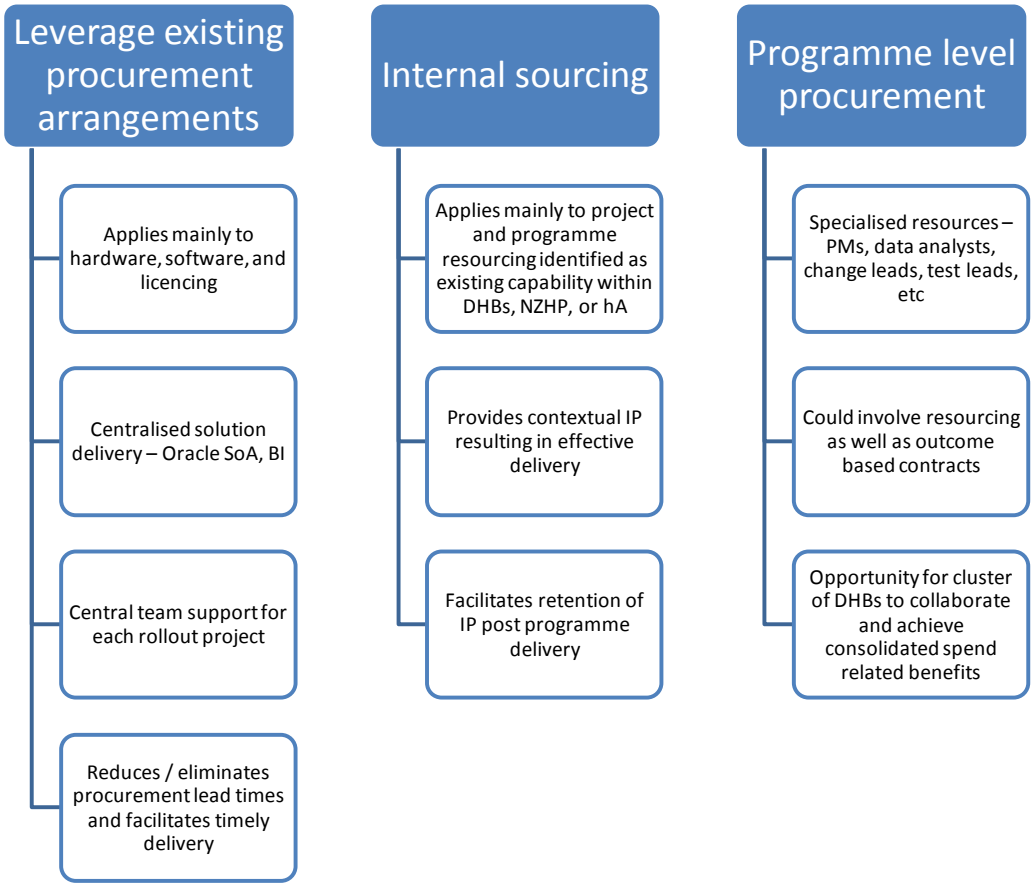

Figure 30 Procurement strategies

21

Leverage Existing procurement arrangements

A significant component of the proposed option leverages the NOS solution (Oracle application and infrastructure) in terms of design, software, hardware and licenses. With this in mind, this business case proposes to:

- Leverage existing procurement arrangements for key aspects such as licensing, hardware, software and centralised program delivery resources.
- Continue with agreements already in place with key suppliers such as Oracle and Revera.

This approach significantly reduces procurement lead cycles and relies on the fact that these existing arrangements have gone through extensive planning and negotiations to get a beneficial deal for the sector. This is particularly relevant for the delivery of the centrally managed programme tasks and delivery of the core central infrastructure. The centralised resourcing for supporting DHB rollouts will also benefit from this procurement approach.

Internal resourcing

This procurement strategy applies predominantly to the people that will need to be onboarded at each DHB to support the rollout of the solution for their business. Key resourcing that will be covered under this procurement approach includes:

- Business SMEs across supply chain, procurement and finance (process and change experts).

- Data SMEs to assist with data cleanse, reconciliation and validation.
- Oracle technical and functional resources from existing providers to support areas of work including data extraction, integration of DHB specific 3rd party systems.

Programme level procurement

This procurement strategy is relevant to procurement of specialist resources and structuring pieces of work to be done to integrate existing DHB specific 3rd party systems with the central Oracle application.

In most cases, the procurement strategy would be governed by the individual DHB procurement approvals process under defined delegated financial authority.

In the case of DHB specific 3rd party systems integration, there will be existing relationships, procurement arrangements and contracts with the respective suppliers. The project level procurement will leverage this to deliver their project objectives.

In certain cases, involving specialised resources, there may be an opportunity to seek leverage scale (project managers, training / change professionals, test leads etc.) by identifying and approaching specialised suppliers with a good track record of delivering similar initiatives in the past for other public sector or corporate sector clients.

7.3 Programme implementation services

7.3.1 Requirements

Programme implementation services are required to implement the FPIM solution. This consists of programme management, project management, data cleansing, data migration, change management, training services, and technical ERP services.

The experience and capability of the individuals who constitute the programme team, are critical to the success of the programme. The team will have the right level of technical skill, subject matter expertise and DHB experience.

There are several distinct areas which need to be catered for:

- Completion of the infrastructure build
- Completion of those system components which were not implemented with Wave One, e.g. Oracle Service-Oriented Architecture (SOA)
- Migration of the Wave One DHBs to the national technology solution
- Implement Wave Two DHBs on to the national technology solution.

Note that a resource management plan addressing these areas is currently being developed.

7.3.2 Procurement strategy

The procurement strategy for the implementation services will be tailored to meet the distinct areas which the programme needs to deliver.

It is essential that the programme team charged with the completion of the FPIM product as well as the migration and implementation activities includes team members who come from within DHBs.

In addition, the existing FPIM programme team has some specific skills and IP which should be retained on the programme.

Additional resources are likely to be required and sourced externally to the health sector.

We have invested considerable time and effort with Oracle and Revera, to complete the design and preparation work for the national technology solution. Both Oracle and Revera have significant IP with respect to the EXA and associated infrastructure technology in general, and the FPIM design in particular. The programme will leverage this IP and their commitment to the programme, with a view to completing the infrastructure build.

The programme team will be comprised of:

- Existing FPIM team members
- Functional and technical capability from the Northern region service provider (healthAlliance)
- Capability from within the DHBs
- New capability which will be brought in externally
- Oracle and Revera, for specific national infrastructure build activity.

7.3.3 Procurement plan

The procurement plan will confirm the implementation delivery model. The options that have been considered are (in line with the overall procurement strategy):

- Build an insourced (health sector internal) programme team (i.e. "Internal resourcing")
- Work with a specialised niche delivery firm who would build the programme team and bring together the various technical, system and management components (tier three systems integrator) to deliver to agreed outcomes (i.e. "Programme level procurement")
- Work with a large and established tier two systems integrator. A tier two system integrator would be expected to have substantial in-house Oracle EBS capability, as well as the ability to source additional resources as necessary (i.e. "Programme level procurement").
- A mix of the above.

FPIM governance will approve the implementation delivery model, at which point, the procurement plan can be confirmed, This will:

- Either engage a recruitment firm to recruit those resources which need to be sourced externally, or
- Select a systems integrator.

Because of the immediate requirement for DHBs to mitigate their risk, programme management would continue with existing staff until external procurement was finalised and the new team established.

The following procurement plan is indicative and will be initiated in early 2019.

Table 22 Security and performance testing services procurement milestones[46]

Procurement Milestone	Indicative Date
Pre-procurement	Feb 2019
Agree implementation delivery model	Feb 2019
Approve delivery model	March 2019
Tender	Apr 2019
Evaluation	May 2019
Post-evaluation	June 2019

An Evaluation committee will be formed from project and DHB staff with relevant expertise who will evaluate and recommended a preferred supplier to the FPIM Programme Governance boards.

7.3.4 Type of contract

The contract will be for variable price services with IP being retained by NZ Health Partnerships. The contract will seek to share risk with the provider, potentially with a shared risk, shared reward approach.

Variations to contract will be in writing and signed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority.

[46] These dates are provisional only. They rely upon the timing of final approvals by Cabinet to "un-pause" the programme. The dates for the procurement activities will inevitably be staggered with some procurement activities starting on the proviso of Cabinet approval.

7.3.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will rest with the GM Procurement, New Zealand Health Partnerships. This person will develop a contract and relationship management plan in consultation with the successful supplier. Day to day management of the contract and direction of the supplier will be undertaken by the SRO.

The supplier's performance will be reviewed annually as per the NZ Health Partnerships Procurement Strategy.

7.3.6 Accountancy treatment

The costs will be treated as part of the FPIM Programme capital and hence reside on the balance sheet of NZ Health Partnerships once capitalised.

7.3.7 Payment mechanisms

Wherever possible, payments will be linked to delivery milestones agreed with the supplier.

7.4 ERP application software

7.4.1 Requirements

To support the DHB business functions of the programme, namely Finance, Procurement, and Supply Chain, a software application is required that has the breadth and depth of functionality to meet the business requirements.

7.4.2 Procurement strategy

In 2012 under Health Benefits Ltd (HBL), the decision to use Oracle as the software provider was approved by the HBL Board as 12 of the 20 DHBs were already utilising Oracle eBusiness suite with a considerable investment in licenses. It was determined that it would have been cost prohibitive to go to market for a new software supplier given the existing investment in the sector.

Under HBL, additional licenses were procured in 2013 to support the wider functionality and increased numbers of DHBs that the National Oracle Solution supports, and it is these licenses that have been deployed as Wave One of the NOS went live in July 2018.

Subsequent to the above contract, there is now an All of Government contract agreement with Oracle (Software Framework Agreement – SFA) to which New Zealand Health Partnerships is a participating agency on behalf of the DHBs

7.4.3 Procurement plan

To support the additional DHBs on the National Technology Solution additional database licenses will be required to be purchased in 2019. These database licenses will be purchased under the Oracle Software Framework Agreement.

7.4.4 Type of contract

The Oracle contracts fall under two types:

1. Perpetual Software License Agreement – The original contract purchased Application, Middleware and Operating System licenses that are either processor or user based. All are perpetual Licenses (no end term).
2. Annual Support Licenses – The above software licenses incur an annual software support license costs and is governed by the above Software Framework agreement re annual increases.

7.4.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to GM Procurement, New Zealand Health Partnerships on the signing of the contract.

The supplier's performance will be reviewed annually as per the NZ Health Partnerships Procurement Strategy.

7.4.6 Accountancy treatment

The Perpetual Software Licenses are assets, have been capitalised and as such are on the balance sheet of NZ Health Partnerships.

7.4.7 Payment mechanisms

The Annual Support licenses costs are operating costs and as such paid annually in advance.

7.5 Oracle implementation services

7.5.1 Requirements

The National Oracle Solution comprises of Oracle Application Software which requires deploying onto hardware that is deployed in a Revera Data Centre as per the Revera infrastructure and hosting agreements.

7.5.2 Procurement strategy

In 2016, Oracle were selected to configure and build the application environments due to the specialist nature of the implementation services required.

7.5.3 Procurement plan

Implementation services are covered under the Oracle Software Framework Agreement.

7.5.4 Type of contract

The implementation services follow the terms and conditions of the Software Framework agreements.

7.5.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to GM Procurement, New Zealand Health Partnerships on the signing of the contract. This person will develop a contract and relationship management plan in consultation with the successful supplier.

The supplier's performance will be reviewed monthly as per the NZ Health Partnerships FPIM Programme Governance.

7.5.6 Accountancy treatment

The costs will be treated as part of the FPIM Programme capital and hence reside on the balance sheet of the NZ Health Partnerships once capitalised

7.5.7 Payment mechanisms

The Implementation services are capex and will be paid based upon milestone achievements.

7.6 Security and performance testing services

7.6.1 Requirements

To meet NZ Information Security Manual (NZISM) certification, the National Oracle Technology Solution needs to undertake Security and Performance Testing prior to commissioning.

7.6.2 Procurement strategy

A Request for Proposal (RFP) will be issued to the market for the for Security and Performance Testing services. All of Government panels will be used where possible. The scope of the services (professional services, tools, templates and analysis) will be:

1. Test Approach and planning
2. Test Script creation
3. Test Script execution
4. Security Test Report (results)
5. Performance & Load Testing Report (results)
6. Provision of suitable test tools

7.6.3 Procurement plan

The following procurement plan will be initiated in early 2019 as the services will be required by May 2019.

Table 23 Security and performance testing services procurement milestones[47]

Procurement Milestone	Indicative Date
Pre-procurement	Feb 2019
Tender	April 2019
Evaluation	May 2019
Post-evaluation	June 2019

An Evaluation committee will be formed by project and DHB staff with relevant expertise who will evaluate and recommended a preferred supplier to the FPIM Programme Governance boards.

7.6.4 Type of contract

The contract will be for fixed price services with IP being retained by NZ Health Partnerships.

Variations to contract will be in writing and signed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority.

[47] These dates are provisional only. They rely upon the timing of final approvals by Cabinet to "un-pause" the programme. The dates for the procurement activities will inevitably be staggered with some procurement activities starting on the proviso of Cabinet approval.

7.6.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to GM Procurement, New Zealand Health Partnerships on the signing of the contract. This person will develop a contract and relationship management plan in consultation with the successful supplier.

The supplier's performance will be reviewed annually as per the NZ Health Partnerships Procurement Strategy.

7.6.6 Accountancy treatment

The costs will be treated as part of the FPIM Programme capital and hence reside on the balance sheet of the NZ Health Partnerships once capitalised.

7.6.7 Payment mechanisms

Costs will be negotiated as part of the contract negotiations based upon milestone acceptance.

7.7 Application support services

7.7.1 Requirements

The National Oracle Technology Solution comprises of Oracle Application Software which once deployed onto hardware that is deployed in a Revera Data Centre requires application support services to meet the availability requirements of the DHBs

7.7.2 Procurement strategy

NZ Health Partnerships require a single supplier to manage the Oracle Exadata / Exalogic systems including operating system, database and application support. Oracle Advanced Customer Services (ACS) will provide the support until the FPIM Programme has been completed (estimated to be 2022)

Oracle ACS will provide the following services:

- Oracle Exadata / Exalogic management
- Oracle Database Administration services
- Oracle Applications Database services
- Support Services delivered on the Exadata / Exalogic system
- Project Services to support DHB Implementations.

Due to the Infrastructure Refresh being required no later than Jan 2022, an RFP will be issued 12 months prior to the planned completion of the FPIM Programme to procure Application Support Services.

7.7.3 Procurement plan

Based upon the completion dates of the FPIM Programme, a procurement plan will be put in place no later than May 2021 to go to market, as the infrastructure will require a technology refresh post the end of the agreement term.

Table 24 Application support services procurement milestones[48]

Procurement Milestone	Indicative Date
Pre-procurement	May 2021
Tender	Sep 2021
Evaluation	Oct 2021
Post-evaluation	Jan 2022

7.7.4 Type of contract

The Application Support services will utilise the terms and conditions of the Oracle Software Framework Agreement.

[48] These dates are provisional only. They rely upon the timing of final approvals by Cabinet to "un-pause" the programme. The dates for the procurement activities will inevitably be staggered with some procurement activities starting on the proviso of Cabinet approval.

7.7.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to the manager of the Oracle Administration Team on the signing of the contract. This person will develop a contract and relationship management plan in consultation with the successful supplier.

The supplier's performance will be reviewed monthly as per the NZ Health Partnerships FPIM Programme Governance.

7.7.6 Accountancy treatment

As there are no assets purchased, the delivery of the services is not on the balance sheet of the organisation but are monthly operating costs.

7.7.7 Payment mechanisms

The Application Support Service costs are operating costs and are paid on a quarterly basis.

7.8 Infrastructure and hosting services

7.8.1 Requirements

The National Oracle Solution comprises of Oracle Application Software which requires hosting on approved Oracle Infrastructure in a Tier 3 Data Centre. This also covers security, network connectivity and disaster recovery facilities.

7.8.2 Procurement strategy

In October 2016 a Request for Proposal for All of Government (AOG) services covering the following services was issued to the AOG panel service providers

- Infrastructure as a Service (IaaS)
- Telecommunications as a Service (TaaS)
- Information Technology Management Services (ITMS).

Revera was subsequently selected as the preferred supplier and Participating Agency Agreements were signed in January 2017 for a 5-year term.

7.8.3 Procurement plan

As the above agreements expire on 31 January 2022 a procurement plan will be put in place no later than June 2020 to go to market as the infrastructure will require a technology refresh post the end of the agreement term.

Table 25 Infrastructure and hosting services procurement milestones

Procurement Milestone	Indicative Date
Pre-procurement	May 2020
Tender	Sep 2020
Evaluation	Oct 2020
Post-evaluation	Jan 2021

7.8.4 Type of contract

The Revera contracts are DIA approved. Contract length is 5 years.

As per the PAA, variations to the contracts are in writing and signed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority.

As discussed above the strategy for exiting the contract at the end of its term is to issue an RFP by no later than June 2020.

The contract terms and conditions are as per DIA PAA.

Variations to contract will be in writing and signed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority.

The strategy for exiting the contract at the end of its term is to issue an RFP by no later than June 2020.

7.8.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to GM Procurement, New Zealand Health Partnerships on the signing of the contract. This person will develop a contract and relationship management plan in consultation with the successful supplier.

The supplier's performance will be reviewed annually as per the NZ Health Partnerships Procurement Strategy.

7.8.6 Accountancy treatment

As there are no assets purchased, the delivery of the services is not on the balance sheet of the organisation but consists of monthly operating costs as per the PAA schedules.

7.8.7 Payment mechanisms

Costs are paid monthly.

7.9 DHB implementation services

7.9.1 Requirements

District Health Boards will migrate onto the National Oracle Solution to support their Finance, Supply Chain and Procurement business requirements. In order to migrate onto the solution, the solution must be configured to support the business functions.

7.9.2 Procurement strategy

As NZ Health Partnerships is the responsible owner of the FPIM financial asset for the DHBs, DHBs will need to engage NZ Health Partnerships to configure the solution and assist them to migrate onto FPIM.

DHBs will also need to contract their own local resources to manage their responsibilities for the implementation.

7.9.3 Type of contract

A contract will be negotiated between NZ Health Partnerships and the migrating DHB for NZ Health Partnerships to provide implementation services.

7.9.4 Contract management

DHBs will manage the contracts for their implementation under their own contract management policies and processes.

7.9.5 Accountancy treatment

As there are no assets purchased, the delivery of the services is not on the balance sheet of the organisation but there are monthly operating costs.

7.9.6 Payment mechanisms

It is likely that DHB implementation services will be paid monthly.

7.10 Catalogue high level design services

7.10.1 Overview of work

A project has been scoped to develop the next level of detail required to develop and operate a national shared catalogue beyond that already developed in the business case. It will therefore need to take account of:

- How the master catalogue will be configured and managed on the shared Oracle system proposed for use by 10 DHBs.
- How the catalogue details will be distributed to the other DHBs.
- How compliance against the medical device contracts negotiated by PHARMAC and National Procurement contracts will be managed at DHB level.
- How the reporting will occur, including DHB transactional data to be collected, the mechanisms for collecting this data, mapping to the shared catalogue and how the central reporting repository will operate.
- How the catalogue will operate and be managed.
- How the governance and benefits realisation will operate.

Because of the need to engage with different DHBs operating different systems, a multi-disciplinary working group of DHB staff representing the diversity of DHB situations will be convened. This will cover the expertise required to cover the varying systems and approaches taken in the sector. It will need to cover the varying needs of the DHBs using Tech One, JD Edwards, or Oracle.

7.10.2 Requirements

This business case recommends a design of how a national shared catalogue could be built and operated to achieve the sector procurement benefits contemplated by PHARMAC. It requires the procurement of points advisory services, namely:

- Project lead
- Architect
- Business analyst.

Other services will be provided directly by NZ Health partnerships or DHB staff.

There may also be a need to procure vendor specific staff (e.g. from Tech One or Oracle).

Note that a draft Terms of Reference for this work is included as APPENDIX E: Shared national catalogue high level design project brief.

7.10.3 Procurement strategy

Individuals will be directly contracted for the roles. Where a consulting firm is used to provide the services, the appropriate panels will be used.

7.10.4 Type of contract

The standard NZ Health Partnerships services contract will be used for resources procured centrally.

DHB resources will be provided directly by DHBs. Where required, DHBs may need to contract their own resources. They will use their own procurement processes.

7.10.5 Contract management

The NZ Health Partnerships PMO will manage the contracts with the resource provided centrally. Supplier performance will be reviewed monthly as per the NZ Health Partnerships FPIM Programme Governance.

Any procurement of resources managed directly by DHBs will be manged by DHBs. They will also manage the contracts for these resources.

7.10.6 Accountancy treatment

These services will comprise operating expenditure only.

7.10.7 Payment mechanisms

Payment will be made on the submission of invoices.

7.11 Other services

7.11.1 Requirements

Several smaller services are required to support the National Oracle Solution. These services are:

- Supply Chain Scanner Software Support
- Application Wizard Support
- Service Management Software (SaaS)
- IT governance expertise for the Governing Board – an expert in IT governance is proposed to be part of the governing board.

7.11.2 Procurement strategy

As per the government procurement guidelines, a three-quote process will be initiated.

The procurement of the Service Management Software may require an RFP process. This will need to be confirmed.

7.11.3 Procurement plan

The FPIM Programme will get three quotes from appropriately skilled suppliers who can provide the services required. A preferred supplier will be recommended to the FPIM Programme Governance Board and NZ Health Partnerships will contract the supplier directly.

7.11.4 Type of contract

The Application Support services will utilise the terms and conditions of the Oracle Software Framework Agreement.

7.11.5 Contract management

The responsibility for managing delivery under the contract as well as supplier relationship management will pass to the manager of the Oracle Administration Team on the signing of the contract. This person will develop a contract and relationship management plan in consultation with the successful supplier.

The supplier's performance will be reviewed monthly as per the NZ Health Partnerships FPIM Programme Governance.

7.11.6 Accountancy treatment

These services will require some capital purchases for software licences.

7.11.7 Payment mechanisms

The Support Service costs are operating costs and as such paid monthly or at a period agreed with the supplier.

One-off capital expenditure may also be required.

8. Financial case

We have identified the funding requirements of the preferred option and can demonstrate that it is affordable

8.1 Introduction

This section summarises the costs and benefits coming out of the preferred option and how it will be funded. It outlines:

- The costs and how they have been treated in the options analysis
- The benefits and how they have been treated in the options analysis
- How the funding of the preferred option has been managed
- The impact of the quantitative risk assessment on the assessed funding requirements

It should be noted that the cost model has been constructed for comparative purposes and assumes that work can start in the 2018/19 financial year. Because the FPIM programme is currently under a Cabinet-directed "pause", actual spending and benefits for the preferred option will be delayed. Impact on budgets for DHBs for the preferred option of this delay will be determined outside of this business case.

8.2 Costs

8.2.1 Cost treatment

The following assumptions have been made:

- All costs exclude GST.
- Costs have been accounted for from FY2018 to FY2032.
- Previous operating expenditure on the NOS programme has not been accounted for.
- No account is made for cost increases because of CPI.

8.2.2 Costing approach

The preferred option is split into two parts for which detailed cost estimates have been developed.

- The first tranche is focused on completing the remaining build on the National Technology Solution (NTS) infrastructure and migrating the Wave One DHBs, along with delivery of deferred functionality such as analysis and reporting.
- The second tranche covers rollout of the National Oracle solution to the remaining six DHBs with at-risk supply chain, procurement and finance systems.

The following table lists the categories of costs to deliver the preferred option.

Table 26 Cost categories to deliver preferred option

Programme / Project	Capex – General	Capex – Resourcing	Opex – General	Opex – Resourcing
Project 1 Build NTS	• Design + Build – Vendor Contracts	• Project Management • Testing • Deployment	• IaaS Support • Oracle Licensing Support • Third Party Application Support	• Oracle Administration Team Costs
Project 2 Migrate Wave One DHBs	• Design + Build – Vendor Contracts	• Project Management • Testing • Deployment	• NA	• Support Resourcing
Project 3 Complete remaining functionality	• Design + Build + Testing + Deployment Support– Vendor Contracts (Build covers reports build as well) • Integration Design + Build – Vendor Contracts	• Project Management • Business Analysis and Requirements Gathering • Testing • Data Migration (BW) • Training – Content Preparation	• Oracle Licensing Support • Third Party Application Support	• Change Management • Communications • Training Delivery • Support Resourcing
Project 4 Operational support model	• NA	• Business Analysis • Support Model Operationalisation • Project Management	• NA	• NA

Programme / Project	Capex – General	Capex – Resourcing	Opex – General	Opex – Resourcing
Project 5 Rollout	• Solution Design + Build + Testing Support– Vendor Contracts • Integration Design + Build – Vendor Contracts	• Project Management • Business analysis • Business SMEs • Data Migration • Testing • Training Content Preparation • Deployment	• IaaS Support • Oracle Licensing Support • Third Party Application Support	• Change Management • Communications • Training Delivery • Support Resourcing
Project 6 Rollout	• Solution Design + Build + Testing Support– Vendor Contracts • Integration Design + Build – Vendor Contracts	• Project Management • Business analysis • Business SMEs • Data Migration • Testing • Training Content Preparation • Deployment	• IaaS Support • Oracle Licensing Support • Third Party Application Support	• Change Management • Communications • Training Delivery • Support Resourcing
Project 7 Rollout	• Solution Design + Build + Testing Support– Vendor Contracts • Integration Design + Build – Vendor Contracts	• Project Management • Business analysis • Business SMEs • Data Migration • Testing • Training Content Preparation • Deployment	• IaaS Support • Oracle Licensing Support • Third Party Application Support	• Change Management • Communications • Training Delivery • Support Resourcing

8.2.3 Costs included

The following table lists the key costs that have been accounted for.

Table 27 Costs included in the preferred option

Cost	How determined	Comments
Oracle licence fee	NZ Health Partnerships owns some licences, fees determined from contract Additional licences will need to be purchased	
Third party software licence fees	NZ Health Partnerships already owns some licences, fees determined from contracts Additional licences will need to be purchased	
Ongoing costs of Oracle Exadata / Exalogic platforms	From existing contracts	
Infrastructure as a service	From contracts agreed with Revera	
Oracle Administration Team (OAT) ongoing support	Based on estimated team size	Estimated on basis of salaried staff

Cost	How determined	Comments
Programme implementation	Based on estimated programme team size overlaid against the planned implementation schedule	Estimated on basis of a mix between salaried staff and external resources.
DHB implementation	Based on estimated team size Modelled for small, medium, and large DHBs	Estimated on basis of mix of contract and backfilled DHB subject matter experts
Depreciation on prior years capital	Based on depreciation calculated	

8.2.4 Costs excluded

The following table lists the costs have been excluded from the cost model.

Table 28 Costs not quantified

Cost	Description	Why excluded
Oracle EBS upgrades	Oracle EBS will require ongoing upgrades – typically once every five years	DHBs currently fund their own upgrades Under preferred option additional costs for Oracle upgrade will be more than offset by existing upgrade costs
Migration to cloud services	Migration of the privately hosted Oracle EBS to cloud based services	This will be managed as a standalone business case when cloud services demonstrate the necessary maturity
Existing end user support costs	Costs for existing first level end-user support	These costs remain – the preferred option provides for technical support (via the OAT)

8.2.5 Estimation

There are two distinct approaches taken towards arriving at the financial costs:

1. Using the cost estimates already developed for components that are proposed to be delivered by the central solution delivery and enablement team. The assumption here is that the cost estimates received from the Wave One programme are derived using a bottom-up estimation.

   This approach is applicable for:

   - Project 1: Standing up of the National Technology Solution (NTS) (Infrastructure)
   - Project 2: Migration of Wave One DHBs on to the NTS (Infrastructure)
   - Project 3: Implementation of Service Oriented Architecture interfaces
   - Project 4 – Operationalising the OAT and finalising a rollout delivery framework with deliverables, templates, phases etc
   - Project 5, 6, 7: Implementation (Rollout) of National Oracle Solution for Northern Region DHBs, Taranaki, and Southern. (Note: only the central solution delivery and implementation (rollout) support costs)

2. Use of industry benchmarks and good practice. This is a combination of historical information and analogous estimations through experienced judgement.

   The approach followed was:

   - Gather the ADHB rollout costs for their implementation on the Northern Region Oracle application. Compare and adjust against the NOS aspects.
   - Adjust for other DHBs in comparison to ADHB on parameters such as relative complexity.
   - Validate with relevant stakeholders and leads to provide assurance of coverage against the following cost components:
     - Fit gap analysis and additional design / build
     - Testing (solution validation using DHB specific data)
     - Data migration
     - Data quality enhancement (profiling, cleansing, reporting)
     - Deployment + post go live enhanced support
     - Change management + communications management +training
     - Integration changes to local DHB 3rd party systems
     - Project management, coordination and independent quality assurance

The categorisation of costs as capex or opex is determined under individual organisational policy.

A summary of the estimated costs is shown in the following table.

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Table 29 Total costs for Option 3 – excluding contingency

		2018 – 19	2019 – 20	2020 – 21	2021 – 22	2022 – 23	2023 – 24	2024 – 25	7 Years	10 Years
Benefits										
	Operating savings Northern region				2.000	2.000	2.000	2.000	8.000	14.000
	Total Benefit				2.000	2.000	2.000	2.000	8.000	14.000
Costs										
	Operating									
	IaaS Hosting & Support	2.379	2.379	2.379	2.379	2.397	2.397	2.397	16.706	23.897
	Oracle Infrastructure	1.057	1.057	1.057	0.864	0.671	0.671	0.671	6.049	8.061
	Oracle Licensing	3.409	3.409	3.409	3.409	3.409	3.409	3.409	23.864	34.091
	Third Party Support Fees	0.148	0.353	0.353	0.353	0.353	0.353	0.353	2.264	3.322
	Application support	5.548	5.548	5.548	5.548	5.548	4.833	4.833	37.406	51.905
	DHB implementation	0.002	1.557	1.064					2.623	2.623
	Central Programme implementation		0.308	0.137					0.445	0.445
	Quality Assurance		0.525	0.375					0.900	0.900
	Total Operating Costs	12.544	15.136	14.322	12.553	12.378	11.663	11.663	90.257	125.244
	Capital									
	Core Build	9.694	4.775						14.468	14.468
	DHB implementation	0.010	5.048	1.392					6.450	6.450
	Central Programme implementation	0.023	7.401	3.448					10.872	10.872
	Hardware Refresh									2.100
	Total Capital	9.727	17.224	4.840					31.791	33.891
	Total Cash Out	22.270	32.360	19.162	12.553	12.378	11.663	11.663	122.047	159.135
	Net Cash	(22.270)	(32.360)	(19.162)	(10.553)	(10.378)	(9.663)	(9.663)	(114.047)	(145.135)
	Indicative impairment	22.000								

21

8.2.6 Costing assumptions

The following key assumptions have been made while estimating the costs involved to deliver the outcomes of this business case:

- The proposed governance and resourcing structure as well as the programme delivery plan are the basis of the costing.
- OAT team is operational in business as usual mode and has clear transition to business as usual criteria outlined for DHB implementations at least 3-4 months prior to Wave 2 rollout.
- For Northern Region – A combination of internal DHB resources and external contractors have been considered for project resourcing. A detailed cost model is available to evidence the breakdown.
- For Southern DHB – The DHB has assumed that they will second their BAU internal resources to the project and backfill their BAU roles.
- Internal resources have been costed using healthAlliance rate cards.
- The rollout waves tranche (Project 5,6, and 7) are planned to be completed within 18 months and delivered in 3 rollouts.
- A Rollout Wave enabling team for data migration, testing and training is established as per the proposed programme delivery structure to enable consistent delivery of rollouts.
- Third party DHB system integration costs are estimated by the respective technology teams who are considered experts in this area.
- Infrastructure (National technology solution) is ready for the rollouts to commence by July 2019.
- Within Northern region, there is allowance within the cost model for the impact of FTE increase on account of running a split shared service for the duration of the rollout wave tranche.
- "Regrettable" stabilisation spend of $0.850 million imperative is included in all options for Northern Region to enable immediate risk to be addressed while system build taking place.
- Data cleansing related costs are outside of these estimates and will have to be factored in by the DHBs.
- Note that the costs included for Oracle BI (reporting) include only analysis for what is required. Implementation has not been explicitly included. The scope and requirements for BI reporting will need to be revalidated to take into account feedback from Wave One DHBs. Once requirements are confirmed, the cost to implement BI will be able to be better estimated.

8.3 Benefits

8.3.1 Treatment

Benefits have been treated as follows:

- Cost avoidance benefits regarding reduced unit procurement costs have been treated as a financial benefit.
- Cost avoidance benefits have been estimated based on current estimated expenditure for categories. They have not been adjusted for CPI.

Note that we have assumed no cost avoidance savings on medical device or other procurement for Option 3. These will only become available when the national catalogue, data standards, data repository, and compliance at point of procurement are implemented (e.g. in Options 5 or 6).

8.3.2 Benefits included

The following table lists the key benefits that have been accounted for.

Table 30 Financial benefits considered

Financial Benefit	How recognised	Comments
Operational Savings	Operational savings at healthAlliance on account of having the whole of Northern Region on a single common catalogue resulting in operational savings of $2 million within the shared service procurement and supply chain function at healthAlliance	Estimated by the healthAlliance FPSC team

8.3.3 Benefits excluded

The following table lists the benefits have been excluded from the cost model.

Table 31 Benefits not quantified

Financial Benefit	How recognised	Comments
Reduction in DHB licence fees	Reduction in DHB licence fees in case of new central system Not quantified	Will depend on DHB circumstances and meeting requirements for archiving
Reduction in DHB upgrade costs	Reduction of system upgrade costs in case of new central system. System upgrades will occur once as opposed to DHB by DHB Assumed to be cost neutral in worst case (i.e. cost of central upgrade will be equal to or less than combined DHB upgrades required)	Upgrades not costed in business case as DHBs already need to budget for upgrade costs
Procurement efficiencies	Reduced cost of operating procurement Qualitative only	Expected to take place from EDI. Not quantified
Master data management	Reduced DHB cost of managing master data	Reduced DHB costs displaced by increase in central data management costs Costs not included in preferred

Financial Benefit	How recognised	Comments
		option costs.
System upgrade costs	Reduced requirement for system upgrades	Reduced DHB system upgrade costs as upgrades only occur centrally
PHARMAC projected costs	Qualitative only	Preferred option provides only 73% of the sector with a common catalogue. While this comprises 80% of the procurement spending, we have assumed that this is not enough to enable the PHARMAC level benefits to be achieved from across the sector.

8.4 Funding

8.4.1 Funding for preferred option – Option 3 Single system for 10 DHBs

The overall funding for the preferred option is proposed to be provided by the participating DHBs. The following table shows the basis of the cost split between DHBs.

Table 32 Funding split for projects

Project	Costs Split
Project 1: Build NTS	All 10 DHBs
Project 2: Migrate Wave One DHBs	Wave One DHBs only
Project 3: Complete remaining functionality	All 10 DHBs
Project 4: Operationalise support model	All 10 DHBs
Project 5,6,7: Implement DHBs	Northern Region DHBs, Taranaki, and Southern DHB

Based on the table below, using the 2018/19 PBF revenue net of IDF inflows and outflows, the costs for each DHB have been estimated out as follows. Note that this excludes depreciation (as this is a non-cash expense).

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Table 33 Allocation of cost to DHBs for preferred option 7 Year – EXCLUDING CONTINGENCY

DHB	Core Build	Wave 1 Migration	Northern & Southern Implement + General costs	Central Programme implement	Total CAPEX	DHB implement – Northern & Southern	Central Programme implement – Northern Region	QA	Application Support (7 Years)	Ongoing Opex (7 Years)	Total OPEX	TOTAL (OPEX + CAPEX)
West Coast	$145,109	$43,457		$121,029	$309,594		$4,948	$10,019	$416,403	$509,993	$941,363	**$1,250,957**
Waikato	$1,715,830	$513,854		$1,431,097	$3,660,780		$58,509	$118,467	$4,923,735	$6,030,368	$11,131,079	**$14,791,859**
Bay of Plenty	$896,086	$268,358		$747,386	$1,911,830		$30,556	$61,869	$2,571,404	$3,149,340	$5,813,169	**$7,725,000**
Canterbury	$2,028,366	$607,451		$1,691,769	$4,327,586		$69,167	$140,045	$5,820,586	$7,128,791	$13,158,589	**$17,486,175**
Auckland	$2,653,915		$1,448,509	$2,213,512	$6,315,937	$686,730	$90,498	$183,235	$7,615,660	$9,327,317	$17,903,440	**$24,219,377**
Counties Manukau	$1,664,580		$1,198,477	$1,388,352	$4,251,410	$507,717	$56,762	$114,928	$4,776,670	$5,850,250	$11,306,328	**$15,557,737**
Waitemata	$1,655,517		$1,089,216	$1,380,793	$4,125,526	$504,049	$56,453	$114,302	$4,750,662	$5,818,397	$11,243,863	**$15,369,389**
Northland	$708,425		$872,579	$590,865	$2,171,869	$345,632	$24,157	$48,912	$2,032,891	$2,489,794	$4,941,387	**$7,113,256**
Taranaki	$418,187		$791,591	$348,791	$1,558,570	$297,085	$14,260	$28,873	$1,200,028	$1,469,740	$3,009,986	**$4,568,556**
Southern	$1,149,278		$1,049,608	$958,561	$3,157,447	$282,072	$39,190	$79,350	$3,297,960	$4,039,193	$7,737,765	**$10,895,212**
Tairawhiti										$33,742	$33,742	**$33,742**
Hawkes Bay										$107,225	$107,225	**$107,225**
Hutt										$95,824	$95,824	**$95,824**
Lakes										$69,297	$69,297	**$69,297**
MidCentral										$117,522	$117,522	**$117,522**
Nelson Marlborough										$92,440	$92,440	**$92,440**
South Canterbury										$37,289	$37,289	**$37,289**
Capital & Coast										$2,211,676	$2,211,676	**$2,211,676**
Wairarapa										$258,746	$258,746	**$258,746**
Whanganui										$46,095	$46,095	**$46,095**
TOTAL	**$13,035,293**	**$1,433,120**	**$6,449,980**	**$10,872,155**	**$31,790,548**	**$2,623,286**	**$444,500**	**$900,000**	**$37,406,000**	**$48,883,039**	**$90,256,825**	**$122,047,373**

Table 34 Allocation of cost to DHBs for preferred option – 7 Year – INCLUDING CONTINGENCY

DHB	Total Capex	29% Capex Contingency	Total Including Contingency	Total Opex	15% Opex Contingency	Total Including Contingency	Grand Total
West Coast	$309,594	$89,782	$399,376	$941,363	$141,204	$1,082,567	$1,481,943
Waikato	$3,660,780	$1,061,626	$4,722,407	$11,131,079	$1,669,662	$12,800,741	$17,523,147
Bay of Plenty	$1,911,830	$554,431	$2,466,261	$5,813,169	$871,975	$6,685,145	$9,151,406
Canterbury	$4,327,586	$1,255,000	$5,582,586	$13,158,589	$1,973,788	$15,132,377	$20,714,963
Auckland	$6,315,937	$1,831,622	$8,147,558	$17,903,440	$2,685,516	$20,588,956	$28,736,515
Counties Manukau	$4,251,410	$1,232,909	$5,484,318	$11,306,328	$1,695,949	$13,002,277	$18,486,595
Waitemata	$4,125,526	$1,196,402	$5,321,928	$11,243,863	$1,686,580	$12,930,443	$18,252,371
Northland	$2,171,869	$629,842	$2,801,711	$4,941,387	$741,208	$5,682,595	$8,484,306
Taranaki	$1,558,570	$451,985	$2,010,555	$3,009,986	$451,498	$3,461,484	$5,472,039
Southern	$3,157,447	$915,660	$4,073,106	$7,737,765	$1,160,665	$8,898,430	$12,971,536
Tairawhiti	$0	$0	$0	$33,742	$0	$33,742	$33,742
Hawkes Bay	$0	$0	$0	$107,225	$0	$107,225	$107,225
Hutt	$0	$0	$0	$95,824	$0	$95,824	$95,824
Lakes	$0	$0	$0	$69,297	$0	$69,297	$69,297
MidCentral	$0	$0	$0	$117,522	$0	$117,522	$117,522
Nelson Marlborough	$0	$0	$0	$92,440	$0	$92,440	$92,440
South Canterbury	$0	$0	$0	$37,289	$0	$37,289	$37,289
Capital & Coast	$0	$0	$0	$2,211,676	$300,126	$2,511,802	$2,511,802
Wairarapa	$0	$0	$0	$258,746	$34,977	$293,723	$293,723
Whanganui	$0	$0	$0	$46,095	$0	$46,095	$46,095
TOTAL	**$31,790,548**	**$9,219,259**	**$41,009,807**	**$90,256,825**	**$13,413,148**	**$103,669,973**	**$144,679,781**

The following should be noted:

- The ongoing opex is made up of Oracle license support, Infrastructure as a Service (IaaS) costs, application support, and lease costs for the Oracle EXA infrastructure.
- The Oracle EXA infrastructure costs are capital expenditure that were funded via a lease rather than seeking capital funding from DHBs in the 2016-17 year.
- Wave One, Northern Region, Taranaki & Southern, being part of the programme will continue to pay for the lease costs as part of IaaS opex.

Of the 10 DHBs not continuing with the programme, four have been charged these costs in 2018-19 as part of the deferral wash-up (but have not yet paid). The remaining six DHBs will be charged in full in July 2019. This is the most administratively effective way for DHBs and NZHP to finalise the capital programme commitments.

The Capital and Coast and Wairarapa seven operating costs include Oracle licences.

8.4.2 Funding for national shared catalogue high level design

The funding for the design of the shared catalogue will be shared across all DHBs using the PBF revenue net of IDF inflows and outflows. This is shown in the following table.

Table 35 Allocation of costs for investigation of national shared catalogue

DHB	PBF	High level design funding
Auckland	14.93%	89,561
Bay of Plenty	5.04%	30,240
Canterbury	11.41%	68,451
Capital & Coast	6.78%	40,693
Counties Manukau	9.36%	56,174
Hawkes Bay	3.38%	20,309
Hutt	3.02%	18,113
Lakes	2.25%	13,490
MidCentral	3.75%	22,492
Nelson Marlborough	3.01%	18,063
Northland	3.98%	23,907
South Canterbury	1.16%	6,953
Southern	6.46%	38,784
Tairawhiti	1.09%	6,522
Taranaki	2.35%	14,112
Waikato	9.65%	57,904
Wairarapa	0.79%	4,742
Waitemata	9.31%	55,868
West Coast	0.82%	4,897
Whanganui	1.45%	8,724
	100.00%	**$600,000**

8.5 Potential impairment

8.5.1 Overview

Each DHB's investment in the FPIM programme is represented as a nominal value of shares in NZHP held by each DHB in proportion to the proposed benefits that each would receive from implementation of the business case, plus the value of the intangible asset representing the rights to access the FPIM programme.

NZHP is the owner of the FPIM asset on behalf of the DHBs and so is responsible for assessing what impairment, if any, of the asset is required each year. Each DHB is responsible for assessing the value of its investment in NZHP and making appropriate adjustment.

NZ Health Partnerships has assumed that the approved CCR capital of $12 million will be called up and spent.

The following table shows indicative DHB splits based on 2016-2017 PBF% (net of IDF). NZHP has already impaired $5.773 million as at 30 June 2018. It is up to the DHBs to decide how much they will each impair.

Table 36 Indicative DHB splits

	A	B	C	A+B+C
DHB	Capital invested to Date	Full capital call	NZHP already impaired	Total
Auckland	12,420,000	1,688,736	-812,423	13,296,313
Bay of Plenty	3,021,000	598,139	-287,755	3,331,384
Canterbury	5,936,000	1,375,746	-661,848	6,649,897
Capital & Coast	6,468,000	814,570	-391,876	6,890,694
Counties Manukau	5,779,000	1,124,022	-540,748	6,362,274
Hawkes Bay	2,504,000	414,262	-199,295	2,718,968
Hutt	1,927,000	370,216	-178,105	2,119,111
Lakes	1,469,000	267,726	-128,799	1,607,928
MidCentral	2,990,000	460,617	-221,595	3,229,022
Nelson Marlborough	2,255,000	362,311	-174,302	2,443,009
Northland	2,249,000	463,454	-222,960	2,489,494
South Canterbury	734,000	146,151	-70,311	809,840
Southern	4,469,000	789,765	-379,943	4,878,822
Tairawhiti	836,000	132,247	-63,622	904,625
Taranaki	1,418,000	287,433	-138,279	1,567,154
Waikato	6,948,000	1,153,762	-555,056	7,546,706
Wairarapa	541,000	98,766	-47,515	592,251
Waitemata	4,819,000	1,171,583	-563,629	5,426,954
West Coast	567,000	102,408	-49,267	620,141
Whanganui	983,000	178,087	-85,674	1,075,412
TOTAL	**68,333,000**	**12,000,000**	**-5,773,000**	**74,560,000**

Indicative impairments for each option are as follows:

8.5.2 Option 1 Status quo / shutdown FPIM

The total investment as per the above table is $80.33 million ($68.33 + $12 million). NZHP has impaired $5.773 million and will further impair $56 million (total on non-Wave 1 DHBs) of the total $80 million.

The Wave 1 DHBs and Hutt Valley DHB who took a copy of the original solution PLUS any of the DHBS have a right under the Shareholders Agreement to take a copy of the solution for their own use. The DHBs may choose to retain the value of their investment in the Oracle solution. Their value is summarised in the following table.

Table 37 Wave One capital value

	A	B	C	A+B+C
DHB	Capital invested to Date	Full capital call	NZHP already impaired	Total
Bay of Plenty	3,021,000	598,139	-287,755	3,331,384
Canterbury	5,936,000	1,375,746	-661,848	6,649,897
Waikato	6,948,000	1,153,762	-555,056	7,546,706
West Coast	567,000	102,408	-49,267	620,141
TOTAL	**16,472,000**	**3,230,055**	**-1,553,926**	**18,148,128**

The total value of $74.6 million would be impaired by $56 million so that the $18 million above remained.

8.5.3 Option 2 Clustered risk mitigation

This is similar to Option 1. It is up to the DHBs to determine how much they impair as it will depend upon the current value they have in their books that represents their shareholding in NZHP. NZHP may impair up to $56 million which is the sum of non-Wave 1 DHBs in the above table.

Wave One DHBs may also choose to impair a portion of their carrying cost of $18.1 million if they believe they will not achieve the benefits that they originally forecast. E.g. If the Wave One DHBs impaired 50% of their carrying cost this would increase the impairment from $56 million to $65 million.

8.5.4 Option 3 Single system for 10 DHBs

The DHBs that implement the solution will retain the value of their investment and NZHP may impair up to $22 million which is sum total of DHB investment from the table above, that are not in Option 3.

It has been assumed that the 10 Oracle DHBs will continue to hold their investment at cost even though no additional procurement benefits are shown under this option (PHARMAC maintains that the incremental benefit of 5% can only be achieved if all DHBs are using and complying with a national catalogue). The 10 DHBs may judge that the risk mitigation benefits justify the further investment. They may also consider that they will gain some procurement benefits from having 80% of the sector expenditure occurring through one unified system. Their value is summarised in the following table.

Table 38 Option 3 DHBs capital value

	A	B	C	A+B+C
DHB	Capital invested to Date	Full capital call	NZHP already impaired	Total
Auckland	12,420,000	1,688,736	-812,423	13,296,313
Bay of Plenty	3,021,000	598,139	-287,755	3,331,384
Canterbury	5,936,000	1,375,746	-661,848	6,649,897
Counties Manukau	5,779,000	1,124,022	-540,748	6,362,274
Northland	2,249,000	463,454	-222,960	2,489,494
Southern	4,469,000	789,765	-379,943	4,878,822
Taranaki	1,418,000	287,433	-138,279	1,567,154
Waikato	6,948,000	1,153,762	-555,056	7,546,706
Waitemata	4,819,000	1,171,583	-563,629	5,426,954
West Coast	567,000	102,408	-49,267	620,141
TOTAL	**47,626,000**	**8,755,048**	**-4,211,908**	**52,169,139**

The total value of $74.6 million would be impaired by $22 million so that the $52 million above remained.

8.5.5 Option 4 Clustered risk mitigation plus national catalogue

This is similar to Option 1. It is up to the DHBs to determine how much they impair as it will depend upon the current value they have in their books that represents their shareholding in NZHP. NZHP may impair up to $56 million as for Option 2.

8.5.6 Option 5 Single system for 10 DHBs plus national catalogue

This option assumes that a number of DHBs in Option 3 will have implemented the solution. These DHBs will retain the value of their investment. Similar to Option 3, NZHP may impair up to $22 million of the remaining value of the asset.

8.5.7 Option 6 National system and integrated catalogue

There will be no further impairment in this option for any DHBs as further investment in the National solution will build upon previous investment listed in the above table.

8.6 Impact of Quantitative Risk Assessment on preferred option costs

8.6.1 Introduction

A Quantitative Risk Assessment (QRA) was conducted on the cost and benefits model to identify the likely funding ranges required for the business case and what aspects of the programme will most impact costs. This section discusses the impact on the preferred option, namely Option 3.

The QRA process is described above in section 6.5 Impact of Quantitative Risk Assessment.

The probabilities for the key inputs were modelled through the cost/benefit spreadsheet to determine the ranges of funding required over the business case period and the impact on NPV.

8.6.2 Impact on capital

The following table summarises the impact of uncertainty on capital for Option 3.

Table 39 Impact of uncertainty on capital costs and NPV

Factor	Base estimate	Mean	85th percentile
Capital (10 years)	$33.891	$41.758	$43.726
% difference from base		23.2%	29.0%

For capital, the mean (i.e. expected cost) is 23% above the based estimates as shown in the cost model. This indicates that the estimates in the cost model are optimistic and therefore additional contingency is required.

The difference from the base varies from 28% to 30% from the 80th to 90th percentile. It is good practice to ensure that there is contingency available to at least the 85th percentile for capital. This indicates that 29% contingency should be added to the capital sums. The project team should focus on achieving the outcomes at the base estimate level (i.e. as per the cost model), with the Governance Board and Programme Board managing the allocation of the additional contingency.

The ranking of the uncertainties driving the capital costs is illustrated in the following diagram.

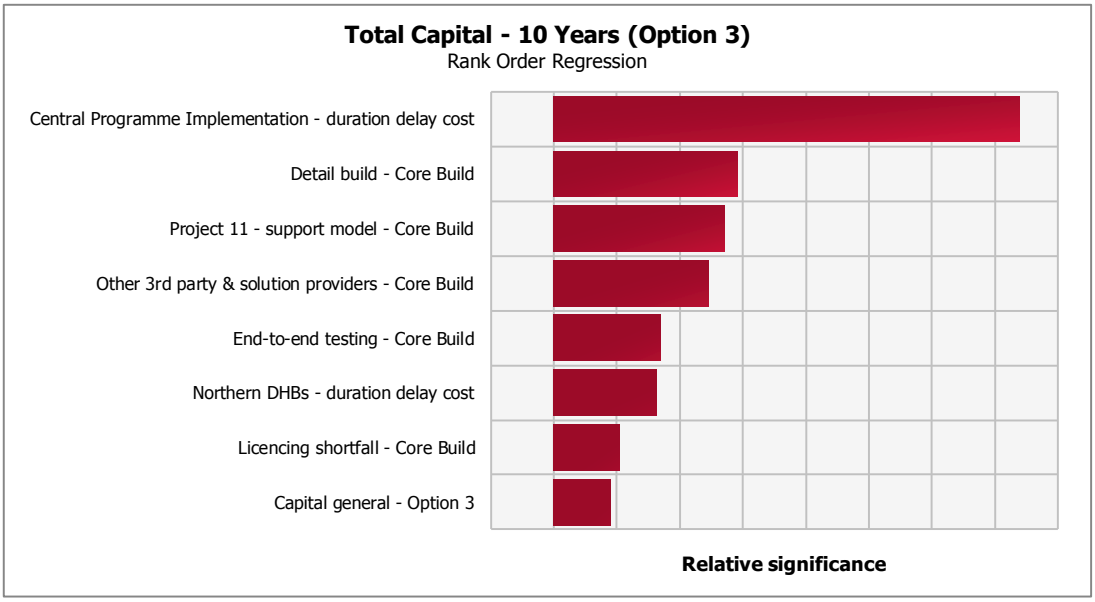

Figure 31 Ranking of the uncertainties driving capital costs

The three main impacts are from the following:

- *Central Programme Implementation – duration delay cost* – this relates to the impact on capital costs of extended implementation times on the central programme costs.
- *Detailed build* – this relates to uncertainties relating to the building of the infrastructure.
- *Project 11* – support model – this relates to the uncertainties regarding setting up the full support model and all the infrastructure required to support it.

These aspects of the programme (and the others noted in the diagram) will need careful management to ensure that costs do not escalate.

8.6.3 Impact on operating

Only one cost was considered material to the operating costs, namely, the OAT support costs. At the pessimistic level, it was considered that this cost could be 15% higher than the estimate.

The OAT costs are approximately 40% of the seven-year operating costs. If the pessimistic level of OAT costs was incurred, an additional 6% in operating costs would be required. It would therefore be prudent to allow 15% contingency in operating costs, with the Governance Board and Programme/Services Board managing the allocation of the additional contingency.

8.6.4 Impact on NPV

The following table summarises the impact of uncertainty on NPV. This takes into account the uncertainties in both capital and operating (albeit only one operating item – OAT support costs – had uncertainty applied).

Table 40 Impact of uncertainty on capital costs and NPV

Factor	Base estimate	Mean	85th percentile
NPV (10 years)	(109.639)	(118.259)	(121.733)
% difference from base		-7.9%	-11.0

When all modelled impacts are taken into account, there is a minor variation in the seven-year NPV – i.e. up to a maximum of 11%.

The ranking of the uncertainties driving the seven-year NPV is illustrated in the following diagram.

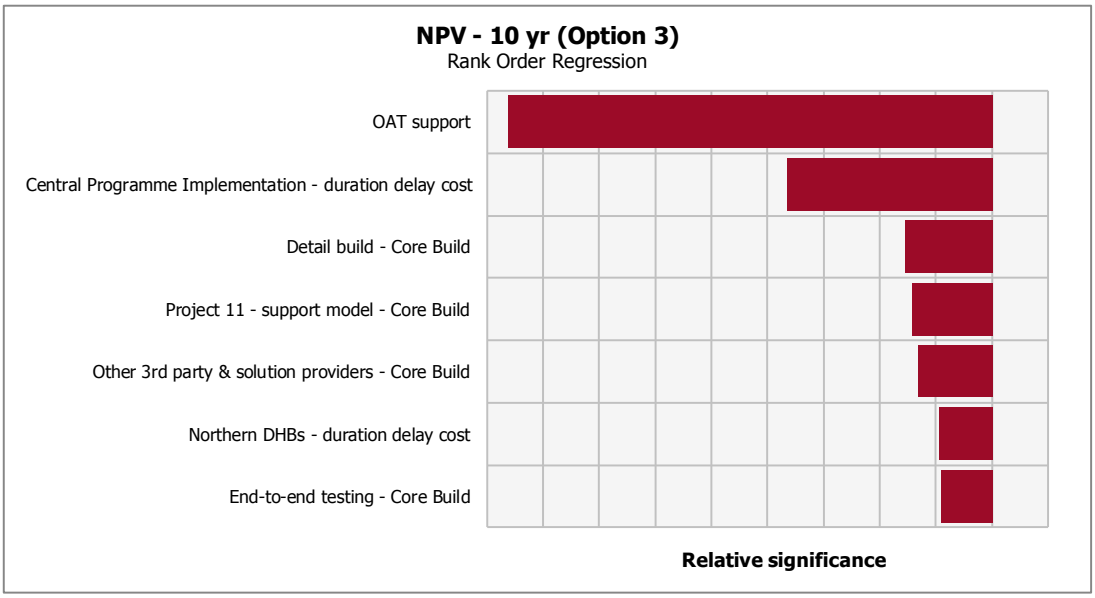

Figure 32 Ranking of the uncertainties driving NPV

As can be seen variations in the OAT support costs will have the biggest impact on the seven-year NPV. This is because OAT costs are approximately 40% of ongoing operating costs and therefore any variation in these costs has an impact on the discounted seven-year cost.

It will therefore be critical that the ongoing OAT support costs (and the value delivered) are carefully managed.

9. Management case

This management case describes how the programme will manage the delivery of the preferred option; it demonstrates that the proposal is achievable and details the arrangements needed to both ensure successful delivery and to manage project risks

9.1 Introduction

The programmes will deliver a standardised, sector-designed, consistent common Oracle system for the 10 DHBs facing immediate stability and sustainability issues. The programme will deploy a common Oracle R12 Enterprise Business Solution (EBS) that will enable the DHBs to operate either under a shared service arrangement (e.g. Northern Region healthAlliance) or as a stand-alone entity to undertake their financial, procurement and supply chain activities. The solution will also provide a national procurement catalogue, common master data across all DHBs, and consolidated purchase data to enable the key benefits to be realised.

The management case consists of the following sections:

- The transition approach for moving the DHBs to the central infrastructure
- Resourcing, organisation and governance
- Programme and project management
- Monitoring and reporting
- Risk and issue management
- Change management
- The operating model
- Benefits realisation
- Quality assurance.

9.2 What will be different this time?

The FPIM programme has been in train for seven years – what will be different this time?

Following unanimous DHB approval of the Change Control Report in 2017, the four Wave One DHBs went live on FPIM on 2 July 2018 as planned. This notwithstanding, the programme has a long and challenging history and irrespective of the reason, DHBs are once again being asked to approve a Business Case to meet their finance, procurement and supply chain needs.

Through the consultation process some DHB stakeholders have asked *'What is or will be different this time?'* This section responds to that question and in doing so provides important context. It also directs the reader to specific sections in the business case that address the issues in more detail.

1. The programme is taking a fundamentally different approach to achieving the required benefits – we are no longer asking all DHBs to migrate to a single system (but are retaining that possibility for the future)

Since the inception of FPSC in 2011/12, the programme has always promoted a single national system as the central proposal.

This time we started from a "clean sheet of paper". We have gone back to first principles and in workshops with DHB representatives, looked at the fundamental problems we are trying to solve, the benefits of solving them and the options available to do so. As a result, the recommendations contained in this Business Case represent a fundamental change in approach from the past.

This business case recommends a phased approach that will enable those DHBs with end of life systems to mitigate their risk, in parallel with work to fully consider how a shared national catalogue would deliver the clean data and purchasing compliance required to achieve procurement benefits.

While noting that further investigative work is required, the recommended pathway is a "distributed" model in which the non-Oracle DHBs would remain on their current systems should they choose to do so, with a shared national catalogue and common chart of accounts being used nationally – regardless of whether DHBs are on the FPIM system and infrastructure or not.

(The pathway and options are laid out in the Economic Case. The conclusions from the Economic Case are described in section 6.8 Conclusions.)

2. The governance has been significantly strengthened with an overarching governing board chaired by the DG of Health and with involvement from the DHBs, PHARMAC, and NZ Health Partnerships

The programme governance structure has been changed with a Governing Board rather than the NZ Health Partnerships' Board having ultimate oversight and decision-making authority. The Governing Board which will provide greater central leadership, will be Chaired by the Director General of Health, and will include involvement from PHARMAC, DHBs, and NZ Health Partnerships.

The Governing Board will ensure overall alignment of both the programme and service with health sector policy and priorities and to the objectives of all organisations involved. It will set strategic direction and be the decision-making body for material changes outside of the agreed business as usual parameters.

3. FPIM is already operational for four DHBs and the outstanding issues are being resolved – we are not starting from scratch

An important difference between now and previous business cases and change cases, is that FPIM is now live and supporting four DHBs which together account for 27% of the sector by PBF.

The system itself is stable and functioning as expected. There is a range of technical and process enhancements that are being worked through via an integrated service enhancement plan. This includes moving from the interim support model (provided by the former programme team) to a permanent business as usual model, as well as meeting DHBs' needs around reporting which was de-scoped prior to go-live.

4. Operationalising of the target service model for FPIM is already underway

As indicated above, the plan to transition to the permanent support model is already in train. Recruitment for senior positions is underway and all processes are being mapped to assist with the handover to new team members. It is envisaged that some current Oracle Administration Team members will continue in the team which will help retain important IP.

The bulk of the team will be established in Auckland alongside NZ Health Partnerships. As per the original design some team members may be relocated remotely within DHBs and/or DHB regions.

(The target operating model is described in the Management Case in section 9.13 Operational support model.)

5. This business case includes DHB implementation costs and change planning requirements

In response to DHB direction that they would manage their own implementations, neither 2015 revised Business Case, nor the 2017 Change Control Report, included DHB implementation costs nor any central change support function.

One of Cabinet and the Ministry of Health's core requirements for this Business Case is explicit inclusion of implementation and change management costs for DHBs and PHARMAC. The inclusion of these requirements and the accompanying resource plans provides a more transparent and holistic view of the cost benefits model.

(Details of the scope of costs included can be found in the Financial Case in section 8.2 Costs.)

6. A benefits realisation plan supported by the strengthened governance has been developed

As above, neither the 2015 revised Business Case, nor the 2017 Change Control Report included Benefits Realisation planning and management. Again, one of Cabinet and the Ministry of Health's core requirements for this Business Case is explicit consideration of Benefits Realisation.

(The benefits realisation plan and governance is described in the Management Case in section 9.14 Benefits realisation.)

7. There are reduced risks and interdependencies in the proposed approach

The revised approach, implementing multiple interfaces to create a single national shared procurement catalogue, removes the requirement for all DHBs to migrate to a single system. This in turn frees up DHBs to prioritise their system upgrades in line with their needs. DHBs do not need to migrate in a set sequence, which could potentially clash with changing business imperatives. Equally, with the single system approach, a delay in the migration of a preceding DHB could impact the timing of subsequent DHB migrations, causing a ripple effect and the need for a DHB to re-plan other initiatives. This reduces the number of dependencies for a DHB, increases flexibility and reduces risk.

It should be noted however, that the proposed national shared catalogue – which requires further investigative work – may have a higher degree of benefits realisation risk.

8. We have included appropriate funding contingency informed by a Quantitative Risk Assessment – 29% capital and 15% operating

The programme was reset (from FPSC to NOS) in April 2015 and the scope was confirmed in the programme's November 2015 Stage Gate.

At the time of the reset, the sector inherited an $88 million programme, most of which had been spent by the now defunct HBL, leaving $10.8 million to deliver a national finance and supply chain system.

The stage gate report also estimated that the programme could be completed within the original budget, but with no financial or time contingency. This was not a realistic proposition for a programme of this complexity and scope.

The 2017 Change Control Report did apply a 15% contingency to Capex. Given the history of the programme and the recommendations of an independent Quantitative Risk Assessment a 29% contingency has been recommended for capital costs and a 10% contingency for operating costs.

(The results of the Quantitative Risk Assessment and how it has been applied to contingency is summarised in the Financial Case in section 8.6 Impact of Quantitative Risk Assessment on preferred option.)

9.3 Transition Approach

The following overall approach will be taken to moving the 10 DHBs to a common solution:

- The FPIM solution will be completed
- The 10 DHBs will be transitioned in structured rollout waves, making best use of lessons learnt from Wave One.

The proposed investment can be logically split into the following tranches:

Tranche One

Complete the design and build of the FPIM solution, including moving the Wave One DHBs to the full solution. This includes:

1. Complete the build of the national technology solution to provide the infrastructure that all DHBs will share as they use FPIM
2. Complete the implementation of Oracle Business Intelligence (BI) and the Service Oriented Architecture (SOA) to enable more effective use of FPIM
3. Migrate the existing Wave One DHBs to the new technology solution (Bay of Plenty, Canterbury, Waikato, West Coast) in parallel with the BI and SOA implementation.
4. Operationalise the support model on the national technology solution and finalise the rollout wave framework, phases, methodology, deliverables, entry and exit criteria, templates, roles / responsibilities and post go live transition to business as usual operation.

Tranche Two

Migrate the remaining DHBs in successive rollout waves. The rollout waves will be prioritised for the six DHBs (Northern Region, Taranaki, and Southern DHB) to address the severe risk profile with these DHBs' current supply chain, procurement and finance systems.

9.3.1 Tranche One – Complete the FPIM solution/migrate Wave One DHBs

The first tranche involves the following key pieces of work.

Table 41 Tranche One projects

ID	Project Title	Description
Project 1	National Technology Solution (NTS) (Infrastructure) Build	infrastructure; test security, high availability, disaster recovery and performance; and commission for go live: Oracle Build, Revera Build, End to End testing.
Project 2	Migrate Wave One to NTS	Deliver technical migration of Wave One from the existing Oracle Data Appliance (ODA) Technology to the National Technology; and complete build of final project environments. Migrate and test Wave One DHBs.
Project 3	Delivery of Deferred functionality to complete FPIM application	On National Technology, complete outstanding design, development and testing of national integration solution. On National Technology, implement national EDI for suppliers that already have this capability as at as at 1 July 2019 with Wave One and Wave Two DHBs. Subsequent supplier on-boarding will be subject to individual business cases. Analyse the requirements for BI reporting for Wave One DHBs and develop a solution for future implementation.

ID	Project Title	Description
Project 4	Operationalise Support Model and Finalise Rollout Wave Framework	Operationalise the functional and technical support model to support DHBs on, or on-boarding to, FPIM. Essentially this will involve expanding the existing support function and including its scope to support the NTS and associated systems. From a rollout wave delivery perspective, this project will also finalise the rollout wave framework, phases, methodology, deliverables, entry and exit criteria, templates, roles / responsibilities and post go live transition to business as usual.

9.3.2 Tranche Two – Transition DHBs to FPIM

One of the overarching principles of the business case is to ensure that risks across the supply chain and operations are managed through the delivery. As such this means, that within a single rollout, there cannot be more than one DHB within the same metropolitan area going live at the same time. For the purposes of the Tranche 2 DHBs being transitioned to FPIM, this means there will be three rollout waves as follows.

Table 42 Tranche Two projects

ID	Project Title	Description
Project 5	Rollout Wave Two	Rollout of FPIM solution on National Technology Solution (NTS Infrastructure) to Counties Manukau DHB, NZ Health Partnerships, Southern DHB, healthAlliance and healthAlliance FPSC
Project 6	Rollout Wave Three	Rollout of FPIM solution on National Technology Solution (NTS Infrastructure) to Waitemata DHB, Taranaki DHB, Northland DHB
Project 7	Rollout Wave Four	Rollout of FPIM solution on National Technology Solution (NTS Infrastructure) to Auckland DHB and its trusts / other entities

Key points to note regarding the transition of DHBs in rollout waves are:

1. A common fit gap,[49] a common design, a common build and a common test phase will be run for the six DHBs (Northern Region, Taranaki, and Southern DHB) to eliminate the need for three separate fit gaps and other resourcing constraints at healthAlliance by virtue of them being a shared services organisation to four Northern Region DHBs.
2. Each wave will implement multiple DHBs and supporting entities in a standard process. Experience gained in Wave One indicates that it takes between 9-12 months to transition a DHB, including DHB planning, preparation, and change activities. The provisional plan assumes that each of the five waves will take 52 weeks. This is therefore a conservative approach.
3. These windows will be based upon the length of time required to ensure migrated DHBs are stable before transitioning new DHBs to:

[49] "Fit gap" is a process to take the FPIM solution as a baseline and work through with DHB and healthAlliance subject matter experts to understand the areas of difference with respect to current functionality or processes used at the DHBs. This identifies gaps that need to be addressed to enable effective functioning of the DHBs. Solutions to address the gaps could include enhancement of the FPIM solution, change management at the DHB, data cleansing, training, and/or staffing changes.

a. ensure the migration has not introduced any additional risks to existing DHBs on the solution

b. allow the increased support calls that follows a migration to reduce to business as usual levels

c. allow for any lessons learnt to be applied to the next implementation grouping.

4. The approach proposes that each of these implementation windows will be at least 12 weeks apart, with three rollout waves required to complete transition of the Northern Region and Southern DHBs.

5. Agreement to the proposed nominated wave will be governed by the FPIM Programme governance. It will consider (among other things) DHB capability, risk, and impact to existing onboarded DHBs.

6. The FPIM programme team will be responsible for completion of Tranche One and defining and finalising a rollout wave framework that covers phases, timeline, approach, entry and exit gates, measurement approach, deliverables including fit into various phases, roles / responsibilities and templates for the deliverables. The intention here is to have a consistent delivery methodology and a DHB readiness assessment approach to ensure a successful and aligned delivery. The FPIM programme team also holds responsibility for socialisation and alignment of this framework with the incoming DHBs prior to the rollout wave commencing.

7. The FPIM central programme implementation team will coordinate each wave implementation until completion.

8. The FPIM programme team will also produce a robust framework to enable a DHB transition from post Go Live support into business as usual support by the Oracle Administration Team (OAT). This framework will be socialised and aligned with the incoming DHB at least two months prior to Go Live or before the end of month seven of the rollout wave commencing.

9. In a typical wave, a DHB is expected to go live in nine months and transition to business as usual is expected to be performed between month 11 and 12. Agreement to the proposed nominated wave, along with mobilisation of the rollout wave teams are pre-requisites for commencement of the wave.

9.3.3 Data migration

Each incoming DHB will agree what data it will migrate across from its legacy system. It will need to collect, cleanse, map and load the data to agreed National Standards which will be provided and audited by the OAT.

During the Scoping Phase, an agreement will need to be reached with the OAT Project team and DHB on the final list of supported migrated data. This is expected to include (but not limited to):

- Master data items:
    - Items, Bill of Materials (local)
    - Price Schedules (local)
    - Suppliers (local)
    - Cost Centres
    - Users, locations, approval hierarchies etc
    - Customers (local)

- Transactions
    - Assets
    - Open Projects
    - Inventory Balances
    - GL Balances (five years)

Where possible DHBs will close out open accounts payable, invoices, and purchase orders and hence have a manual process to manage this for any remaining open transactions at cutover.

Reconciliation and validation of the migrated data is a DHB responsibility and they will need to factor in appropriate resourcing and effort for this.

Due to the wide variety of data structures, formats, and requirements, it is not practical to develop a national repository to retain legacy data to support a DHB's requirement under the Electronic Transactions Act 2002 (ETA). It will be the responsibility of the DHB to define its management of legacy data to meet its obligations under the Act.

9.3.4 Testing

System testing and System integration testing:

FPIM is already live with Wave One DHBs. It is therefore a working, tested system. A DHB will not need to conduct systems testing and system integration testing for the FPIM applications but will need to conduct systems / systems integration testing for any DHB specific interfaces that it has developed.

Similarly, if a DHB develops any local reports, these will be required to undergo systems acceptance testing prior to user acceptance testing. It is proposed that for the rollout waves, a common testing phase is scheduled to cover this on the back of a common fit gap, common design and build phase.

Data and Process validation testing

A DHB will be responsible for planning data and process validation testing by planning and executing end to end scenarios for processes within the test environments using data that is migrated from their legacy systems.

This is key as the FPIM system is a working system and the focus during the rollout waves is on ensuring the migrated data works with the FPIM processes and any gaps are addressed through change management, communications and data cleansing / enrichment.

The central team will help with guidance to the incoming DHB on testing framework, generic scenarios, scripts and plans.

The FPIM programme will support the DHB during this testing and will be responsible for resolving any issues relating to the Oracle R12 functional modules, Oracle Integration Services (SOA) and Business Intelligence (BI) reports based upon agreed issue severity level definitions. In addition, the FPIM team will also be responsible for setting up appropriate testing environments and load data provided by the DHB team into the environment prior to commencement of testing.

A DHB will be responsible for resolving any issues with its integrations to local system and any local reports it has developed.

User Acceptance Testing

A DHB will be responsible for the planning and execution of User Acceptance Testing (UAT) within the DHB. The FPIM programme will provide the DHB with test scripts and the DHB will modify accordingly for any local variation in business process.

The FPIM programme will support the DHB during the user testing and will be responsible for resolving any issues relating to the Oracle R12 functional modules, Oracle Integration Services (SOA) and Business Intelligence (BI) reports based upon agreed issue severity level definitions.

A DHB will be responsible for resolving any issues with its integrations to local system and any local reports it has developed.

The DHB and the FPIM programme in consultation with the OAT must agree, based on pre-defined entry and exit criteria when UAT has been passed and the DHB can initiate its "go-live" activities.

The overall data testing phase is proposed to run for six weeks.

Post production support

The FPIM programme will support the OAT team in providing post production support once a wave has gone live. The post production support will be monitored by pre-defined exit to business as usual criteria covering key aspects to be fulfilled prior to transition of a DHB into business as usual. As soon as these criteria are fulfilled, the DHB will be transitioned to business as usual.

There will be a formal handover of operational support to the Oracle Administration Team once each DHB is operating on a business as usual basis.

9.3.5 Project plan and milestones

A timeline has been developed based on the proposed approach. This has the following key assumptions:

- The start date for initiation for Rollout Wave Two is July 2020.
- Three rollout waves will be required to transition the Northern Region, Taranaki, and Southern DHBs into the FPIM solution.
- A common fit gap, followed by common build (configuration and interfaces) and common core testing will be carried out for all six DHBs in Wave Two, Three, and Four. The fit gaps would be run in two parallel tracks (one for Northern region DHBs serviced by healthAlliance and the second for Taranaki DHB and Southern DHB).

The overall programme timelines are proposed to be as follows:

Note that the plan has been developed on the basis of a 1 July start date after a Cabinet agreement to "un-pause". Because of the pressure that this puts on DHBs needing to address their systems risk, actions are underway outside the business case to accelerate some of this work. These dates should therefore be considered provisional only.

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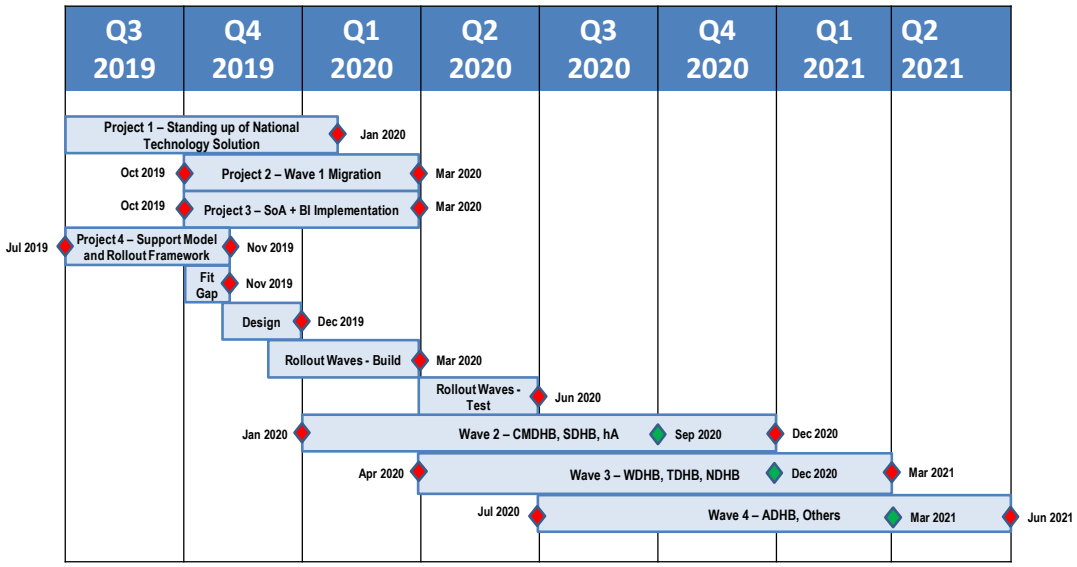

Figure 33 Provisional programme plan

Each rollout Wave is proposed to be run within a 12-month timeframe as follows:

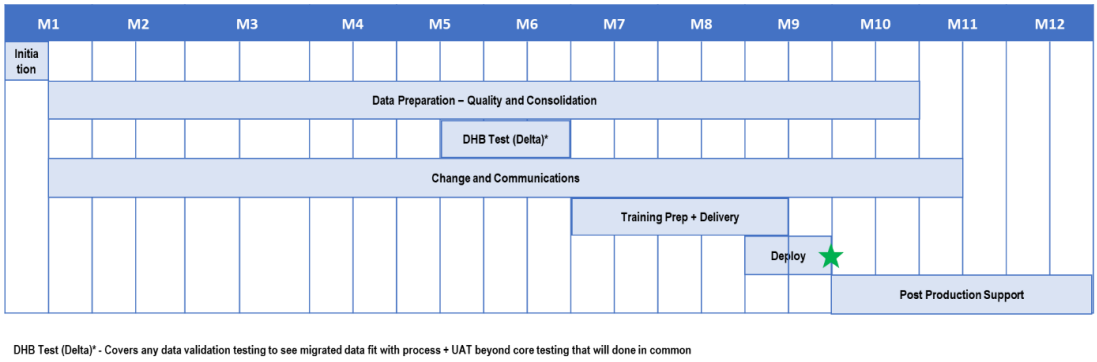

Figure 34 Provisional rollout wave schedule

9.3.6 Key Programme Milestones

Key programme milestones across the duration of the initiative are summarised in the following table.

Table 43 Provisional programme milestones

Key Project Milestone	Approximate Date
Project 1 Complete	1 January 2020
Project 2 Commences	1 October 2019
Project 2 Complete	30 March 2020
Project 3 Commences	1 October 2019
Project 3 Complete	30 March 2020
Project 4 Commences	1 July 2019
Project 4 Complete	30 November 2019
Rollout Waves Fit-Gap Commences	1 October 2019

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Key Project Milestone	Approximate Date
Rollout Waves Fit Gap Complete	30 October 2019
Rollout Waves Design Commences	23 October 2019
Rollout Waves Design Complete	30 December 2019
Rollout Waves Build Commences	1 December 2019
Rollout Waves Build Complete	31 March 2020
Rollout Waves Testing Commences	1 April 2020
Rollout Waves Testing Complete	20 September 2020
Rollout Wave Two – Project 5 Commences	1 January 2020
Rollout Wave Two – Project 5 – Go Live	6 September 2020
Rollout Wave Two – Project 5 Complete	30 December 2020
Rollout Wave Three – Project 6 Commences	1 April 2020
Rollout Wave Three – Project 6 – Go Live	1 December 2020
Rollout Wave Three – Project 6 Complete	31 March 2021
Rollout Wave Four – Project 7 Commences	1 July 2020
Rollout Wave Four – Project 7 – Go Live	5 March 2021
Rollout Wave Four – Project 7 Complete	30 June 2021

9.4 High level design of the catalogue

9.4.1 Introduction

The high-level design of the catalogue and how it will operate will occur in parallel with the implementation of the preferred option.

The objectives of the shared national catalogue high-level design are:

- To develop a high-level design of the shared national catalogue including the catalogue and provision of data, development of data standards, enhanced data repository, procurement compliance
- To identify how the shared catalogue will be developed and operate
- To refine how the national shared catalogue will support the benefits as contemplated by PHARMAC for medical devices
- To update the costs for the development and operation of the national shared catalogue and the financial benefits and timing
- To confirm the governance and benefits realisation
- To update the business case recommendations as required.

9.4.2 Scope

The scope of the shared national catalogue high level design is summarised in the following table.

Table 44 Scope of high-level design

Area	Included	Excluded
Overall	• High level design for the shared national catalogue including the catalogue and provision of data, development of data standards, enhanced data repository, procurement compliance • How national shared catalogue will be developed and managed • How national shared catalogue will support the medical device benefits as contemplated by PHARMAC • Updated costs for development and operation of national shared catalogue • Updated business case recommendations and next steps	• Other procurement areas outside medical devices and NZ Health Partnerships identified national procurement
High level systems design	• How national shared catalogue using largest Oracle cluster on single system will be established using existing FPIM • How systems to distribute catalogue items to DHBs will be built – to Tech One, JDE, Oracle DHBs	• Build / operation of national catalogue hosted on any other systems

Area	Included	Excluded
	• How DHB transitional data gathering and reporting infrastructure will be built	
Design of operations	• Management of the catalogue (loading, updating, removing, notifications, etc) • Management of the data standards (gaining agreement from DHBs, managing compliance, managing changes) • Managing compliance at DHB level • Reporting, including DHB transactional data mapped to the catalogue • Support, maintenance, change control	
Achieving the benefits	• Central requirements • DHB requirements • Overall governance	
Costs	• Development costs • Central operating costs	• DHB operating costs
Updating business case recommendations	• Updated recommendations and costs for next stage • Next steps	• Full redeveloped business case

9.4.3 Approach

The project will develop the next level of detail required to develop and operate a national shared catalogue beyond that already developed in the business case. It will therefore need to take account of:

- How the master catalogue will be configured and managed on the shared Oracle system proposed for use by 10 DHBs. This will include how new items are added, existing items are updated, and how obsolete items are retired. It will also consider use of standards as part of the catalogue (e.g.GS1).
- How the catalogue details will be distributed to the other DHBs. It will therefore need to take account of the updating of catalogue items on Tech One, JD Edwards, and Oracle systems. This will include the technical approaches and how the respective data will be updated.
- How compliance against the medical device contracts negotiated by PHARMAC and National Procurement contracts will be managed at DHB level. This will need to cover how this will occur in the various systems.
- How the reporting will occur, including DHB transactional data to be collected, the mechanisms for collecting this data, mapping to the shared catalogue and how the central reporting repository will operate.
- How the catalogue will operate and be managed.

- How the governance and benefits realisation will operate.

Because of the need to engage with different DHBs operating different systems, a multi-disciplinary working group of DHB staff representing the diversity of DHB situations will be convened. This will cover the expertise required to cover the varying systems and approaches taken in the sector. It will need to cover the varying needs of the DHBs using Tech One, JD Edwards, or Oracle.

A series of workshops will be held to consider the key aspects of the catalogue and its operation. These workshops will include the working group and other key stakeholders in the wider sector. The working group will take the output of each workshop, refine it, and develop the next level of detail to ensure that it will achieve the benefits in a cost-effective manner.

In parallel with the workshops the costing will be updated, and the final report updated and refined.

The diagram on the following page summarises how this will operate.

9.4.4 Timing

The following diagram summarises how the timing of the high-level catalogue design will intersect with the implementation of Option 3.

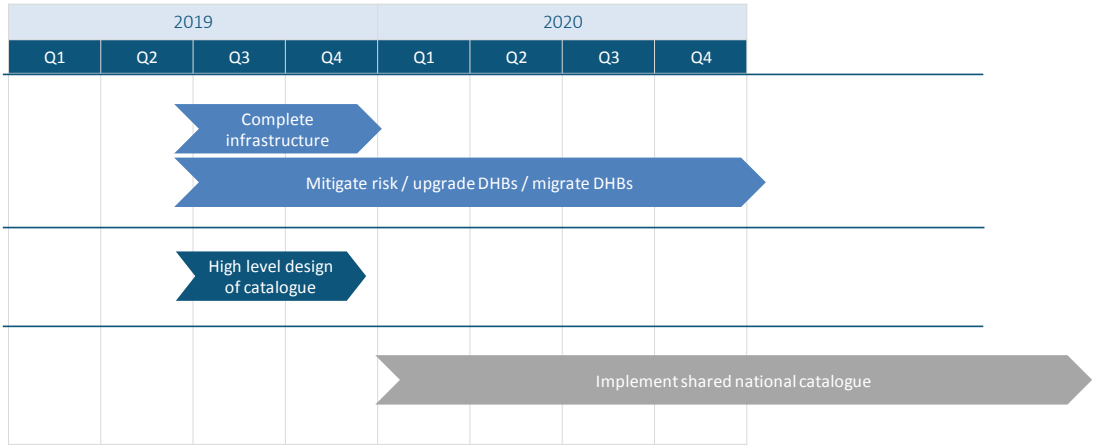

Figure 35 Timing of development of high-level design of catalogue

As can be seen, it is proposed that there will be a 6-month project.

Further detail can be found in APPENDIX E: Shared national catalogue high level design project brief.

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9.5 Programme governance

Governance for the programme needs to balance the requirements of individual DHBs with the overall goals of the programme while recognising each DHB's ability to manage their own costs and quality of transition. The governance structure has been designed to remove duplication and provide clear lines of reporting, responsibility and ownership.

The structure is also intended to ensure leadership of the programme is collaborative and sector led through the inclusion of DHB senior executives in key roles.

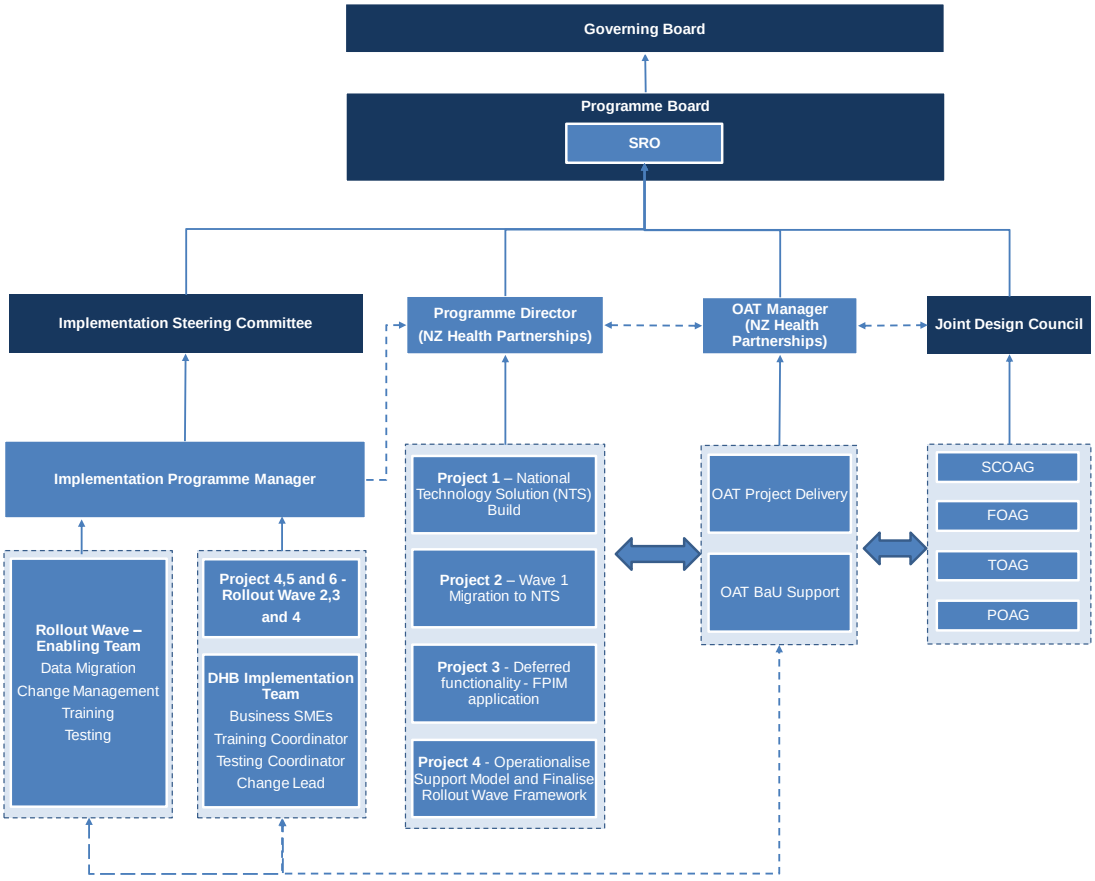

Figure 36 Proposed governance and management structure

The governance bodies are described in the following table.

Table 45 Governance bodies and roles

Group / Person	Role	Membership
Governing Board	• Investment decision, defining direction and ensuring overall alignment of programme to organisation strategies • Decision makers for material changes outside of the agreed programme parameters • Not involved any day to day programme activities including design decisions.	• DG Health (chair) • Chair PHARMAC • A DHB chair • Chair NZ Health Partnerships • External IT governance expert

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Group / Person	Role	Membership
Programme Board	• Drives the programme forward and delivers outcomes and benefits • Decision makers for escalations that fit within the programme agreed boundaries • Responsible to provide each tranche with the framework to operate within – deliverables, milestones, acceptance criteria, gates.	• CE NZ Health Partnerships (chair) • Deputy Director General: Data and Digital – Ministry • CE PHARMAC • Treasury representative • DHB CEs • Independent IT/Programme advisor
Joint Design Council	• Responsible to ensure the design for each tranche conforms • Reviews/approves/declines any change requests to the central design • Responsible to ensure that the on-going solution design meets National requirements	• DHB CFOs (4X) • DHB CIO (2X) • Independent Technical Advice
Implementation Steering Committee	• Responsible to ensure the projects and rollout waves operate within the framework provided by the Programme Board • Drives the projects forward and delivers outcomes and benefits • Approves wave gates prior to Programme Board approval • Decision-makers for escalations and change requests that fit within the project agreed boundaries	• SRO NZ Health Partnerships (chair) • DHB CFOs – reflects current implementation waves • External expert advisors as required
Programme Director	• Responsible for directing overall programme of work to achieve outcomes • Reports to the SRO	• Appropriate expertise
OAT Manager	• Responsible for DHB operational support services and master data • Reports to the SRO	• Appropriate expertise

9.6 Resourcing

9.6.1 Introduction

This section summarises the roles for:

- The central programme team, including the resources to manage the transition of the Wave One DHBs
- The DHB programme teams for the Northern DHBs and Taranaki
- The DHB programme team for Southern DHB.

Full details on the resourcing timetable and FTE level for the roles can be found in the costing model.

Each role table indicates which role will be internally provided by existing staff from DHBs or DHB related organisations, and which will be externally contracted. External staff have been costed at external rates while internal staff have been costed at internal rates that reflect the cost for staff backfilling.

9.6.2 Central programme team

The following table summarises the key roles for the central programme team.

Table 46 Central programme team roles

Role	Category	Int / Ext
Programme Director	Project Management	External
Project Coordinator	Project Management	Internal
Project Accountant	Project Management	Internal
Business Analyst – Rollout	BA	Internal
Business Analyst – Rollout	BA	External
Business Analyst – Rollout	BA	Internal
Business Analyst – Rollout	BA	External
Data Migration Analyst – 1 – Rollout	Data Migration	External
Data Migration Analyst – 2 – Rollout	Data Migration	External
Data Migration Developer – 1 – Rollout	Data Migration	Internal
Data Migration Developer – 2 – Rollout	Data Migration	External
Data Migration Analyst 3 – Rollout	Data Migration	External
Data Migration Developer – 3 – Rollout	Data Migration	External
Test Manager – Rollout	Testing	Internal
Test Specialist – Rollout	Testing	Internal
Test Specialist – Rollout	Testing	Internal
Training Lead – Rollout	Training	External
Trainer 1 – Rollout	Training	Internal
Trainer 2 – Rollout	Training	External
Data Lead – Programme	Data Migration	External
Change Manager – Rollout	Change Management	External
Change Manager – Rollout	Change Management	External

9.6.3 Northern DHBs and Taranaki DHB programme team

The following table summarises the key roles for the central programme team.

Table 47 Northern DHBs and Taranaki DHB programme team roles

Role	Category	Int / Ext
DHB Project Lead 1 – ADHB	Project Management	Internal
DHB Project Lead 2 – CMHDHB	Project Management	Internal
DHB Lead 3 – WDHB	Project Management	Internal
DHB Lead 4 – NDHB	Project Management	Internal
DHB Lead 5 – TDHB	Project Management	Internal
Business SME – Procurement – ADHB	Business SME	Internal
Business SME – Supply Chain 1 – ADHB	Business SME	Internal
Business SME – Supply Chain 2 – ADHB	Business SME	Internal
Business SME – Finance 1 – ADHB	Business SME	Internal
Business SME – Procurement – WDHB	Business SME	Internal
Business SME – Supply Chain 1 – WDHB	Business SME	Internal
Business SME – Supply Chain 2 – CMHDHB	Business SME	Internal
Business SME – Finance 1 – WDHB	Business SME	Internal
Business SME – Procurement – CMHDHB	Business SME	Internal
Business SME – Supply Chain 1 -CMWDHB	Business SME	Internal
Business SME – Finance 1 – CMHDHB	Business SME	Internal
Business SME – Procurement – NDHB	Business SME	Internal
Business SME – Supply Chain 1 – NDHB	Business SME	Internal
Business SME – Finance 1 – NDHB	Business SME	Internal
Business SME – Procurement – TDHB	Business SME	Internal
Business SME – Supply Chain 1 – TDHB	Business SME	Internal
Business SME – Finance 1 – TDHB	Business SME	Internal
Oracle Functional – Finance	Local healthAlliance	Internal
Oracle Functional – Supply Chain	Local healthAlliance	Internal
Oracle Functional – Procurement	Local healthAlliance	Internal
Oracle Developer	Local healthAlliance	Internal
Oracle Developer	Local healthAlliance	Internal
Solution Architect	Local healthAlliance	Internal
Enterprise Architect	Local healthAlliance	Internal
Bus Data Lead – ADHB	Data Migration	Internal
Bus Data Lead – WDHB	Data Migration	Internal
Bus Data Lead – CMHDHB	Data Migration	Internal
Bus Data Lead – NDHB	Data Migration	Internal
Bus Data Lead – TDHB	Data Migration	Internal
Test Coordinator – ADHB	Testing	Internal
Test Coordinator – WDHB	Testing	Internal
Test Coordinator – CMHDHB	Testing	Internal
Test Coordinator – NDHB	Testing	Internal
Test Coordinator – TDHB	Testing	Internal
Training Coordinator – ADHB	Training	Internal
Training Coordinator – WDHB	Training	Internal
Training Coordinator – TDHB	Training	Internal
Training Coordinator – NDHB	Training	Internal
Training Coordinator – CMHDHB	Testing	Internal
Business SME – Procurement – ADHB	Business SME	Internal
Business SME – Supply Chain 1 – ADHB	Business SME	Internal

Role	Category	Int / Ext
Business SME – Supply Chain 2 – ADHB	Business SME	Internal
Business SME – Finance 1 – ADHB	Business SME	Internal
Business SME – Procurement – WDHB	Business SME	Internal
Business SME – Supply Chain 1 – WDHB	Business SME	Internal
Business SME – Supply Chain 2 – CMHDHB	Business SME	Internal
Business SME – Finance 1 – WDHB	Business SME	Internal
Business SME – Procurement – CMDHB	Business SME	Internal
Business SME – Supply Chain 1 – CMDHB	Business SME	Internal
Business SME – Finance 1 – CMDHB	Business SME	Internal
Business SME – Procurement – NDHB	Business SME	Internal
Business SME – Supply Chain 1 – NDHB	Business SME	Internal
Business SME – Finance 1 – NDHB	Business SME	Internal
Business SME – Procurement – TDHB	Business SME	Internal
Business SME – Supply Chain 1 – TDHB	Business SME	Internal
Business SME – Finance 1 – TDHB	Business SME	Internal
Comms Lead – ADHB	Communications	Internal
Comms Lead – WDHB	Communications	Internal
Comms Lead – CMDHB	Communications	Internal
Comms Lead – NDHB	Communications	Internal
Comms Lead – TDHB	Communications	Internal
Change Lead – ADHB	Change Management	Internal
Change Lead – WDHB	Change Management	Internal
Change Lead – CMDHB	Change Management	Internal
Change Lead – NDHB	Change Management	Internal
Change Lead – TDHB	Change Management	Internal
Training Coordinator – ADHB	Training	Internal
Training Coordinator – WDHB	Training	Internal
Training Coordinator – TDHB	Training	Internal
Training Coordinator – NDHB	Training	Internal
Training Coordinator – CMDHB	Testing	Internal
Data Quality Analyst – Rollout – Profiling	Data Quality	External

9.6.4 Southern DHB programme team

The following table summarises the key roles for the Southern DHB transition team.

Table 48 Southern DHB team roles

Role	Category	Int / Ext
DHB Lead 3 – SDHB	Project Management	Internal
Business Analyst – 1	BA	Internal
Business Analyst – 2	BA	Internal
Business SME – 1	Business SME	Internal
Business SME – 2	Business SME	Internal
Bus Data Lead – SDHB	Data Migration	Internal
Test Analyst 1	Testing	Internal
Test Analyst 2	Testing	Internal
Test Coordinator – SDHB	Testing	Internal
Training Coordinator – SDHB	Testing	Internal
Business SME 1	Business SME	Internal
Business SME 2	Business SME	Internal
Comms Lead – SDHB	Communications	Internal
Change Lead – SDHB	Change Management	Internal
Training Coordinator – SDHB	Testing	Internal
Data Quality Resource 1	Data Quality	Internal
Data Quality Resource 2	Data Quality	Internal

9.6.5 Catalogue operation high level design

The following table summarises the key roles for the development of the high-level design for the development and operation of the national catalogue.

Table 49 Catalogue high level design roles

Resource	Source
Lead	External
Architect	External
Business analyst	External
Working group	DHBs
Cost and benefits analyst	NZ Health Partnerships
Project support	NZ Health Partnership
Communications support	NZ Health Partnerships

9.7 Programme management

9.7.1 Introduction

This section summarises how the programme will be governed, managed, and controlled.

9.7.2 Applicable standard

Managing Successful Programmes (MSP) will be used as the guidance for programme approach and artefacts.

9.7.3 Programme management plan

A Programme Management Plan (PMP) will form the basis of the management of the Programme, stating the objectives, benefits, budget, resources, schedule, programme controls, and the basis for assessing the overall success. Plans and registers will provide the lower levels of detail to support the implementation of the direction contained in the PMP. Once baselined, any changes to the PMP must be agreed by the Governing Board in a Change Request. All changes will be reflected in the PMP.

9.7.4 Stakeholder engagement and communications

There will be a Stakeholder Engagement and Communications Plan for the Programme and per individual Project in the Programme.

9.7.5 Integrated programme schedule

There will be an overall Programme Schedule showing the key milestones, projects, timeframes and interdependencies.

9.7.6 Resource and cost forecasting

A resource management plan will be identified and aligned to the resource management strategy to manage the allocation of resources to the projects within the Programme, resources used by the projects and forecasts to completion. The Resource and Cost Forecast will include:

- A list of all resources, projected usage by reporting period at a project level
- History of expenditure to date
- Tracking against approved budget
- Reconciliation to change requests
- Forecast of cost until the end of the project.

Programme costs will be managed through Oracle Project Accounting. Purchase Orders will be raised for all programme commitments and monthly financial reports will be provided to the FPIM Governance Board and the Implementation Steering Committee, including:

- Actual versus Budget
- Estimates to complete
- Total to complete
- Variances

9.7.7 Change control

The NZ Health Partnerships Change control guide outlines the change control process. The process will apply to any baselined artefact or product and any change within the programme (or individual project) that if approved will have a material impact upon benefit realisation, objectives as outlined in the business case, time, budget or scope (negative or positive). The delegated authorities approved by the Governing Board will be applied to ensure change management requirements are controlled at the identified levels.

The purpose of the change control process is to provide Programme Governance with a control mechanism to support on-going changes to the programme.

The change control process does not guarantee additional project funding, contingency release or the rebase-lining of milestones, costs, quality and benefits. However, the process will create an audit trail of factors affecting the project throughout its life cycle, ensuring appropriate steps are taken to assess and control the impact of each change. The key points are as follows:

- An effective change control process is underpinned by the concept of signed-off authorisation of project documentation. Signed-off documents are the 'baseline' against which Change Controls are assessed.
- All Change Controls require authorisation. The appropriate level of authorisation will vary depending on the nature and scale of the proposed change.
- Material changes to the project include changes to scope, milestones, costs, benefits, and resource requirements as defined and agreed.
- All proposed changes need to be examined initially at project level against the base-lined agreed Business Case, and then a Change Control must be formally submitted to the Programme Director and the Programme Office.
- Change Control is not a retrospective process. It must be used to assess and agree changes to project baselines prior to the change being implemented.

9.7.8 Programme issues management

The NZ Health Partnerships Issue Management guide outlines the issue management process that will apply to the FPIM programme (this also covers project issue management).

All issues escalated to a programme level will be outlined in an issue report.

An Issues Register will be maintained for the Programme which will be an aggregate view of the issues identified at project level with a flag for those that have been escalated to the Programme level. The issues escalated will be those that are causing a deviation from the approved Programme Management Plan. The Issues Register will be updated every week by individual projects and reviewed fortnightly at a programme level at the Governing Board.

9.7.9 Programme risk management

The NZ Health Partnerships Risk Management guide outlines the risk management process that will apply to the FPIM programme (this also covers project risk management).

A Risk Register will be maintained for the Programme which will be an aggregate view of the risks identified at project level with a flag for those that have been escalated to the Programme level. The risks escalated will be those that have a potential of causing a deviation from the approved Programme Management Plan (PMP). An initial programme risk assessment process will be undertaken as part of development of the Programme Management Plan. The NZ Health Partnerships Risk Management Framework will be used to assess programme risks. Projects will also

use this framework to assess project level risks. The Risk Register will be updated every week at a project level and reviewed fortnightly from a programme level at the Governing Board. The Programme Board will be responsible for identifying and managing risk mitigation plans for Programme risks. Regular risk workshops will be held to ensure that appropriate risk management is in place to minimise risk impact.

9.7.10 Programme assurance management

A fit-for-purpose assurance plan will be developed to cover the programme and the ICT operational environment. This will include any Independent Quality Assurance (IQA) reviews that will be undertaken. Key Assurance activities to include:

- Regular risk register reviews
- Project retrospectives including lessons learned
- Programme Board level review of status updates
- Scheduled IQAs including technical quality assurance activities.
- Treasury Gateway reviews as per the gateway schedules.

The programme assurance plan will use the GCDO guidance and template.

9.7.11 Programme action and decision register

A register will be kept of all Governing Board and Programme Board actions and decisions. This will be managed and updated as part of the agenda and minutes processes for the Governing Board and Programme Board.

9.7.12 Programme reports

A Programme dashboard will be produced by the Programme Management Office on a fortnightly basis for the Programme Board and on a monthly basis for the Governing Board to inform the governance forums on the status of the Programme. The Programme dashboard will contain the following:

- Overall summary of programme status including programme Health RAG status
- Summary of Project Status including significant achievements for the period, planned for next period
- RAG status on each project, reporting on progress, supported by metrics and comments as required
- Summary of progress in achieving Milestones
- Finance Summary including budget, actuals, estimate to complete, total to complete and variances
- Contingency drawdown
- Programme high impacting Issues and resolution plans
- Programme extreme / high rated risks and mitigation plans
- Change requests identifying Resource, Time, Cost impact and status
- Decision Register.

9.7.13 Programme tolerances

The Delegated Authorities approved by the Governing Board outlines all decision making and tolerances.

Any variances to plan around scope, cost/resource, time, and quality will be flagged through the fortnightly status reporting as soon as they are known. Risk escalations will also be noted when these have occurred. There will be tolerances defined for scope, cost, resource, time, and quality.

9.7.14 Lessons learned register

The Programme Director will create and maintain a repository of any lessons learned during the Programme that can be usefully applied to other projects or programmes.

9.8 Project management

Each project within the programme will operate according to defined standard processes

9.8.1 Introduction

Projects within the overall programme will be managed using a standard set of guidelines and templates. (These are currently in common use in the NZ Health Partnerships PMO.) These are summarised below.

9.8.2 Applicable standard

PRINCE2 will be used as the guidance for project management approach and artefacts.

9.8.3 Project initiation documents

A Project Initiation Document (PID) will form the basis of the management of projects. The PID will state the objectives, approach, benefits, budget, resources, schedule, project controls and the basis for assessing the overall success. Plans and registers will provide the lower levels of detail to support the implementation of the direction contained in the PID. Once approved by the SRO, the PID will provide the baseline for the project. Any changes to the PID must be agreed by the Programme Board, and depending upon the level of change, as defined in the delegated authorities, by the Governing Board.

9.8.4 Project schedule

There will be a project plan showing the tasks schedule and key resources assigned for each project. Key milestones for each project will be reflected in the Integrated Programme plan.

9.8.5 Project resource and cost forecast

The resource and cost plan will be used to manage the resources assigned to the project and the costs incurred to date and planned to be incurred. The Resource and Cost Plan will include:

- A list of all resources, cost rates, projected usage by reporting period
- History of expenditure to date
- Tracking against approved budget
- Reconciliation to change requests
- Forecast of cost until the end of the project
- Total costs for project and any variances.

9.8.6 Change control

The NZ Health Partnerships Change control guide outlines the change control process. The process will apply to any baselined artefact or product and any change within the programme (or individual project) that if approved will have a material impact upon benefit realisation, objectives as outlined in the business case, time, budget or scope (negative or positive). The delegated authorities approved by the Governing Board will be applied to ensure change management requirements are controlled at the identified levels.

The purpose of the change control process is to provide Programme Governance with a control mechanism to support on-going changes to the programme.

The change control process does not guarantee additional project funding, contingency release or the rebase-lining of milestones, costs, quality and benefits. However, the process will create an audit trail of factors affecting the project throughout its life cycle, ensuring appropriate steps are taken to assess and control the impact of each change. The key points are as follows:

- An effective change control process is underpinned by the concept of signed-off authorisation of project documentation. Signed-off documents are the 'baseline' against which Change Controls are assessed.
- All Change Controls require authorisation. The appropriate level of authorisation will vary depending on the nature and scale of the proposed change.
- Material changes to the project include changes to scope, milestones, costs, benefits, and resource requirements as defined and agreed.
- All proposed changes need to be examined initially at project level against the base-lined agreed Business Case, and then a Change Control must be formally submitted to the Programme Director and the Programme Office.
- Change Control is not a retrospective process. It must be used to assess and agree changes to project baselines prior to the change being implemented.

9.8.7 Project issues management

An Issues Register will be maintained for every Project in the common Programme issues register. Escalated Issues will be flagged within the register to be raised at the programme level to the Programme Director.

9.8.8 Project risk management

A Risk Register will be maintained for every Project within the common Programme risk register. This log will contain information about every risk, analysis, appropriate mitigation plans, and status. This register will follow the standard NZ Health Partnerships risk processes and be reviewed on a weekly basis within the project. Escalated Risks will be flagged within the register to be raised at the programme level to the Programme Director.

9.8.9 Programme Board action and decision register

A register will be kept of all Programme Board. This will be managed and updated as part of the agenda and minutes processes for the Implementation Steering Committee.

9.8.10 Project reports

Project Highlight Reports will be delivered by the Project Managers / Project Leads to the Programme Director on a weekly basis (these will be loaded to the programme documents repository). These will inform the programme reporting managed by the Programme Director as outlined in the programme management section above. Other reports will only be produced on an exception basis. The highlight report will contain the following:

- Overall summary of project's status
- Progress against milestones
- Status on each work-stream, supported by comments as required
- Summary of work that is planned in next two weeks for each work-stream

- RAG reporting on scope, schedule, budget, risk, quality, and resourcing, supported by metrics and comments as required
- Current risk register snapshot
- Current issues register snapshot
- Change requests.

9.9 Monitoring and reporting

The monitoring and reporting processes will ensure that information flows to where it is needed for rapid evaluation and response

Programme and project reporting will summarise the current status, key issues and advancements relating to each project and the programme. Each Project Manager will create the weekly highlight report. The PMO will produce a Programme Status Report for review by the Programme Director. The SRO is responsible for approving the final Programme Status Report.

The reports will focus upon issues and changes that have arisen during the reporting period. The PMO will be responsible for managing the reporting process and co-ordinating the report submission timetable.

9.10 Risk and issue management

A robust risk and issue management process will be incorporated into the programme

9.10.1 Introduction

NZ Health Partnerships has a risk management framework which provides the processes and templates for management of programme risk.

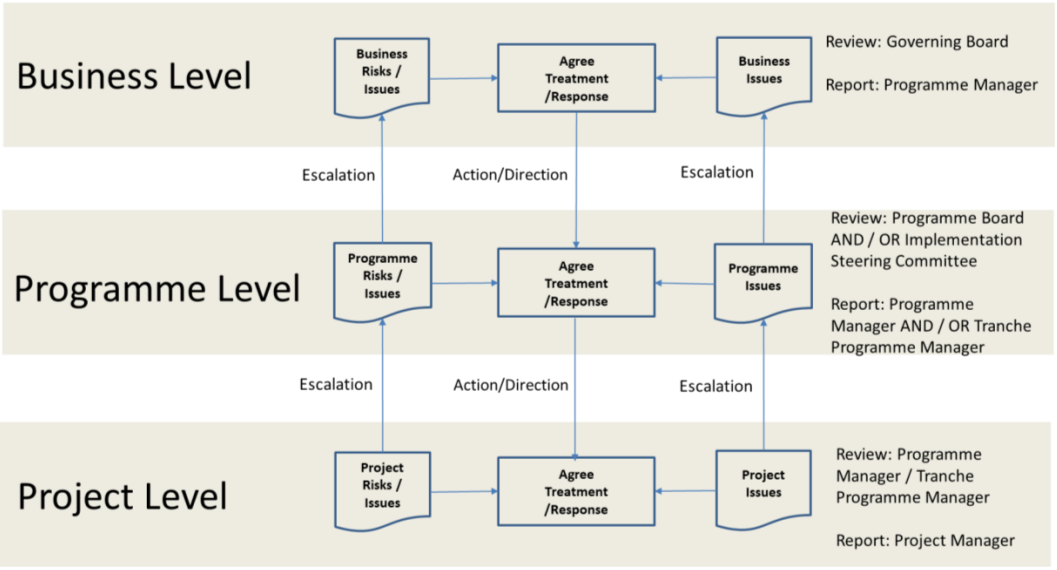

Figure 37 Risk management process

9.10.2 Overall structure of reporting and management

Reporting, monitoring and management of risks and issues will be in accordance with the Monitoring and Reporting arrangement detailed above.

- Anyone who identifies a risk will record it in the Risk Register.
- The Project Manager will assign responsibility for management of the risk and will be responsible for tracking of the risk until it no longer exists (is resolved or has become an issue).
- Reporting of open risks will be included in the project highlight report.
- Any risks categorised as Extreme, or High requiring FPIM Governing Board oversight will be reported in the project highlight report and reviewed by the Programme Director and / or the Tranche 2 Programme Director as applicable, who will advise the PMO of the requirement to include in the next FPIM Programme Board meeting pack or the FPIM Implementation steering committee as applicable.
- The FPIM Programme Board AND / OR the Implementation steering committee will review and agree on the risks that need to be included in the FPIM Programme risk register. They will also provide advice on mitigations and action plans to manage the risks.
- Key Risks will be noted and discussed each month at the FPIM Governing Board.
- Risks will be evaluated at the planning stage of each phase of the project and then monitored on an on-going basis throughout the life of the project.

- Anyone who identifies a potential issue will advise the Project Manager to log it in the appropriate issues management tool.
- The Project Manager will assign responsibility for the resolution of the issue, set a target resolution date, and will be responsible for the subsequent tracking of the issue until it is resolved.
- If it is not possible for the issue to be resolved within the project team, the Project Manager will escalate it to the Programme Director AND / OR the Tranche Programme Director for review.
- Reporting of key outstanding issues will be included in the project highlight reports.
- The Programme Director AND / OR the Tranche Programme Director will identify those that need to be discussed at FPIM Programme Board or Implementation steering committee meetings.

9.10.3 Key risks for preferred option

The following table summarises the key risks for the preferred option.

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Table 50 Key risks for Option 3 Single system for 10 DHBs

Risk ID	Risk Name	Risk Description	Impact if RISK materialises	Risk Impact	Risk Likelihood	Risk Rating	Untreated Risk Impact	Untreated Risk Likelihood	Untreated Risk Rating	Mitigation
1	**IF** Timely decision making is not achieved to enable the National infrastructure build to be completed by Sep 2019	**THEN** 1) The Programme will not be able to secure key Oracle resource 2) The identified date for Oct 2019 for Wave 1 DHBs to migrate will not be achieved. 3) The schedule for rollout waves will not be achieved	**RESULTING IN** 1) Possible system failure with DHBs unable to fulfil medical device procurement with the potential of impacting clinical procedures 2) On-going regrettable spend on remedial activities for existing systems. 3) Timelines for rollout waves will be extended resulting in an increase in resource requirement and costs 4) Loss of key resources with existing IP	Moderate	Likely	High	Major	Almost Certain	Extreme	1) Detailed project plan to include key milestones and critical path 2) Ensure contingency is built in to timelines and cost. 3) Maintain a close relationship with the head of Oracle New Zealand
2	**IF** The Programme Governance structure to support BC approval and Programme delivery	**THEN** 1) The Programme may not have appropriate direction 2) The ability for the Programme to make key decisions will be impacted 3) The Programme may have restrictions in addressing key issues and challenges	**RESULTING IN** 1) Increase in timelines due to turnaround of key decision making 2) Increase in costs due to increased timelines 3) Issues are not managed effectively and in a timely manner	Major	Unlikely	High	Major	Possible	Extreme	1) Maintain high engagement with DHBs for input to the BC 2) Align BC to customer requirements 3) Ensure Governance is representative of Programme participation during phasing
3	**IF** The approval timelines identified for DHB and Cabinet sign off on the BC are not met	**THEN** 1) All key milestones will be impacted 2) DHB commitment to the Programme may be lost 3) Will not be able to secure key Programme resource	**RESULTING IN** 1) FPIM BC not signed off 2) Increased timelines 3) Inability to meet deadlines 4) Increased costs 5) Loss of key resource with IP	Moderate	Likely	High	Major	Possible	Extreme	1) Maintain high engagement with DHBs 2) On-going relationship management with vendors
4	**IF**	**THEN**	**RESULTING IN**	Moderate	Likely	High	Major	Possible	Extreme	1) Developing and managing a

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Risk ID	Risk Name	Risk Description	Impact if RISK materialises	Risk Impact	Risk Likelihood	Risk Rating	Untreated Risk Impact	Untreated Risk Likelihood	Untreated Risk Rating	Mitigation
	There is inadequate suitable project resource available to meet programme requirements	1) The start dates identified in the plan will not be achieved 2) Activities may take longer than estimated to deliver	1) Increased timelines 2) Increased costs							detailed resource management plan 2) Initial discussions with consultancy agencies
5	**IF** DHBs are not able to complete data cleansing and consolidation activities within timeframes and to required standards.	**THEN** 1) The start dates identified in the plan will not be achieved 2) Activities may take longer that estimated to deliver .	**RESULTING IN** 3) Increased timelines 4) Increased costs	Major	Possible	High	Major	Likely	Extreme	1) Finalise a rollout wave delivery framework and methodology covering phases, key deliverables, templates, entry and exit criteria as well as roles and responsibilities to transition a DHB. 2) Work closely with DHB implementation to ensure readiness according to criteria. 1) Enable a consistent measurement of data readiness with regular checkpoints through the rollout waves to help capture issues early and work to resolve.
6	**IF** The FPIM solution does not meet DHB Requirements	**THEN** 1) the detailed design will require re-work to complete 2) key requirements may not be included in the build	**RESULTING IN** 1) delays to key milestones, delay in the build project, 2) compromise on functionality 3) increased cost, scope, time	Major	Possible	High	Major	Likely	Extreme	1) Complete a Fit Gap analysis 2) Detailed integrated plan for the service model
7	**IF** DHBs are not ready to go live	**THEN** 1) The start dates identified in the plan	**RESULTING IN** 1) Increased timelines 2) Increased costs	Moderate	Possible	Moderate	Major	Likely	Extreme	1) Finalise a rollout wave delivery framework and methodology covering phases,

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Risk ID	Risk Name	Risk Description	Impact if RISK materialises	Risk Impact	Risk Likelihood	Risk Rating	Untreated Risk Impact	Untreated Risk Likelihood	Untreated Risk Rating	Mitigation
	in line with the rolling transition plan.	will not be achieved 2) Activities may take longer than estimated to deliver								key deliverables, templates, entry and exit criteria as well as roles and responsibilities to transition a DHB. 2) Work closely with DHB implementation to ensure readiness activities including organisational change management are being completed as per framework. 3) Establish key check points to review progress and readiness against entry and exit criteria to pick issues early and work to resolve with DHBs
8	**IF** Change is not managed effectively in the DHBs.	**THEN** 1) DHBS will not be fully informed on the impact of changes 2) DHBs will not be adequate prepared for process change in the new environment 3) DHBs will not be adequately training on the new functionality	**RESULTING IN** 1) Operational issues caused by process gaps 2) Customer loss of confidence in programme 3) Increased timelines 4) Increased costs.	Moderate	Unlikely	Moderate	Moderate	Possible	High	1) Finalise a rollout wave delivery framework and methodology covering phases, key deliverables, templates, entry and exit criteria as well as roles and responsibilities to transition a DHB. 2) Work closely with DHB implementation to ensure readiness according to criteria. 3) Enable a consistent measurement of change readiness with regular checkpoints through the rollout waves to help capture issues early and work to resolve.
9	**IF** Other projects / programmes /	**THEN** 1) Planned delivery dates and key	**RESULTING IN** 1) Increased timelines 2) Increased costs.	Major	Unlikely	Moderate	Major	Likely	Extreme	1) Secure executive buy-in for the programme and have an effective stakeholder

NZ HEALTH PARTNERSHIPS

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Risk ID	Risk Name	Risk Description	Impact if RISK materialises	Risk Impact	Risk Likelihood	Risk Rating	Untreated Risk Impact	Untreated Risk Likelihood	Untreated Risk Rating	Mitigation
	priorities impact delivery of the programme due to resourcing and priority conflicts.	milestones for the programme will not be achievable 2) Activities will take longer that estimated to deliver.								engagement plan to ensure this programme is prioritised among the organisations. 2) Raise key challenges in time and work through with relevant business stakeholders

9.11 Change management

Change management will be critical to the success of the DHB implementations – it has been built into the resourcing plan and approach to transition

9.11.1 Introduction

Effective change management will be critical to achieving user acceptance of the new systems and ways of working as well as achieving the benefits. Change management will be built into the programme from the beginning. The FPIM programme change manager will lead a team to support the DHBs in achieving the changes and benefits that they need to achieve.

This section summarises how this will work in the FPIM programme in terms of:

- Roles and responsibilities
- Principles of operation.

9.11.2 Roles and responsibilities

The FPIM programme will have a change manager, training manager, business analysts and master trainers. They will be responsible for facilitating the DHBs to effect the changes that they will need to effectively use the systems and gain the benefits in this business case. They will provide the key conduit for the DHBs for the wider expertise in the FPIM programme to ensure that DHBs can have smooth implementations and gain the benefits contemplated in this business case.

Table 51 Change management roles and responsibilities

FPIM programme team	DHB
• Develop stakeholder management plan for whole programme • Develop communications plan for whole programme • Assist DHBs to develop their stakeholder management and communication plans	• Develop stakeholder management plan for DHB • Develop communications plan for DHB
• Advise re the key policy changes that will be needed to gain benefits (e.g. "no purchase order no payment")	• Develop local policy changes, communicate, and implement
• Provide standard training material for adaptation by DHBs • Provide standards business process material for adaptation by the DHBs • Train DHB trainers (where required)	• Localise training • Localise standard operating procedures or business process material • Train users
• Provide post-Implementation Support • Advise on how DHBs can gain the benefits	• Support users to use the system and gain the benefits
• Provide guidance on monitoring and measuring change adoption	• Monitor change adoption and remediate as necessary

9.11.3 Principles of operation

John Kotter has identified eight steps for change.[50] How these will be used in the programme are summarised in the following table.

Table 52 Change management principles

Kotter's eight steps	How they will be applied
1. Increase urgency **2. Create a guiding team**	• This business case will be used to support the change imperative needed among DHBs to embrace FPIM and drive its benefits • The FPIM programme will work with the DHBs to develop common strategic approaches to achieving change and buy-in • Each DHB will work with the FPIM programme to identify the key people who will need to support the change • Each DHB will develop its own change management plan using advice and sample artefacts from the FPIM programme. These plans will be supported by evidence and lessons learned from the wave one implementations • Each DHB will have its own change champions to recruit staff to the vision and lead the change • Standard processes to assess engagement and readiness will be established to measure staff engagement and inform ongoing engagement activities
3. Develop a vision	• The FPIM programme will develop vision artefacts that can be used to show DHB staff how the new environment will look and why this is worth doing • Each DHB will develop its own vision for the Finance and Procurement systems based on the standard FPIM footprint • The FPIM programme will support the DHBs and share learnings across DHBs
4. Communicate for buy-in	• The FPIM programme will support DHBs in developing communications that will work effectively (e.g. simple and heartfelt, not complex and technocratic, speaking to what people are feeling) • Each DHB will communicate to its staff and work at gaining the buy-in to the changes • The DHBs will work together, supported by the FPIM programme team to achieve this • DHB leads will "walk the talk" • The FPIM programme will identify best practice across DHBs and share them
5. Empower employees for broad-based action	• The FPIM programme will work with DHBs to determine how best to empower employees under the new system and policy settings • This will include (e.g.) recognition/rewards, feedback, making changes in job descriptions to reflect new realities, identifying key change makers and supporting them

[50] See John P. Kotter, *Leading Change* (Harvard Business School Press: Boston, MA, 1996), and John P. Kotter & Dan S. Cohen, *The heart of change: real-life stories of how people change their organisations* (Harvard Business School Press: Boston, MA, 2002).

Kotter's eight steps	How they will be applied
	• The FPIM programme will provide a means to share individual DHB good practice with the other DHBs
6. Create short term wins	• The FPIM programme will have a standard set of short-term wins that a DHB can achieve from the new systems; these will be based on lessons learned and experience from wave one • Each DHB will take this list and develop its own approach to achieving short term wins in its own organisation • These short-term wins will be clear gains that will enable buy-in • The FPIM programme will collect learnings regarding short term wins and share these with the other DHBs
7. Don't let up	• The FPIM programme will provide a means to share individual DHB good practice with the other DHBs so that DHBs can work together to consolidate existing change and generate more change achieving benefits • The FPIM programme will continue to share learnings after a DHB has gone live, as new lessons are learned from new DHBs taking up FPIM
8. Make change stick	• DHBs will build the changes into new employee induction • Benefits realisation will include continued communication and support of policy and process changes

9.12 Stakeholder engagement and communications

The programme will be collaborative, with the focus on specific stakeholders shifting as different projects and "waves of DHBs" progress under the programme schedule.

9.12.1 Overall approach

The overall approach will aim to keep all stakeholders informed on progress and opportunities to engage in the programme. The table below shows how we will engage with and communicate with stakeholders.

Table 53 Stakeholder communications

Activity Channel Frequency	Stakeholders										
	Health sector						Other government agencies			Vendors	
	Ministry of Health	DHBs				PHARMAC	Treasury	MBIE	GCDO	Oracle	Revera
		Chairs	CEs	CFOs	CIOs						
Representation on programme and Programme governance groups	■	■	■	■	■	■					
Programme updates: monthly via email	■	■	■	■	■	■	■	■	■	■	■
DHB Chair and C-suite forums: monthly and quarterly meetings		■	■	■	■						
NZHP six-weekly sector wide updates via email		■	■	■	■	■					
NZHP post-Board meeting communications: six-weekly emails	■	■	■								
NZHP quarterly report and accompanying DHB Board ready cover paper		■	■	■	■						
Individual face-to-face meetings, telephone calls and emails, as required (structured Government Relations Plan)	■	■	■	■	■	■	■	■	■	■	■

9.12.2 Targeted approach

As the programme moves through different stages it will focus on different clusters of DHBs. Governance representation will adjust as the focus moves from building national technology, through to the different implementation waves. The emphasis of the communication and engagement will adjust accordingly with targeted communication more focussed on the 10-high-risk

DHBs initially, while the emphasis for the other 10 will be on the work to look at the interfaced catalogue.

Table 54 Approach through different phases

Tranche	Stakeholder Group	Approach
1. Risk mitigation: infrastructure build and migration of high-risk DHBs onto platform	The 10 high-risk DHBs: Auckland Bay of Plenty Canterbury Counties Manukau Northland Southern Taranaki Waikato Waitemata West Coast	Engagement and communications through representation on Governing and Programme Boards, Implementation Steering Committee processes. Separate stakeholder engagement and communications plans will be developed for DHB waves and other individual projects in the programme. The Change Management Plan will include targeted communication for relevant DHB finance, procurement and supply chain teams. The programme team will also work alongside DHBs comms teams and assist them to develop complementary local stakeholder engagement and communication plans.
2. Interfaced catalogue	The 10 lower-risk DHBs: Capital & Coast Hawkes Bay Hauora Tairawhiti Hutt Valley Lakes Marlborough MidCentral Nelson South Canterbury Wairarapa Whanganui	Depending on how this option progresses may include all engagement and communication elements for high risk DHBs (above).

21

9.12.3 Risks and mitigation

The stakeholder engagement risks and their mitigations are summarised in the following table.

Table 55 Risks and mitigations

Risk	Description	Mitigation
Irreconcilable stakeholder views on optimal pathway	Lower risk DHBs may prefer the interfaced catalogue option but other stakeholders may not be satisfied it will deliver sufficient national benefits in a reasonable time horizon.	• Aim to get stakeholder agreement on the decision-making criteria up front prior to conducting the work • Ensure analysis is robust and clearly lays out trade-offs • Actively work to achieve stakeholder consensus • If consensus cannot be achieved, be transparent about basis for

Risk	Description	Mitigation
		recommendation
Stakeholder support is lost through delays in implementing the business case	The business case is expected to recommend a staggered approach to implementation with the timeframe for "a wave of DHBs" dependent on successfully completing a previous wave. A delay in one wave could adversely affect stakeholder support for DHBs in subsequent waves.	• Apply best practice programme governance and strict project management discipline • Clear open and early communication about any risks of delays and actively work with DHBs to adjust plans as needed.

9.13 Operational support model

We have defined an operating model for the ongoing operation of FPIM that addresses governance, services, users, systems & services management

9.13.1 Introduction

Once a DHB has moved to using FPIM, it will need to be supported on a business as usual basis. This section outlines how business as usual operation will occur.

This section describes the proposed operating model to support FPIM and the national shared catalogue infrastructure.

9.13.2 Overall approach to support

This business recommends a centralised model for the support of the common systems that this business case proposes. This centralised approach has been taken for the following reasons.

Scenarios that rely on one DHB to own and support a system and provide services to other DHBs have not worked well in the sector. Typically, the requirements of the DHB owning and operating the system have taken priority over the requirements of the other DHBs. These other DHBs have therefore not been able to rely upon the "neutral" provision of service.

The shared support models that have worked best are those where a single organisation at arm's length from the DHBs involved has been able to provide a service that does not favour one DHB over another. healthAlliance is an example of this kind of organisation.

The operation of Option 3 will require an organisation that is can represent all 10 DHBs who will be using the system, without favouring one DHB or one group of DHBs. The implementation of a national catalogue and national benefits realisation will require am organisation that can represent the interests of all 20 DHBs. This latter case will require a truly national organisation representing all DHBs.

This business case therefore proposes that a national organisation representing the interests of all DHBs, and not favouring on DHB or group of DHBs over others, will deliver the support. The working assumption for this business case is that this organisation will be NZ Health Partnerships.

NZ Health Partnerships will be responsible for the operation of the core finance, procurement, and supply chain system. This will include:

- The management of all contracts for the operation of the finance, procurement, and supply chain system
- Management to agreed service level agreements with all users
- The facilitation of the governance of the service
- The facilitation of the strategy and future direction of the systems and service
- Data management and analysis
- Support of benefits realisation (see next section)
- The management of third parties, e.g. Oracle
- The operation of the Oracle Administration Team (OAT).

9.13.3 Systems and service management

The Oracle Administration Team (OAT) will be key to the successful operation of the FPIM service to the 10 DHBs, and to the successful operation of a national shared catalogue that all DHBs use.

The OAT will manage the business as usual operation of FPIM and the delivery of its services. It will be a shared service provider of the FPIM technology to the sector. It will perform the following key functions:

- Facilitate development and approval of FPIM Strategy and FPIM Annual Plan
- Deliver the Strategic and Annual Plan for FPIM in partnership with DHBs
- Advise, review and report on delivery of the strategic and annual plan to the Joint Design Authority
- Advise, review and report on adherence to FPIM Principles to the Joint Design Authority
- Maintain the integrity and quality of the FPIM
- Maintain the National Catalogue to the standard required to enable benefits realisation
- Operate the processes that protect the integrity of the FPIM
- Commission new projects that deliver new functionality
- Manage and resolve break/fix issues within agreed service levels
- Approve and prioritise minor enhancements within the funded budget envelope
- Review major enhancements and projects and provide recommendations to the Advisory Groups and the FPIM Authority
- Manage release of changes into the various environments.

The first line of support for users will come from DHB's own support arrangements. This may be DHB staff or contracted staff or organisations. If the local support cannot resolve issues or meet the service request, this will be passed to the OAT.

Note that the OAT is currently being established to support the Wave DHBs using FPIM. It will be extended to support all 10 DHBs as Option 3 is implemented.

9.13.4 Resourcing

The resource requirements for the OAT are summarised in the following table. (These have been costed in this business case.)

Table 56 Oracle Administration Team resourcing

Role	Activities	Resourcing
MANAGEMENT		
Oracle Administration Team Manager	Direct and manage the OAT, lead engagement with sector	1.0
Administration	Provide administrative support for OAT	1.0
BUSINESS AS USUAL		
Systems Administration and Error Management	Manage workflow, user security and access, alerts monitoring	2.0

Role	Activities	Resourcing
Finance and Supply Chain Functional Support	Functional support, training, master data maintenance, BAU and minor projects	6.0
Reporting	Standards framework, shared reports development, SQL scripts	1.0
Integration and Minor developments	SOA support, scanner support, interface support, EDI support, FPIM customisations support, minor developments	2.0
Release Management	Manage master data and control framework, Oracle service request management, manage application and database patch requirements and functional impact, coordinate DR and incident resolution	1.0
Relationship Management	Manage DHB relations, manage service provider relations	1.0
SOLUTION INTEGRITY		
Common Services Management	Manage common services framework, resource testing, Quality Assurance	3.0
Management and Administration	Manage alliance agreement, manage FPIM administration services	1.0
PROJECTS		
Project Resources (depending on project)	For example: new suppliers, new interfaces, new functionality and/or modules, upgrades	2.0
TOTAL		**21**

The OAT will use outsourced Technology services to ensure that it can provide the necessary after-hours coverage and retain the deep expertise needed to provide 365 x 24 hours support to users of FPIM.

9.13.5 Governance

The OAT is the core of the ongoing operating model for FPIM. When the programme is underway it will report to the SRO and Services Board. How this structure will transition to business as usual governance is summarised in the diagram on the following page.

As can be seen:

1. The OAT continues to report directly to the SRO, also part of NZ Health Partnerships.
2. The FPIM Programme Board transitions to becoming a Services Board.
3. The Joint Design Council transitions to becoming an Operating Steering Committee. It continues to receive advice from the advisory groups.

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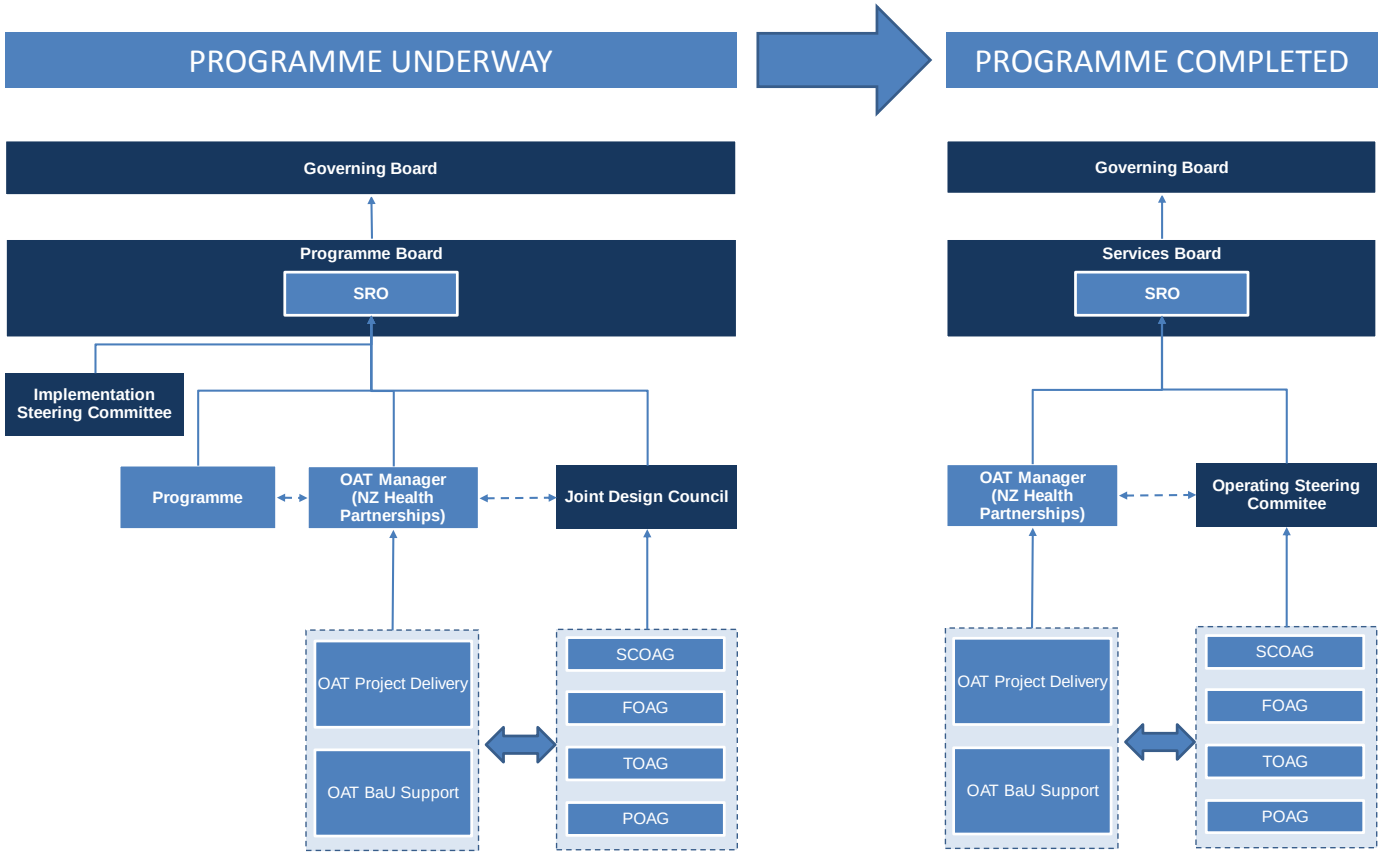

1. Programme completes, implementation steering committee shutdown
2. Programme board -> Services board
3. Joint design council -> Operating steering committee

Figure 38 Operating model governance transition

The governance bodies are described in the following table.

Table 57 Governance bodies and roles

Group / Person	Role	Membership
Governing Board	• Investment decision, defining direction and ensuring overall alignment of programme to organisation strategies. • Decision makers for material changes outside of the agreed business as usual parameters. • Not involved any day to day business activities.	• DG Health (chair) • Chair PHARMAC • A DHB chair • Chair NZ Health Partnerships • External IT governance expert
Services Board	• Sets strategic direction for finance, procurement, supply chain systems and services • Overseas achieving the benefits from investment • Decision makers for escalations that fit within agreed boundaries	• CE NZ Health Partnerships (chair) • Deputy Director General: Data and Digital – Ministry • CE PHARMAC • Treasury representative • DHB CEs • Independent IT/Programme advisor
Operating Steering Committee	• Responsible to ensure that systems and services meet service level agreement agreements • Responsible to ensure that the on-going solution design meets National requirements • Responsible to ensure the design for the systems and service conforms • Reviews/approves/declines any change requests to the central design	• SRO NZ Health Partnerships (chair) • DHB CFOs – reflects current implementation waves • CIO representation • External expert advisors as required
OAT Manager	• Facilitate development and approval of FPIM Strategy and FPIM Annual Plan • Deliver the Strategic and Annual Plan for FPIM in partnership with DHBs • Responsible for DHB operational support services and master data, to agreed SLAs • Reports to the SRO	• Appropriate expertise

9.14 Benefits realisation

Benefits realisation will be governed by the benefits realisation governance body who will direct NZ Health Partnerships to monitor and manage the benefits – this will scale from the initial DHBs participating in the single Oracle FPIM instance through to the implementation of a national shared catalogue

9.14.1 Introduction

Once FPIM is implemented, the benefits contemplated in this business case will need to be realised. This will require an ongoing management and governance regime.

This section describes how the post-implementation realisation of benefits will occur. It describes:

- The overall benefits map describing how the preferred solution will drive the benefits
- The approach to managing and governing the benefits
- The individual benefits and potential measures
- How implementation will occur.

9.14.2 Benefits governance and management

The following diagram shows how the benefits management will operate. The solution components need to be managed to achieve the benefits.

1. The Programme Board / Services Board will oversee the governance and management of the benefits. This group will include senior representation from the Ministry of Health, NZ Health Partnerships National Procurement, and PHARMAC, a key partner in ensuring that the benefits are realised. The Programme Board / Services Board will operate closely with the NZ Health Partnerships Board.
2. The Programme Board / Services Board will be accountable to the Chief Executives of the DHBs represented in the preferred solution and will formally report every quarter. The Board will consult with the represented DHBs on its proposed initiatives and benefits management.
3. The Programme Board / Services Board will be supported by advisory committees consisting of DHB representatives with the requisite expertise. It is expected that there will be advisory committees for data standards, procurement, supply chain, and finance. These advisory committees will support the Board on key design and policy issues.
4. NZ Health Partnerships will be the key organisation to monitor and manage benefits under direction from the Programme Board / Services Board. The key parts of NZ Health Partnerships that will contribute are:
    - National procurement
    - Data governance
    - Data management and analysis
    - Oracle Administration Team.
5. NZ Health Partnerships will gather and analyse key diagnostic data via the data management and analysis team, supported by the OAT. It will produce the key KPI reports and dashboards for the Programme Board / Services Board. It is expected that reporting will occur quarterly. NZ Health Partnerships will also advise the Board of issues relating to benefits management and how these could be resolved.

6. The Programme Board / Services Board will consider the reports from NZ Health Partnerships in conjunction with the advisory committees. It will then direct NZ Health Partnerships to act – applying feedback and control. NZ Health Partnerships will manage the national catalogue, data standards, consolidated reporting database, and compliance regime on the direction of the Board.
7. If major initiatives are required, the Programme Board / Services Board will commission projects. If these projects cannot be undertaken under NZ Health Partnerships business-as-usual arrangements, additional funding will be sought from DHBs or other sources.
8. These projects will be managed under formal governance reporting to the Programme Board / Services Board.

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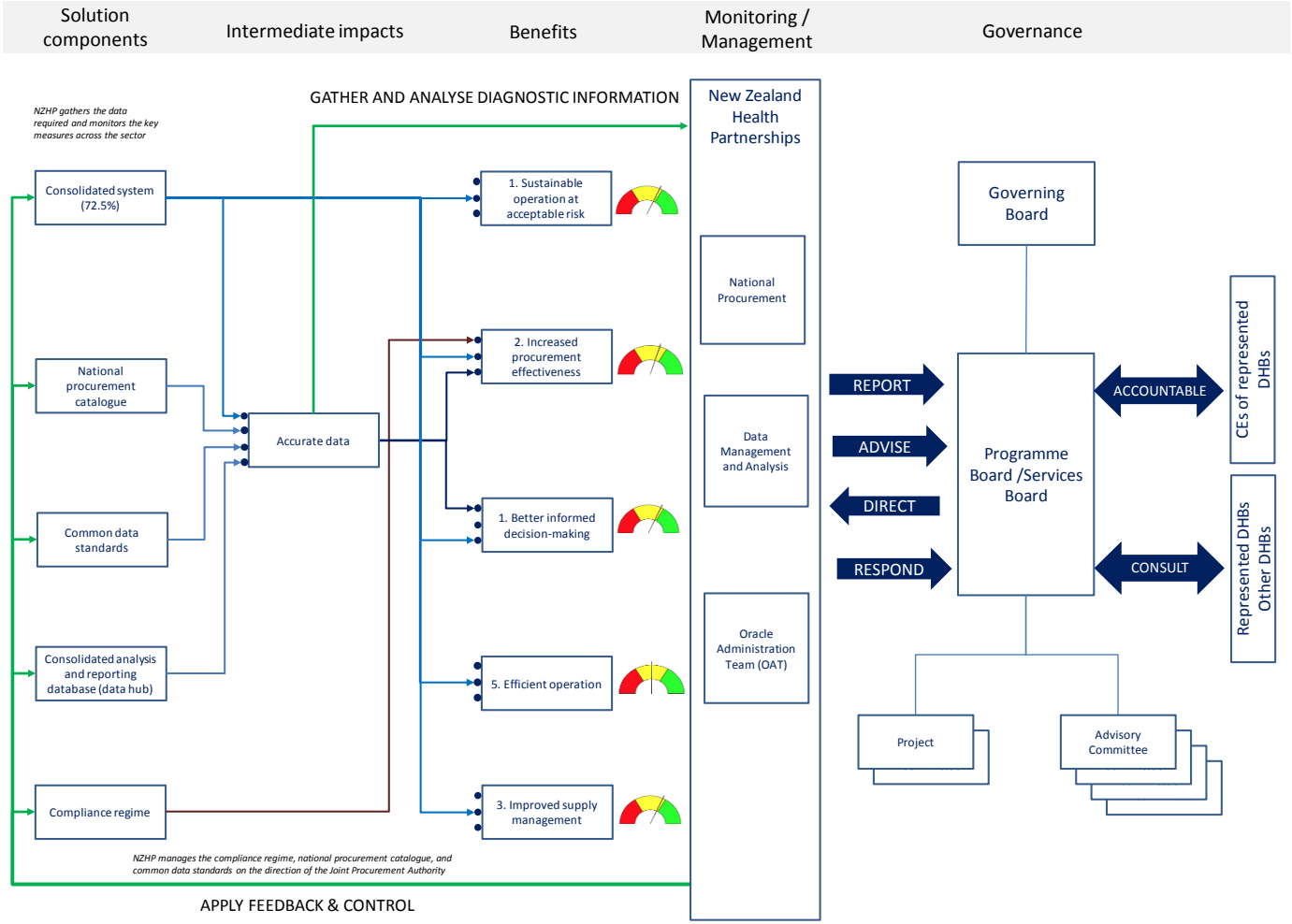

Figure 39 Benefits realisation for preferred option

9.14.3 Resourcing for monitoring/management

In addition to the Oracle Administration Team, there will be national procurement and data management and analysis staff to effect the Programme Board / Services Board's direction. The proposed resourcing is summarised in the following table. (This has been costed in this business case.)

Table 58 Resourcing for monitoring and managing benefits

Role	Activities	Resourcing
National procurement	Monitor the effectiveness and value of procurement across DHBs Develop and manage improvement plans for procurement related benefits	2.0
Data management & analysis	Manage the common data standards across all DHBs Monitor the quality of data Monitor the usage of the national catalogue and off-catalogue expenditure Undertake analysis and reporting as required to support realising benefits	3.0

9.14.4 Benefits

The key individual benefits and how they will be managed are summarised in the following table. Please note that these are provisional only. A refined set of KPIs will be developed as part of the implementation.

Table 59 Provisional benefits and measures

Benefit Area 1: Sustainable operation at acceptable risk	
Investment Objective	**1: Sustainable operation at acceptable risk**
Benefit Description	Reduced risk and increased flexibility
Candidate measures	• Number of IT related risks on corporate risk registers at medium or above for each participating DHB • Number of systems and platforms no longer eligible for premium support from suppliers • Time to recover systems from primary systems failure • Availability of systems
KPI 1.1	***Delivery risk profile***
KPI Description	The level of outstanding sustainability issues
Measure	In the annual audit, the level of future proofing / sustainability related issues identified as "high" or above priority. This will include all issues regarding end-of-life technology components, ability to implement change in a timely manner, staff capability, and process documentation.
Baseline Value & Source	Baseline not established

Target Value	0 issues
Target Timeframe	0 by 2022 for all DHBs having risks addressed through preferred option.
KPI Responsibility	NZ Health Partnerships is responsible for gathering data. Participating DHBs are individually responsible for achieving the benefit. Programme Board / Services Board oversees the achievement of the benefits across all DHBs.
KPI Reporting & Frequency	Annual
Source Data	DHB corporate risk registers

Benefit Area 2: Procurement value	
Investment Objective	**2: Increased procurement effectiveness**
Benefit Description	Increased procurement value for national contracted good and services as achieved by participating DHBs
Candidate measures	• Standard cost tracking against items to determine the purchase price variance • Comparison of the forecast volume and volume related costs versus the actual • Reduction in average age of stock • Reductions in write-offs of stock • Reductions in working capital • Reductions in freight cost per item • Improved national catalogue utilisation and reduced off-catalogue spending • Reduced duplication of catalogue items • Reduced average category costs • Reduced on-cost for an inventory item or delivery of an ordered item to where it is required • Reduction in purchase order discrepancies • Reduction in cost to process procurement document
KPI 2.1	***Reduction of purchase price from standard cost.***
KPI Description	Average measured reduction of product cost against pre-negotiation price, including supplier rebates. *NOTE: This KPI relies upon all DHBs purchasing medical devices against the national catalogue and achieving the level of compliance required.*
Measure	% average reduction of actual product cost.
Baseline Value & Source	2% [PHARMAC]
Target Value	7% Max [PHARMAC target] *NOTE: Target assumes that all DHBs can achieve level of compliance required by PHARMAC. Will need to be reduced if all DHBs cannot move to compliant use of national catalogue for medical devices.*
Target Timeframe	Target value from 2022
KPI Responsibility	PHARMAC is responsible for negotiating contracts for medical devices (approximately $640 million pa).

	NZ Health Partnerships is responsible for negotiating national contracts for other goods and services under direction of Programme Board / Services Board. Programme Board / Services Board owns benefit.
KPI Reporting & Frequency	Monthly
Source Data	National data hub [NZ Health Partnerships] (as upgraded by implementation of national shared catalogue)

Benefit Area 3: Data quality	
Investment Objective	**3: Better informed decision-making**
Benefit Description	Improved data quality supports better informed decision-making
Candidate measures	• Increase in proportion of data fields that can be matched across participating DHBs against the national procurement catalogue • Increase of proportion of national procurement spend that can be mapped to a product category • Reduced missing key data fields in core data tables
KPI 3.1	***National procurement spending mapped***
KPI Description	Proportion of national procurement spending that can be matched to a defined product category.
Measure	% of procurement transactions that can be completely successfully matched to a category with no data errors.
Baseline Value & Source	25% [NZ Health Partnerships]
Target Value	99%
Target Timeframe	99% from 2022
KPI Responsibility	NZ Health Partnerships gathers data and reports. Programme Board / Services Board owns benefit.
KPI Reporting & Frequency	Monthly
Source Data	National data hub [NZ Health Partnerships] (as upgraded by implementation of national shared catalogue)

Benefit Area 4: Efficient operation	
Investment Objective	**4: Efficient operation**
Benefit Description	Increased efficiency of Finance, Procurement, and Supply Chain
Candidate measures	• Reduced on-cost for an inventory item or delivery of an ordered item to where it is required for participating DHBs
KPI 4.1	***Inventory item on-cost***
KPI Description	Average additional cost per item to receive goods (including freight cost) and deliver to place of usage.
Measure	On-cost per category of for each DHB.
Baseline Value & Source	TBD

Target Value	TBD by DHB.
Target Timeframe	TBD
KPI Responsibility	NZ Health Partnerships is responsible for gathering data. DHBs are individually responsible for achieving the benefit. Programme Board / Services Board oversees the achievement of the benefits across all DHBs.
KPI Reporting & Frequency	Annual
Source Data	National data hub [NZ Health Partnerships] (as upgraded by implementation of national shared catalogue) Calculated after allocation of overhead by each DHB.
KPI 4.2	***Procurement-to-payment transaction cost***
KPI Description	Average labour processing cost for procurement transactions from order through receipt through payment.
Measure	Average cost per procurement-to-payment transaction for participating DHBs
Baseline Value & Source	TBD
Target Value	< $5 across participating DHBs [TBC]
Target Timeframe	2023
KPI Responsibility	NZ Health Partnerships is responsible for gathering data. Participating DHBs are individually responsible for achieving the benefit. Programme Board / Services Board oversees the achievement of the benefits across all DHBs.
KPI Reporting & Frequency	Annual
Source Data	National data hub [NZ Health Partnerships]. Calculated after allocation of overhead by each DHB.

Benefit Area 5: Supply management	
Investment Objective	**5: Improved supply management**
Benefit Description	Reduced supply risk through improved product tracking and supply chain risk management for participating DHBs
Candidate measures	• Increased proportion of medical device information stored against clinical systems (sourced from Finance, Procurement, Supply Chain systems) • Reduced time to identify patients who have received a specific product across all DHBs (relies upon clinical systems scanned data sourced from Finance, Procurement, Supply Chain systems) • Reduced time to identify alternate supplies of products or services in the case of a supplier failure
KPI 5.1	***Tracked medical devices***
KPI Description	The overall proportion of medical devices purchased by DHBs that includes cross-reference data to usage against an event or person. This enables recalls to be managed, thereby reducing clinical risk.

Measure	% of medical devices requiring tracking cross-referenced to event and/or person.
Baseline Value & Source	10% [based on baseline estimate from Wave One FPIM]
Target Value	99%
Target Timeframe	99% from 2022
KPI Responsibility	NZ Health Partnerships is responsible for gathering data. DHBs are individually responsible for achieving the benefit. Programme Board / Services Board oversees the achievement of the benefits across all DHBs.
KPI Reporting & Frequency	Monthly
Source Data	National data hub [NZ Health Partnerships].
KPI 5.2	***Supply chain visibility***
KPI Description	The overall proportion of national contracted medical devices that can be matched for each participating DHB.
Measure	% of medical devices matched to national catalogue
Baseline Value & Source	10% [based on baseline estimate from Wave One FPIM]
Target Value	99%
Target Timeframe	99% from 2022
KPI Responsibility	NZ Health Partnerships is responsible for gathering data. DHBs are individually responsible for achieving the benefit. Programme Board / Services Board oversees the achievement of the benefits across all DHBs.
KPI Reporting & Frequency	Monthly
Source Data	National data hub [NZ Health Partnerships].

21

9.14.5 Implementation

The following diagram summarises how implementation will occur.

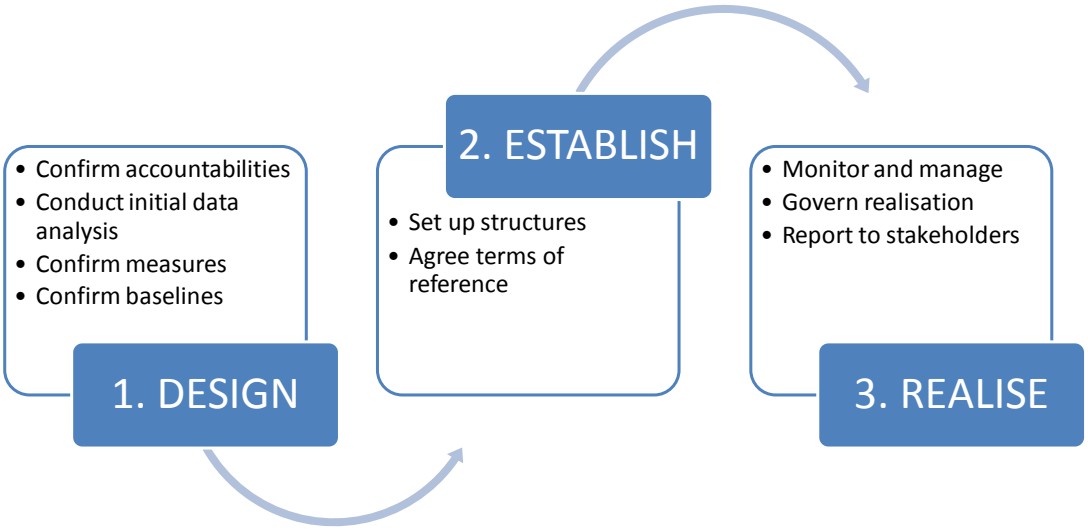

Figure 40 Benefits realisation implementation

While the programme is still operating, accountabilities will be confirmed, initial data analysis will be conducted to refine the potential measures, and a final set of measures will be confirmed.

At the end of the programme the benefits realisation regime will be established. This will include setting up the structures, processes, and policies required. The terms of reference for the Benefits Realisation management accountabilities of the Programme Board / Services Board will be agreed.

Once the benefits realisation regime is established it will then operate on a quarterly reporting basis.

9.15 Quality assurance

Comprehensive Quality Assurance processes have been incorporated into the programme plan and processes

9.15.1 Overview

Quality assurance will be managed in accordance with the assurance plan. The overarching objective of the assurance plan is to provide the Senior Responsible Owner (SRO), Programme Board, Governing Board, the NZ Health Partnerships Board, and key stakeholders, with the confidence that the FPIM programme is well managed and will deliver the agreed outcomes, to specification, to time and within budget.

The FPIM programme will adopt an integrated assurance approach as follows:

- Day-to-day project management processes and controls based on the PRINCE2 methodology consistently applied, including quality control of project deliverables
- Internal governance and oversight, including clear and signed off terms of reference for all governance groups:
    - Governing Board
    - Programme Board
    - Services Board
    - Implementation Steering Committee
- External review, including:
    - Treasury Gateway reviews — at least three
    - At least five independent quality assurance reviews, including:
        - Programme health checks
        - Functional review
        - Technical reviews, as required.

9.15.2 Plan on a Page

The table below outlines the high-level plan for assurance activities.

Table 60 Quality assurance plan plan-on-a-page

Assurance Activity	Purpose	Audience
Bi-monthly programme risk reviews.	Review and update programme level risks. This includes adding new risks, reviewing status of existing risks and recalibrating, noting that some risks may have become issues.	Programme Director, implementation steering committee (ISC)Programme Board (PB), SRO, NZ Health Partnerships ELT, Governing Board, NZ Health Partnerships Board
Weekly project risk reviews.	Review and update the risks associated with the programme's subprojects. Consider if any project risks need to be treated at a programme level.	Project Managers, Programme Director, SRO and Joint Design Council (JDC)

Assurance Activity	Purpose	Audience
Programme monthly Status reports.	Report on the programme's status, in particular with respect to budget, timeline and risks.	ISC, Governing Board, and NZ Health Partnerships Board.
Project weekly highlight reports.	Report on each project's status, including, budget, timeline, issues, risks, scope change requests.	Project Managers, Programme Director, programme management office (PMO), and SRO.
Bi-Weekly JDC meetings	Primary governance group that will consider any change requests relating to FPIM and to provide expert advice on scope change requests and design. Included in the JDC is an external technical expert advisor who provides a level of on-going independent quality review for the JDC.	Programme Director, NPB, SRO, Governing Board.
Bi-weekly PB meetings	Provide the necessary governance and support the SRO's decisions, to enable the programme to deliver outcomes aligned to programme goals and objectives. Provide advice, guidance, recommendations, and support, to ensure programme success Ensure appropriate sector and business owner input, ownership and alignment, particularly in relation to programme delivery.	JDC joint chairs, Programme Director, SRO, ISC, Governing Board.
Monthly Governing Board meetings	Engage the FPIM Executive Sponsoring Group (20 x DHBs) to gain a common or collective view, drive associated business change and to gain the commitment required to ensure programme success. Provide executive level governance of programme scope (time, cost, outcomes). Remove obstacles to programme delivery, support the SRO and ensure the programme is appropriately supported. Assist in managing and mitigating significant programme issues and risks.	ISC, SRO, Programme Board, NZ Health Partnerships Board.

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Assurance Activity	Purpose	Audience
Monthly Implementation Steering Committee Meetings	Responsible to ensure that each tranche operates with the framework provided by the PB Drives the tranche forward to ensure it delivers the agreed outcomes and benefits Approve Tranche gates prior to PB approval Decision makers for escalations and change requests that fit within the tranches agreed boundaries	SRO, PB, Governing Board, NZ Health Partnerships Board.
Monthly ELT review.	Review issues and risks and how the NZ Health Partnerships ELT can work together to address these.	NZ Health Partnerships CE, SRO, Programme Director and NZ Health Partnerships ELT.
Independent Quality Assurance (IQA) reviews	A review which is independent from the programme. Assurance will enable informed decision-making and provide transparency. It will sharpen focus on the pivotal characteristics that drive success for the programme. Provide an evidence-based assessment, unencumbered by internal politics or influences	Programme Director, SRO, Programme Board, ISC, Governing Board, NZ Health Partnerships Board.
Treasury Gateway Reviews	At specific milestones, provides assurance that the programme can move to the next stage. The gateway reviews will add a second level of assurance, increase confidence in aligning the programme with Government strategic objectives, and increases confidence in delivery of the required programme to time and budget.	Programme Director, SRO, Programme Board, ISC, Governing Board, NZ Health Partnerships Board.
Technical Quality Assurance (TQA)	Provide independent technical assurance that the FPIM Technology Solution (NTS) is fit for purpose.	Programme Director, JDC, ISC, SRO, Programme Board, Governing Board.

21

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APPENDIX A: Draft Investment Logic Map

The following diagram shows the draft Investment Logic Map (ILM) that was used to inform the Strategic Case.

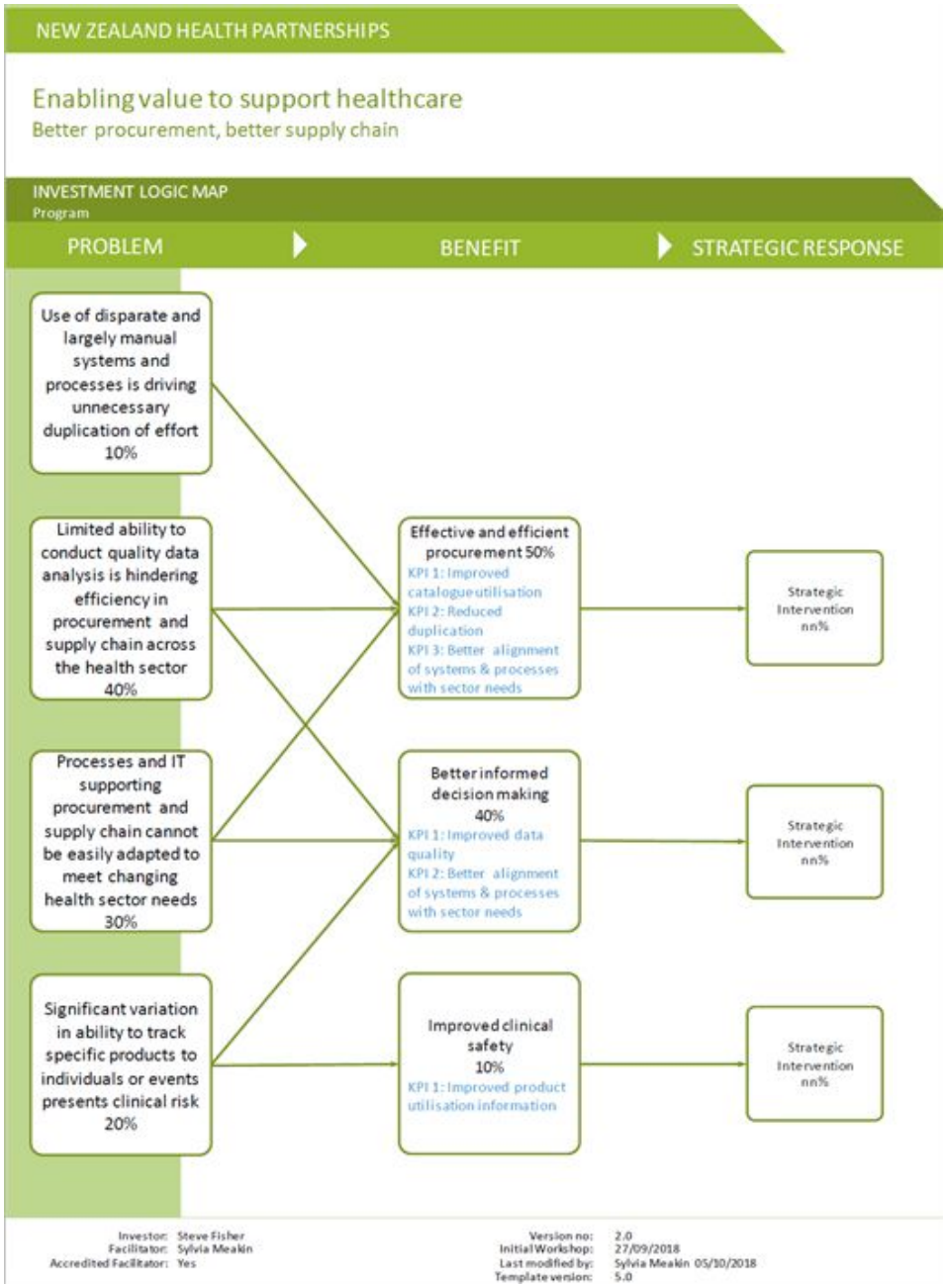

Figure 41 Draft Investment Logic Map diagram

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APPENDIX B: Lessons learned and how addressed

This appendix shows how the lessons learned report findings have been applied in this business case

An independent consultant conducted interviews with key stakeholders involved in the implementation of Wave One and compiled a lessons learned report. This appendix provides a summary of the key points responding to the lessons learned with a cross-reference of how they relate to the lessons learned report. A fuller report is available if required that reconciles the responses to the lessons learned report.

Table 61 Summary of responses to lessons learned

Area	
Central programme team	The overall Programme Director role will be separate from DHBs and separate from individual DHB implementation teams. Central FPIM programme management will be outsourced to ensure expertise available as well as providing a measure of risk sharing. The central implementation team will focus on ensuring the needs of all DHBs will be met as transitions occur. Its focus will be on ensuring that business outcomes are met, not purely on completing a technology transition. This will include such things as ensuring documentation is completed when it is needed and that all required knowledge transfer takes place. It will work closely with the DHB teams, enabling them to fulfil their accountabilities. The central team will include the necessary sector expertise. Staff will be seconded from the sector to support the core team where required.
DHB implementation teams	DHB resources have been estimated based on feedback from Wave One implementation and estimates for Northern DHBs and Southern DHB carried out as part of the development of the Risk Mitigation Business Case. DHB projects will be planned in conjunction with the central programme to ensure that all lessons learned are applied. This will include an early focus on data cleansing and mapping. The central programme team will help ensure that each DHB has the level of resource and expertise it needs and that these staff receive early guidance and training.
Programme management	Formal programme and project management and governance will be strengthened. Clear differentiations will be made between programme accountabilities and project responsibilities. • Steering committee will have ownership of outcomes and clear delegated authority from sector • SRO will have clear delegated authority from DHBs Steering Committee to direct teams to achieve outcomes required • The management of risk, issues, escalations, and communications will be clearly defined • Supporting committees will meet remotely and face to face on regular basis • The required reporting will be formally defined and adhered to

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Area	
	• PHARMAC will be included in the governance structures as a key stakeholder • There will be a governance secretariat to ensure that administration works smoothly and effectively • Programme and project management standards will be defined and adhered to • There will be integrated planning and management across multiple projects • There will be transparent change control
Communications	There will be regular communications to wider DHB community on what is happening and how it affects them.
Preparation for DHBs	DHBs will be provided with early advice: • Helping DHBs to understand early how the new systems will look • Ensuring standard approaches are in place for DHBs to transition (including Extract, Transform, Load – ETL) • Ensuring that DHB prerequisites are clear (e.g. implementing chart of accounts, DFAs) • Ensuring that DHBs have the necessary infrastructure to support the transition • Ensuring that DHBs have early direction on what they will need to do, especially on data cleansing and mapping • Ensuring that DHBs have an early project plan in place supporting what needs to be done with the time required
Change management	The central programme team will include change management and communications support for DHB project teams. This will help ensure that central team has wider understanding of what the DHBs require. It will also ensure that DHBs have the support they require to fulfil their own accountabilities so that their needs in the transition are met. DHBs will be supported through the change process. Each DHB project team will include a change manager.
Ongoing operation and support	The central support team (Oracle Administration Team – OAT) will be separate from the programme team. After each DHB is implemented and ended post-implementation support, it will be handed over to OAT. Staffing will be managed between the programme team and the OAT to ensure that sufficient post-implementation support is available. OAT will be managed according to clear service level arrangements.
Catalogue management	Ongoing governance will be in place to manage against the common good of all DHBs and the specific needs of each DHB. The procurement catalogue will be centrally managed (i.e. separate from the DHBs, albeit with staff located within DHBs) with clear procedures and service levels on how it is updated. Management of the catalogue will be resourced to ensure that post-go live data changes can be handled in a timely manner. PHARMAC and the Ministry will be integrated into the data management and control processes.
Benefits realisation	There will be a formal benefits realisation plan to ensure that ongoing benefits are gained once the programme has completed. Note that this will include the monitoring and management of all contemplated benefits, not only the procurement benefits. PHARMAC will be included in the benefits oversight.

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Area	
Completion of outstanding issues	The core work required to complete Wave One and prepare the current configuration for rollout to all DHBs will be completed before Wave Two starts. This will include: • Completing all required documentation • Reviewing current design to ensure fit for purpose for remaining DHBs • Ensuring reporting solutions are in place • Ensuring that the national infrastructure is configured to support the environments needed for the transition of the DHBs
QA	Quality management will be defined in the assurance plan.

21

APPENDIX C: Comparison of options 2 and 3

Introduction

A key part of this business case is the choosing of Option 3 Single systems for 10 DHBs over Option 2 Clustered risk mitigation. This appendix provides a more detailed comparison of these options.

Estimated monetary benefits

The following table assess the options against the ability to realise the potential monetary and non-monetary benefits identified in the case for change. Given that the primary benefit drivers for this proposal is risk mitigation, there are few monetary benefits but a significant number of non-monetary benefits.

Table 62 Assessment of options against potential monetary benefits

Monetary Benefits Realised	Option 2 Clustered risk mitigation	Option 3 Single system for 10 DHBs
$2m pa of operational savings for healthAlliance	Yes	Yes

Non-monetary Benefits

The following table assesses the options against potential non-monetary benefits.

Table 63 Assessment of the short list options against the potential non-monetary benefits

Non-monetary Benefits Realised	Option 2 Clustered risk mitigation	Option 3 Single system for 10 DHBs
Mitigation against high likelihood and impact of SPF system outages	Yes	Yes
Stable and supported SPF applications	Yes	Yes
Stable, supported and fit for purpose infrastructure	Yes	Yes
Mitigation against cyber security risks and confidentiality data breaches	Yes	Yes
Operational gains achieved through improved system functionality	Yes	Yes
Potential for secondary procurement savings	Yes	Yes
Technology contingency planned and build underway if the all of sector business case is not successful	Yes	Yes
Mitigate against risk that technical capability and IP are lost	Yes	Yes

Non-monetary Benefits Realised	Option 2 Clustered risk mitigation	Option 3 Single system for 10 DHBs
Public confidence in Health Services maintained	Partial	Yes

Assessment of key risk mitigations for each option

The following table summarises the ability of each option to mitigate current key risks.

Table 64 Risk mitigation assessment for the shortlisted options

Risk	Option 2 Clustered risk mitigation	Option 3 Single system for 10 DHBs
Failure of Infrastructure	Mitigation	Mitigation
Outage in one or more applications operating supply chain, procurement and finance	Mitigation	Mitigation
Loss of technical capability (design, development, training and support)	Mitigation	Mitigation
Opportunity Costs: operational gains which have technology dependencies are prevented	Mitigation	Mitigation

Relative risk assessment of the shortlisted options

A high-level comparison of the relative risks for implementation, and ongoing, for each of the three shortlisted option is detailed below.

Table 65 Relative implementation and ongoing risk comparison for the short-listed options

Risk	Option 2 Clustered risk mitigation	Option 3 Single system for 10 DHBs
Relative Implementation Risks	High	Medium
Relative Ongoing Risks	Medium	Low

Conclusions

The monetary benefits of both options are equal.

The non-monetary benefits of both options are equal.

Both options provide equivalent mitigation for the current risks.

Option 3 Single system for 10 DHBs provides lower ongoing risks and has lower implementation risk.

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APPENDIX D: Development of options

Six key options were developed by stakeholders, including a status quo option – this took place by firstly identifying the possible option dimensions and then picking combinations of the dimensions to select options for analysis

A workshop was held with key stakeholders on 18 October to develop the options to be considered for this business case. A wide set of option dimensions was first developed. Key combinations of these dimensions were then used to develop the options. The options were then further refined after a workshop with DHB Chief Executives on 7 November 2018 and a Steering Committee meeting on 3 December 2018.

Some of the option dimension settings were discarded and so do not form part of the possible options. These dimensions settings and the rationale for not considering them further are summarised as follows:

1. *FPSC system* – "Single system other than Oracle" – rejected as Oracle already covers 84% of the sector by population and effort to replace all with another system is infeasible.
2. *Location* – "Local" – rejected as sector already has level of clustering; no benefit seen in moving back to completely localised infrastructure and systems.
3. *National catalogue* – all options considered.
4. *Master data consistency* – all options considered.
5. *Other standards compliance* – "Low compliance" – rejected as sector has already achieved variable compliance.
6. *Operating governance* – "Independent operation" – rejected as system already operating in clusters.
7. *Operating support* – "Independent" – rejected as hybrid models already in place across sector; no benefit seen in moving back to purely independent operating support.
8. *Transition governance* – "Independent" – rejected as independent and cooperative models already in place across sector; no benefit seen in moving back to purely independent transition model.
9. *Incentives to comply* – "Unequal financial rewards" – not seen as providing the appropriate incentives; "Equal financial rewards" – not seen as realistic given the current nature of government funding.
10. *Speed to benefit* – all options considered.
11. *Benefits management* – "DHB by DHB" – rejected as there is already some clustering in place.

Note that the Platform option dimensions are available for all options. These are further considered as independent options in a subsequent section.

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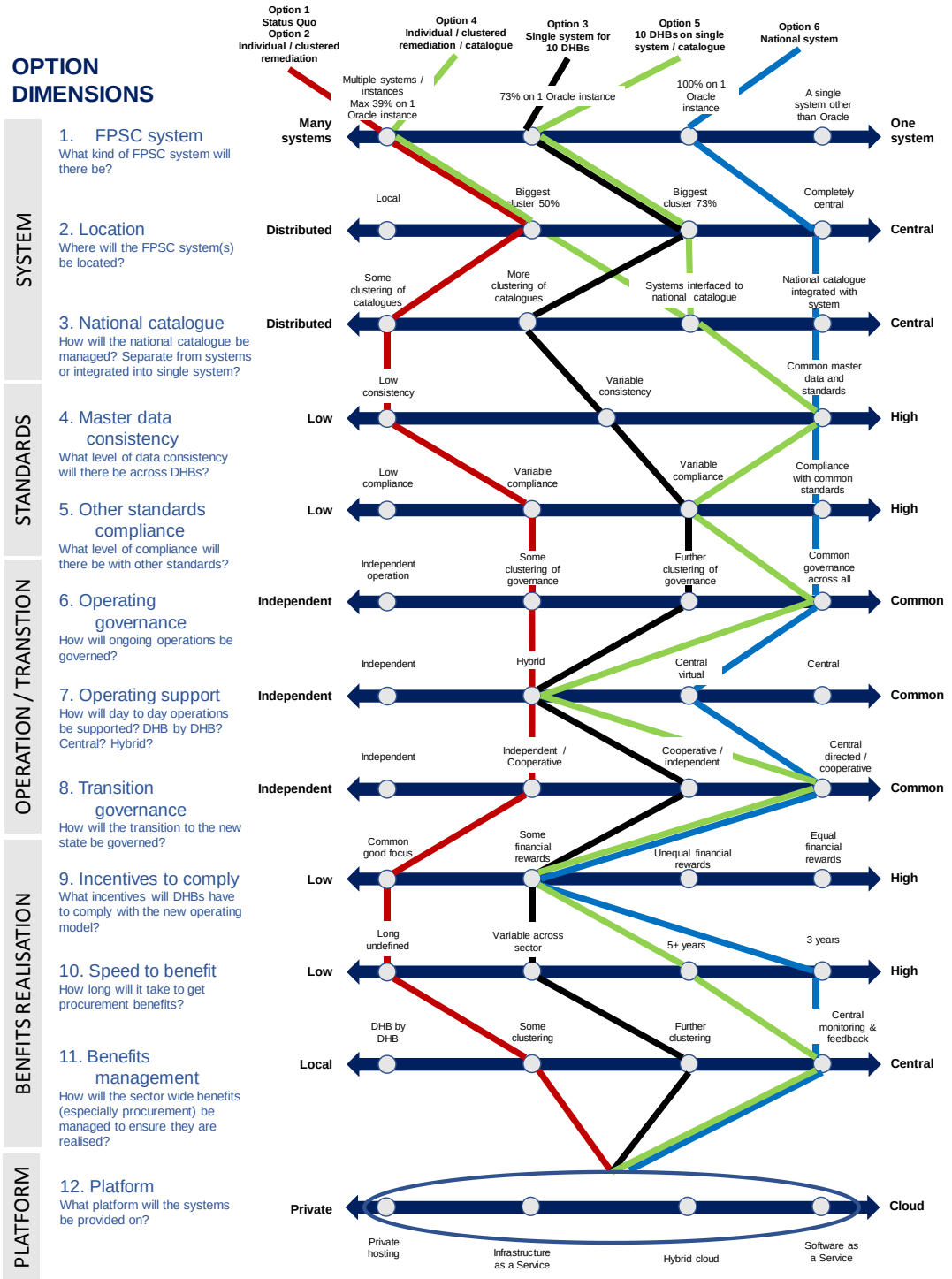

Figure 42 Option dimensions and options

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APPENDIX E: Shared national catalogue high level design project brief

We have developed a draft project brief for the work to undertake the high-level design and refined costing for the shared national catalogue interfaced to DHBs

Background

This project brief outlines the objectives of the high-level design of the shared national catalogue, the deliverables, how the governance will operate, resourcing, the approach to the work, key risks and issues and how they will be managed, the estimated costs for the work, and how it will be funded.

Objectives

The objectives of the shared national catalogue high level design are:

- To develop a high-level design of the shared national catalogue including the catalogue and provision of data, development of data standards, enhanced data repository, procurement compliance
- To identify how the shared catalogue will be developed and operate
- To refine how the national shared catalogue will support the benefits as contemplated by PHARMAC for medical devices
- To update the costs for the development and operation of the national shared catalogue and the financial benefits and timing
- To confirm the governance and benefits realisation
- To update the business case recommendations as required.

Scope

The scope of the shared national catalogue high-level design is summarised in the following table.

Table 66 Scope of high-level design

Area	Included	Excluded
Overall	• High level design for the shared national catalogue including the catalogue and provision of data, development of data standards, enhanced data repository, procurement compliance • How national shared catalogue will be developed and managed • How national shared catalogue will support the medical device benefits as contemplated by PHARMAC • Updated costs for development and operation of national shared catalogue • Updated business case	• Other procurement areas outside medical devices and NZ Health Partnerships identified national procurement

Area	Included	Excluded
	recommendations and next steps	
High level systems design	• How national shared catalogue using largest Oracle cluster on single system will be established using existing FPIM • How systems to distribute catalogue items to DHBs will be built – to Tech One, JDE, Oracle DHBs • How DHB transitional data gathering and reporting infrastructure will be built	• Build / operation of national catalogue hosted on any other systems
Design of operations	• Management of the catalogue (loading, updating, removing, notifications, etc) • Management of the data standards (gaining agreement from DHBs, managing compliance, managing changes) • Managing compliance at DHB level • Reporting, including DHB transactional data mapped to the catalogue • Support, maintenance, change control • Overall governance	
Achieving the benefits	• Central requirements • DHB requirements	
Costs	• Development costs • Central operating costs	• DHB operating costs
Updating business case recommendations	• Updated recommendations and costs for next stage • Next steps	• Full redeveloped business case

Deliverables

The deliverable for this work will be a single report with supporting appendices, alongside the cost and benefit model.

Governance

The project will use the project governance established for the FPIM programme. The project will report through to the SRO and be governed through the programme board. This is illustrated in the following diagram.

Figure 43 Governance

The project lead will provide weekly reports to the SRO and reports for the programme board at their regular meetings.

Approach

The project will develop the next level of detail required to develop and operate a national shared catalogue beyond that already developed in the business case. It will therefore need to take account of:

- How the master catalogue will be configured and managed on the shared Oracle system proposed for use by 10 DHBs. This will include how new items are added, existing items are updated, and how obsolete items are retired. It will also consider use of standards as part of the catalogue (e.g.GS1).
- How the catalogue details will be distributed to the other DHBs. It will therefore need to take account of the updating of catalogue items on Tech One, JD Edwards, and Oracle systems. This will include the technical approaches and how the respective data will be updated.
- How compliance against the medical device contracts negotiated by PHARMAC and National Procurement contracts will be managed at DHB level. This will need to cover how this will occur in the various systems.
- How the reporting will occur, including DHB transactional data to be collected, the mechanisms for collecting this data, mapping to the shared catalogue and how the central reporting repository will operate.
- How the catalogue will operate and be managed.
- How the governance and benefits realisation will operate.

Because of the need to engage with different DHBs operating different systems, a multi-disciplinary working group of DHB staff representing the diversity of DHB situations will be convened. This will cover the expertise required to cover the varying systems and approaches taken in the sector. It will need to cover the varying needs of the DHBs using Tech One, JD Edwards, or Oracle.

A series of workshops will be held to consider the key aspects of the catalogue and its operation. These workshops will include the working group and other key stakeholders in the wider sector. The working group will take the output of each workshop, refine it, and develop the next level of detail to ensure that it will achieve the benefits in a cost-effective manner.

In parallel with the workshops the costing will be updated, and the final report updated and refined.

The diagram on the following page summarises how this will operate.

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Table 67 Approach to national shared catalogue high level design

Streams	Month 1	Month 2	Month 3	Month 4	Month 5
Initiate project	• Recruit project team and working group • Confirm terms of reference • Confirm governance, project framework, roles, and responsibilities				
Overall approach	• Workshop on overall approach to achieving the benefits through a shared catalogue • Outline design, main options, and key issues to resolve	• Ensure overall consistency	• Ensure overall consistency	• Ensure overall consistency	• Ensure overall consistency
Shared catalogue		• Workshop on governance, operation and management of shared catalogue • Working group develops next level of detail on management of shared catalogue	• Document, distribute for feedback / refine		• Finalise
Distribution of catalogue items		• Workshop on distribution of catalogue data, and consolidation transactional data	• Working group develops next level of detail on distribution / consolidation • Document, distribute for feedback / refine		• Finalise
Compliance against national catalogue			• Workshops on managing compliance against national catalogue – one each for Oracle, Tech One, JDE	• Working group develops next level of detail on how compliance will occur • Document, distribute for feedback / refine	• Finalise
Reporting			• Workshop on data gathering and reporting	• Working group develops detail on how data gathering, and reporting will work • Document, distribute for feedback / refine	• Finalise
Governance / benefits realisation	• Define process to agree governance, operating model, and benefits realisation	• Hold governance interviews / workshops	• Develop draft operating model • Refine governance	• Finalise governance, operating model, and benefits realisation	• Finalise
Costing	• Develop cost model based on business case content	• Update / refine costs	• Update / refine cost	• Update / refine cost	• Update / refine cost
Final report	• Develop outline report	• Update	• Update	• Update	• Finalise overall report

21

Resourcing

The following table summarises the resourcing that will be required for the project.

Table 68 Project resourcing

Resource	Role / responsibilities	Source	Effort	Comments
Lead	Leadership of overall project Facilitation of workshops Integration of design, development, and operational aspects Development / refinement of final deliverable Reporting	External	3 days per week	Costed
Architect	Ensures that overall proposed solution fits together Manages overall design of solution and how it will operate	External	Full time	Costed
Business analyst	Collates, analyses, and integrates output from working groups	External	Full time	Costed
Working group	Process expertise regarding how use of shared catalogue will operate centrally and at DHB level Technical expertise around how interfaces and reporting would operate	DHBs	As required	Not costed – DHB contribution
Cost and benefits analyst	Develop and refine the cost and benefits model Develop summary of differences between business case and refined model	NZ Health Partnerships	22 days spread across project	Costed Preferably use existing analyst in NZHP and manage as part of BAU
Project support	Scheduling of workshops and meetings Travel booking	NZ Health Partnership	1.5 day per week	Costed Manage as part of BAU roles
Communications support	Manage communications regarding the project to the sector	NZ Health Partnerships		Not costed BAU role

Risks

The key risks for the project and their mitigation is summarised in the following table.

Table 69 Key risks and their mitigation

Risk	Level	Mitigation
That DHBs do not commit the required staff for the period of time required, resulting in delays to the deliverables and/or lower quality results	Medium	Gain commitment from DHBs early Ensure team has a centrally funded architect to ensure strong integration of all input
That DHBs do not commit to attending the required workshops in the timeframes required resulting in delays, and/or lower quality deliverables, and/or re-litigation of results	Medium	Early advice of approach to the project and importance of DHB engagement Early advice of when workshops attendance is needed Use of a stable working group consisting of DHB staff to ensure DHBs have "back-channels" regarding the project
That DHBs do not buy into the results of the project, resulting in the sector not being able to achieve the benefits from medical device procurement	Medium	Use of working group with DHB staff DHB involvement in workshops Presentation of interim results to existing forums – CFOs, CIOs, CEs

Key Issues

The following key issues will need to be addressed as part of the work:

- How compliance against the PHARMAC medical devices contracts can be managed at point of procurement. PHARMAC has stated that after-the-fact monitoring is insufficient for it to achieve the projected savings.
- How data standards can be managed and enforced across differing systems and DHBs. The current NZ Health Partnerships data hub receives inconsistent data from DHBs and spends significant time in data cleansing.
- How the data repository should be designed and configured to make best use of the deep data that will be available from the 10 DHBs on the single Oracle FPIM instance. How the current NZ Health Partnerships data hub can be used as a starting point.
- How off-catalogue expenditure that impacts PHARMAC contracts will be managed and monitored.
- How change management will occur at DHB procurement level to enable the procurement savings. How existing procurement processes for medical devices will need to change.
- The roles of all key organisations in ensuring that medical device procurement operates effectively and efficiently while achieving the savings.
- How the differing systems will have potential different requirements and implementations to achieve the desired outcomes.
- How operation will occur across the sector so that the common good can be achieved.

Estimated costs

$600,000 including 15% contingency.

Funding

Funding will be split between all DHBs on the basis of PBF net of IDF as summarised in the following table.

Table 70 Funding split by DHB

DHB	PBF	High level design funding
Auckland	14.93%	89,561
Bay of Plenty	5.04%	30,240
Canterbury	11.41%	68,451
Capital & Coast	6.78%	40,693
Counties Manukau	9.36%	56,174
Hawkes Bay	3.38%	20,309
Hutt	3.02%	18,113
Lakes	2.25%	13,490
MidCentral	3.75%	22,492
Nelson Marlborough	3.01%	18,063
Northland	3.98%	23,907
South Canterbury	1.16%	6,953
Southern	6.46%	38,784
Tairawhiti	1.09%	6,522
Taranaki	2.35%	14,112
Waikato	9.65%	57,904
Wairarapa	0.79%	4,742
Waitemata	9.31%	55,868
West Coast	0.82%	4,897
Whanganui	1.45%	8,724
	100.00%	**$600,000**

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Attachment: Current state of national catalogue and data hub

The design work will build on the work that has been completed to date on the national catalogue and the data hub.

National Catalogue

- The national catalogue went live on 2 July 2018 with the Wave One DHBs.
- The national catalogue contains:
    - Suppliers
    - Items
    - Contracts
    - Sourcing rules
    - Price & Value schedules
- There are currently 44,594 items (products) on the master catalogue.
- The national catalogue will continue to grow as more DHBs move to FPIM, and as a result of PHARMAC and National Procurement activity.
- NZ Health Partnerships and the Wave One DHBs are looking at the best way to publish the catalogue to DHBs, most of whom want it as soon as possible.
- The constraints placed on the programme by the Cabinet "pause" have slowed publication.

Data Hub

- NZ Health Partnerships operates a procurement data hub.
- Data quality remains an issue, but this is improving all the time.
- Used by NZ Health Partnerships National Procurement and PHARMAC – the latter are in the early stages of using the data.
- The data hub takes feeds from all 20 DHBs, cleans, consolidates the data, and matches spend information to items and suppliers.
- There is a number of challenges:
    - Variable data from the 20 DHBs
    - Missing data, varying from a full month's data from some DHBs or just missing fields
    - When data at a DHB changes, e.g. new items added, it is time consuming to find the supplier and match to new item
    - Data cleansing and matching is a lengthy process with many manual steps (even though the data hub uses rules to match some items automatically).
- Plans:
    - Work with DHBs to improve quality of data supplied
    - Improve % of rule based automatic matching
    - Continue to investigate artificial intelligence and machine learning to improve data matches.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

23. Confirmation of Minutes of Board Meeting 19 December - Public Excluded
    Confirmation of Minutes of Board Meeting 30 January 2019 – Public Excluded
24. Matters Arising from the Minutes of Board Meeting - Public Excluded
25. Board Approval of Actions exceeding limits delegated by CEO
26. Chair's Update
27. He Ngākau Aotea
28. HB Clinical Council
29. Finance Risk and Audit Committee
30. Whole of Board Appraisal Action Plan

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).