Inquiry into Health Benefits Limited

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In November 2014, Hon Annette King asked me to look into the performance of Health Benefits Limited (HBL), the decision to wind the entity down, what HBL had cost the health sector, and the benefits it had achieved.

After due consideration, I decided to look into the costs and benefits of HBL's work in the health sector and, where possible, identify lessons that might benefit HBL's successor and other shared services programmes. This work also looked at:

- how HBL managed relationships with health sector entities;
- the approach and processes that HBL used in business cases; and
- the governance and management arrangements for delivering HBL's programmes.

HBL's main role was to prepare national programmes in partnership with the health sector to reduce finance, procurement, and supply chain costs for district health boards (DHBs). Together with the health sector, it was tasked to achieve gross savings of $700 million over the five-year period to 30 June 2016. This was an ambitious target.

By the end of June 2014, HBL had reported total gross savings in the health sector of $301.8 million on behalf of the sector, of which $71 million is attributable directly to HBL. This included $54.1 million of savings from HBL's first year of operations in 2010/11, which preceded the five-year period covered by the savings target. Actual savings achieved during the first three years of the five-year period were $247.7 million, compared with estimated savings for the first three years of $220 million.

Apart from these savings, a range of other benefits resulted from HBL's work, such as improvements to DHBs' data integrity and the sharing of good practice in administrative and support services.

The Finance, Procurement and Supply Chain (FPSC) programme, the most significant piece of work that HBL led, aimed to provide a common financial management system, centralised procurement, and more efficient supply chains for DHBs. The FPSC programme was forecast to provide gross benefits of $503.3 million over five years. By 31 March 2015, the FPSC programme had spent $80 million of a revised budget of $92.1 million and was not yet complete. At that time, the programme was modified with a revised budget of $120 million. Because the programme is still developing, it is too early to assess the level of benefits it will deliver.

The FPSC programme was planned to be complete by November 2014. Difficulties with the programme led to it being substantially paused in May 2014 and re-planned with a later delivery date and changed scope. Several factors contributed to these difficulties, which were also relevant to some other HBL programmes:

- the programme was ambitious and complex, with many risks;
- HBL's communication with DHBs was inadequate;

- HBL's board lacked timely and accurate information;
- HBL had no programme management office or similar function that was responsible for maintaining project management discipline; and
- although DHBs approved the FPSC business case, some DHBs' commitment to the programme appears to have been limited.

In response to this situation, HBL's board made some changes in early 2014 that improved relationships with the health sector and enhanced programme governance and management.

The lessons that could help other public entities better manage new programmes are:

1. Ensure that programme governance and management are effective.
2. Establish a clear and efficient decision-making process, particularly when delivering multi-entity programmes.
3. Governance boards need good-quality information before making significant decisions and must be confident that they have enough information before making a decision to proceed with a programme.
4. Integrate design and planning. FPSC work streams managed their plans independently, while co-ordinating with other work streams.
5. Adhere strictly to project control standards.
6. Do not underestimate the scale of change management effort required to effect significant sector-wide initiatives such as the programmes led by HBL.
7. Allow enough time and emphasis for programme recruitment.
8. Have trained staff in place and ready when starting a change programme.
9. Ensure that communication between parties is open and two way.
10. Ensure that sector solutions are scalable. Systems put into effect throughout a sector need to be able to be scaled up or down to meet the different needs of differently sized organisations.
11. Consider fully all tools, including legislative powers, available to achieve successful results.

I thank everyone who contributed to this report, in particular Health Benefits Limited, healthAlliance Limited, the Ministry of Health, the Pharmaceutical Management Agency, DHBs, the HBL Transition Interim Governance Group, NZ Health Partnerships Limited, the Treasury, and Lyne Opinion Limited.

Lyn Provost
Controller and Auditor General

12 October 2015

1 Introduction

Our approach

1.1 We commissioned Lyne Opinion Limited, a consultancy firm that provides independent financial opinions, to help us with the work that supports this report. Health Benefits Limited (HBL) gave our consultants unrestricted access to documents, including business cases, working papers, management reports, board papers, and minutes of meetings.

1.2 We interviewed staff from HBL, Health Alliance Limited, the Ministry of Health, the Pharmaceutical Management Agency (Pharmac), district health boards (DHBs), and the HBL Transition Interim Governance Group.

1.3 We considered the information gathered and drew together our findings.

1.4 We paid particular attention to the Finance, Procurement and Supply Chain (FPSC) programme, and the shared banking and insurance services. We did not look in detail at HBL's other programmes.

Setting up Health Benefits Limited

1.5 In 2009, a Ministerial Review Group was set up to provide independent advice on how to address challenges facing the health sector. On 31 July 2009, the Group published a report, *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*.

1.6 The Ministerial Review Group recommended the creation of "a new Crown Entity to provide shared services to district health boards (DHBs) and reduce the cost of common 'back office' functions so that more resources can be shifted to the front-line". The Group considered that the 20 DHBs could save significant money by reducing the duplication of back-office work.

1.7 In December 2009, the Government set up the Shared Services Establishment Board to prepare a business case for creating a national shared services agency. In consultation with the Ministry of Health, the Ministry of Business, Innovation and Employment (MBIE), and other departments, the Shared Services Establishment Board recommended a commercial model, with a company included in Schedule 4 of the Public Finance Act 1989, as the most appropriate vehicle for the shared services agency.

1.8 A report for the Shared Services Establishment Board prepared by a consultancy firm in January 2010 estimated that DHBs could achieve total gross savings of $700 million over five years from collective procurement activities. The Shared Services Establishment Board validated the work by the consultancy firm, and identified through its own work that the average value of gross savings would likely be $697 million over a six-year period. These savings would come through a range of initiatives, including shared procurement and rationalised financial management. This work led to a savings target of $700 million over a five-year period.

1.9 HBL, an existing Crown-owned company, was reconstituted as the shared services agency.

Health Benefits Limited's operations

1.10 HBL was listed as a Schedule 4A entity in the Public Finance Act 1989. As a Crown-owned company, it was subject to the Companies Act 1993 and the financial management and accountability provisions of the Crown Entities Act 2004. HBL's shareholders were the Ministers of Finance and Health.

1.11 The accountability and legislative framework meant that HBL had:

- a mix of commercial and non-commercial objectives, although, in practice, it has been able to operate in a commercial manner;
- Crown input through ministerial ownership and an accountability framework that included preparing a statement of service performance, including reporting against a statement of intent, and an annual report; and
- flexible ownership arrangements, such as issuing different classes of shares.

1.12 HBL's purpose as set out in its constitution was "...to reduce the costs of District Health Boards (DHBs) by optimising the efficient and effective delivery of administrative, support and procurement services for DHBs". HBL's role was to identify, facilitate, and lead initiatives that save money by reducing DHBs' administrative, support, and procurement costs. HBL was tasked with helping the sector achieve gross savings of $700 million over a five-year period (by 30 June 2016).

1.13 HBL provided some shared services directly, but its main role was to prepare national programmes in partnership with the health sector to reduce finance, procurement and supply chain costs for DHBs. The entities that would supply the services would be either pre-existing health sector shared services agencies or third parties.

1.14 HBL focused on:

- services provided directly to DHBs, such as shared banking and insurance arrangements;
- finance, procurement, and the supply chain and creating a national system and service for these corporate functions;
- facilities management and support services – focusing on linen, laundry, and food services to hospitals; and
- information services – specifically setting up a National Infrastructure Platform to provide back-office information technology infrastructure, such as servers and storage systems.

1.15 In this report, we discuss:

- HBL's costs and savings;
- the FPSC programme;
- HBL's banking and insurance arrangements; and
- lessons for other public entities.

2 Costs and savings

Funding

2.1 In HBL's first year operating under its new purpose, the Ministry of Health provided direct funding of $6 million. It was expected that HBL would work with DHBs, the Treasury, and the Ministry of Health to prepare a sustainable future funding model. HBL presented options to the Ministry of Health, but we understand that a model had not been agreed when the Minister of Health announced that HBL would be wound down.

2.2 Therefore, DHBs directly funded their share of HBL's costs. To do this, DHBs had to approve their share of the cost of business cases and programmes and, through this, fund HBL's activities. Sometimes, this approval was difficult to get. HBL considered that the DHBs had a strong focus on current-year budgets, meaning that programmes that required upfront funding – with benefits later – were difficult for DHBs to commit to.

2.3 On the occasions when funding that the DHBs agreed to was not enough to complete business cases, HBL had to get Crown loans to complete the work. Securing approval from all 20 DHBs for business cases and for Crown loans was time-consuming and contributed to delays. The Crown loans were provided as bridging finance with the intention that they be paid back by vendor finance or by DHBs through successful delivery of programmes.

2.4 DHBs provided $68.3 million capital funding for the FPSC programme through an issue of shares by HBL.

2.5 To achieve the $700 million target, HBL drew up an "invest to save" model that required upfront funding to create future benefits. In some instances, these benefits were not expected to be realised for years and would not necessarily be spread equally throughout the health sector. In effect, DHBs were being asked to support investments that would deliver national savings but might incur local costs.

Operating costs

2.6 Between 1 July 2010 and 30 June 2014, HBL's operating costs were $49 million. Apart from the $6 million that the Ministry of Health gave HBL in its first year, revenue from DHBs or Crown Loans funded these costs. Figure 1 shows HBL's total operating expenditure by programme.

Figure 1
Health Benefit Limited's total operating expenditure by programme, 2010/11 to 2013/14

Year ended 30 June	2011 $m	2012 $m	2013 $m	2014 $m
Collective procurement, shared banking and insurance				1.7
Finance, procurement, and supply chain*				12.7
Facilities management and support services				4.2
Information services				5.3
New opportunities				1.8
Human resources and workforce management				0.6
Not categorised	4.8	8.0	9.9	
Total annual operating expenditure	**4.8**	**8.0**	**9.9**	**26.3**
Total cumulative operating expenditure	**4.8**	**12.8**	**22.7**	**49.0**

* These are costs that HBL incurred in running the FPSC programme, rather than costs of operating the FPSC.
Source: Health Benefits Limited.

Reported savings

2.7 HBL reported total gross savings to the sector of $301.8 million from 2010/11 to 2013/14. This included $54.1 million of savings from HBL's first year of operations in 2010/11, which preceded the five-year period identified by the Shared Services Establishment Board for achieving the savings target of $700 million. Figure 2 shows a breakdown of the gross savings across programmes that HBL reported on.

Figure 2
Total gross benefits by programme, 2010/11 to 2013/14

Year ended 30 June	2011 $m	2012 $m	2013 $m	2014 $m
Collective procurement, shared banking and insurance	55.2	59.7	97.0	92.1
Finance, procurement, and supply chain				0.4
Facilities management and support services				
Information services				
Human resources and workforce management				
New opportunities				
HBL adjustments*	-1.1	-1.6	0.1	
Total gross annual benefits	**54.1**	**58.1**	**97.1**	**92.5**
Total gross cumulative benefits	**54.1**	**112.2**	**209.3**	**301.8**

* Adjustments that HBL made to DHBs' reported savings after auditing them, to more accurately reflect actual benefits.
Source: Health Benefits Limited.

2.8 HBL's estimated and actual (where applicable) sector savings over the five-year period to 30 June 2016 are shown in Figure 3. Actual savings achieved during the first three years of the five-year period were $247.7 million, compared with estimated savings for the first three years of $220 million.

Figure 3
Health Benefits Limited's savings estimates and actual savings, 2011/12 to 2015/16

Year ended 30 June	2012 $m	2013 $m	2014 $m	2015 $m	2016 $m	Total $m
Savings estimate	40.0	60.0	120.0	210.0	270.0	700.0
Actual savings	58.1	97.1	92.5	-	-	247.7

Source: Health Benefits Limited.

2.9 The savings reported under the *Collective Procurement* programme came from several sources, including DHB individual and collaborative procurement initiatives; MBIE's all-of-government initiatives; and healthAlliance procurement, as well as savings from HBL-led procurement initiatives.

2.10 When savings resulting from other activities are removed, the reported savings that are directly attributable to HBL up to 30 June 2014 are $71 million. Figure 4 shows reported savings that arose directly from HBL's services and initiatives.

Figure 4
Health Benefit Limited's total gross benefits by activity and service, 2010/11 to 2013/14

Year ended 30 June	2011 $m	2012 $m	2013 $m	2014 $m	Total $m
HBL-led procurement		9.4	20.2	6.6	**36.2**
Insurance			14.0	11.3	**25.3**
Shared banking			4.6	4.5	**9.1**
Finance, procurement, and supply chain				0.4	**0.4**
Total gross annual benefits		**9.4**	**38.8**	**22.8**	**71.0**

Source: Health Benefits Limited.

2.11 HBL also contributed to procurement savings over the same time period achieved by MBIE's all-of-government initiatives and by healthAlliance Limited, totalling $73.6 million.

Types of savings

2.12 HBL grouped the savings it recorded into two categories – budgetary benefits and non-budgetary benefits. HBL defined budgetary benefits as changes that result in a budget line reduction compared with the previous year. Non-budgetary benefits included preventing projected increases in costs that, because of changes, did not take place, and qualitative benefits, such as productivity improvements or reduced clinician time in administration, arising from changes made.

2.13 HBL reported total savings rather than the amount of savings in each of these categories, despite our recommendations in successive audit reports that they provide the breakdown. However, HBL worked on the methodology to provide DHBs with the breakdown by savings type and intended to publish results in its 2014/15 annual report. The data that HBL gave us indicate that the split for 2013/14 was $52.5 million for budgetary and $40 million for non-budgetary benefits.

How savings were reported

2.14 To quantify and report savings, HBL needed to create a baseline against which future savings could be measured. For example, for procurement activities, baselines were the price of a product or service that a DHB bought before a negotiated contract came into effect.

2.15 The low quality of information from DHBs made it more difficult for HBL to obtain baseline data. The lack of a common chart of accounts in DHBs meant financial information was not directly comparable.

2.16 HBL had to do a lot of work to cleanse and verify data before it could rely on that data. This is a problem that the FPSC programme was designed to solve.

2.17 In the end, HBL relied on the information that DHBs gave it, in line with an agreed methodology with sign-off from the DHBs' chief financial officers. At first, HBL did little to test the accuracy of information that DHBs provided. In our view, this reduced confidence in the numbers reported. In response to our recommendations over successive audits to provide more quality assurance, HBL did make improvements. For example, from 2013/14, HBL employed internal auditors to visit DHBs and test reported savings.

2.18 In September 2014, HBL hired Grant Thornton Limited to audit the benefits that DHBs reported. Grant Thornton's audit found inconsistent reporting of benefits by DHBs, resulting in under- and over-statements of some reported benefits. Grant Thornton recommended ways to address these problems, including updating guidelines for DHBs to report benefits and formalising HBL staff visits to DHBs, of at least once a year, to review information and provide help with reporting.

HBL's managers acted on these recommendations and the savings figures were adjusted accordingly.

Other benefits

2.19 A range of non-financial benefits have resulted from HBL's work. The work to produce baseline data required some DHBs to improve their data integrity. This should help DHBs' financial decision-making. Producing baseline data also allows benchmarking of DHBs' financial performance and allows DHBs to share lessons learned.

2.20 Good practice in administrative and support services is now being shared more between DHBs. Creating a national catalogue for DHB procurement and national contracts has led to options to standardise products.

Our observations

2.21 We question how compatible the "invest to save" model was with the DHBs' operating environment. DHBs agreed with the overall objectives of saving money in administration and corporate services to invest in frontline services. However, DHBs are expected to achieve financial results in the short term. Therefore, investments making immediate savings are more palatable to DHBs than investments that result only in future savings.

2.22 It is worth considering whether DHBs had enough incentive to fully engage with and support HBL's programmes. Lack of total DHB engagement and support contributed to the slow progress. HBL's successor will need to manage these tensions carefully.

2.23 An option that was available but not requested was for the Minister of Health to exercise powers in the Public Health and Disability Act 2000 to direct DHBs. For example, section 33A of that Act provides for the Minister to give directions about administrative, support, and procurement services. This could have resolved situations where HBL had reached an impasse with one or more DHBs, acting in what they saw as the best interests of their district but causing delays in the programmes.

2.24 During the period covered by our inquiry, HBL contributed directly to sector savings of $71 million, at an operating cost of $49 million, a positive result of $22 million. HBL also contributed to a range of non-financial benefits for the sector, as described above.

2.25 DHBs have also incurred capital costs for the FPSC programme, which should be able to support the operation of the programme in future years (see Part 4).

3 Risk and relationship management

Managing risks

3.1 We looked at risk management in the context of HBL's overall risk management policies and processes. This included analysing risks in three categories: delivery risks, financial risks, and capability/capacity risks. A risk management policy, put in place in February 2012, was updated in March 2013. HBL's board regularly reviewed significant corporate and programme risks.

3.2 In general, HBL's risk management policy reflected good practice, was well written, and created a good structure for monitoring risks at corporate and programme levels. The processes that HBL used to put in place its risk management policy were defined, understood, and used well. Any significant risks were referred to the board, which reviewed these risks at every board meeting. We consider that HBL had adequate policies and processes for managing risk. However, our work did not extend to analysing the quality of the decisions made about risks.

Managing relationships with health sector entities

3.3 The way HBL communicated and managed relationships with the sector contributed to the slow progress in achieving objectives. Other than banking and insurance arrangements, HBL's programmes appear to have suffered from communication and engagement problems with DHBs.

3.4 HBL's primary purpose was to lead a series of significant changes in DHBs. As autonomous organisations with legal mandates and responsibilities, DHBs would each need to be convinced that the changes proposed were in the best interests of their district, and to be prepared to take a long view on achieving a return on investment. In this context, HBL needed to exercise strong communication and relationship management to ensure that DHBs could buy in to the programmes, and fully support their implementation.

3.5 Problems contributing to HBL's difficulties in building effective relationships with stakeholders included:

- having a small communication team that appears to have lacked the capacity for the work required;
- the variable flow of information through DHB representatives to DHB decision-makers, possibly a result of the increasing burden on DHB representatives as programmes progressed and demands on their time significantly increased; and
- HBL not engaging enough with the DHB boards that were responsible for approving business cases – HBL appears to have communicated with different people in DHBs, often not reaching decision-makers.

3.6 HBL's board did include senior representation from DHB boards and management, which should have provided a DHB perspective into HBL's work, but this did not appear to prevent HBL having difficulties engaging with the sector.

3.7 As well as problems getting information to DHBs, HBL experienced significant delays getting information from DHBs. This, in turn, contributed to delays in planning, costing, and starting programmes.

3.8 Any significant change programme in multiple entities requires engagement at the most senior levels from the outset. HBL appears to have underestimated the importance of securing engagement and under-resourced its communications efforts. Engagement and communication targeted at senior levels in the DHBs could have led DHBs to give more priority to HBL programmes, resulting in HBL receiving more comprehensive information more quickly, and DHBs making faster decisions.

3.9 Any change in the health sector is likely to affect clinicians. Changes in procurement and supply can affect the tools that clinicians use, the food patients eat, and the linen they sleep on, with the potential to affect health outcomes. Although HBL set up a Clinical Council in March 2013 to provide clinical feedback to HBL, this was several months after the approval of the business case for HBL's largest programme, the FPSC. This suggests that HBL had underestimated the importance of consulting clinicians.

3.10 We look in more detail at how HBL managed relationships for the FPSC programme in Part 4.

The Finance, Procurement, and Supply Chain programme

4

What we considered when looking at the programme

4.1 In looking at the FPSC programme, we considered:

- what was planned and what has been implemented so far;
- the decision-making process for setting up the programme and the quality of information that decision-makers received during that process;
- quality assurance of the programme;
- how HBL managed its relationships with the health sector entities; and
- whether the programme was governed and managed effectively.

What was planned and what has been implemented

4.2 In terms of cost and proposed benefits, the FPSC programme was the most significant that HBL led. The programme was meant to provide a common financial management information system (FMIS) for all DHBs, a centralised procurement function in healthAlliance, and a re-designed supply chain.

4.3 The FPSC programme was forecast to deliver gross benefits of $503.3 million over five years. The forecast cost was $87.9 million, with full implementation planned for November 2014.

4.4 However, the FPSC programme suffered delays. In May 2014, risks to the budget and timeframe led HBL's board to "pause" implementation. At that time, the programme had cost about $59.4 million.

4.5 After this pause, work continued on:

- support for Hutt Valley DHB, which partly implemented the finance system on 1 April 2014;
- the Oracle financial system;
- analysing options for completing the programme; and
- introducing the National Procurement Service, through healthAlliance (FPSC) Limited, which went live on 1 July 2014.

4.6 The National Procurement Service centralises the procurement function of all DHBs for a range of equipment and services, for example imaging, laboratory, and non-clinical support services. The procurement service that was put into effect in July 2014 does not have the support of the new finance system, as proposed in the original scope of the FPSC. We understand that this is planned to be put into effect beginning in the second half of 2016.

4.7 Figure 5 shows the FPSC programme's costs between June 2014, after parts of the programme had been paused, and March 2015.

Figure 5
Finance, Procurement, and Supply Chain costs, June 2014 to March 2015

	$m
Continued development of the Oracle finance system	1.9
Re-planning the FPSC programme	3.4
Operational support required to keep the development environment operating	1.4
Retention of staff required to implement the programme if approved	1.1
Costs associated with establishing the national procurement service within healthAlliance	3.5
Technology operating and licensing costs (such as Oracle licensing costs)	9.3
Total	**20.6**

Source: Health Benefits Limited.

4.8 The FPSC programme, planned to be fully implemented by November 2014, was forecast to provide benefits with a net present value of $412 million. The programme is still not complete, but three aspects of the programme have been put into effect:

- Hutt Valley DHB uses a limited version of the FMIS.
- The national procurement services was set up through healthAlliance in July 2014.
- The national catalogue was set up on 31 March 2015.[1]

4.9 By 31 March 2015, $80 milllion had been spent on the FPSC programme out of a total available budget of $92.1 million. The total available budget figure includes the original budget of $87.9 million and $4.2 million budgeted to be spent on DHBs' existing Oracle licensing costs.

4.10 We understand that, after the re-planning work, HBL's board approved a "pared-down" version of the programme in March 2015, which was subsequently endorsed by all the DHBs. This removed financial shared services (centralising receivables and payables) and consolidating warehousing and logistics functions

1 The national catalogue is a list of all goods and services that one or more DHBs can purchase at an agreed price. It enables the storage and sharing of information on healthcare products between suppliers and DHBs.

from the programme, which could be subject to supplementary business cases in future.

4.11 The pared-down option was forecast to cost $120 million, including money already spent.

4.12 The forecast costs of the FPSC programme increased from $92.1 million to $120 million because:

- **It took longer to put the programme into effect.** The original business case assumed the programme could be delivered by November 2014. The forecast completion date for the programme is now in 2018.
- **The change required had been underestimated.** The scale of the change of the FPSC programme and the effect on DHBs was more challenging than first anticipated. The programme's goals were ambitious, requiring creating a single system that could replace 20 systems and different ways of operating. It appears that HBL underestimated the health sector's fragmentation. This made achieving the programme's objectives in the time allotted particularly challenging.
- **healthAlliance's finance system could not be re-used fully.** The original business case required that the FPSC programme use the Oracle finance system that healthAlliance had prepared. This could not be done to the extent originally forecast.
- **Unbudgeted costs were incurred.** Many costs were not budgeted in the original business case.

Unbudgeted costs

4.13 Many costs were not budgeted in the original business case:

- Including Pharmac on the FMIS increased the cost of building the system by about $1.0 million.
- Integrating DHB clinical, business, and administration systems with the new national FMIS added about $5.0 million to the costs of the programme.
- Hutt Valley DHB's early use of the FMIS, despite the other DHBs not having access to it, meant that the system generated operating costs, including Oracle application licence support and maintenance fees, creating a funding gap of about $8.0 million.
- Re-planning the FPSC programme cost about $6.0 million.

Decision-making process and information quality

4.14 Before HBL was reconstituted as the national shared services agency, the Shared Services Establishment Board[2] had identified the three core objectives of FPSC (procurement discounts, rationalised supply chain management, and rationalised FMIS) as priority initiatives for meeting the goal of saving $700 million over five years. HBL took over the work that the Shared Services Establishment Board carried out on these initiatives and combined them into one programme, because a common FMIS was seen as important for helping to bring about the procurement and supply chain benefits.

4.15 The decision to approve the FPSC business case followed these steps.

4.16 With support from a consultancy firm, HBL prepared an indicative case for change that set out the programme and what it was intended to achieve. In mid-2011, HBL's board endorsed the indicative case for change. In November 2011, the National Health Board's Capital Investment Committee endorsed the case for change, after which it was released to DHBs and unions for feedback.

4.17 After hearing the opinions of DHBs and unions about the indicative case for change, HBL prepared detailed individual business cases for each DHB or group of DHBs (for example, a business case was prepared for the Northern Region), again with help from the consultancy firm. HBL distributed these business cases to DHBs in May 2012.

4.18 In answer to DHBs' concerns about the accuracy of the business cases' stated costs and benefits, HBL asked another consultancy firm to review the FPSC's forecast savings and costs. The consultancy firm stated that the procurement and supply-chain forecast savings were reasonable, but that personnel cost savings appeared to be optimistic. The consultancy firm also stated that the forecast costs were reasonable, but noted that forecasts were based on assumptions that could not be verified and others that would be difficult to achieve.

4.19 In its report, the consultancy firm also raised concerns that all DHBs did not fully support the business case, and that it would be necessary to engage all DHBs in a consensus to manage change if benefits were to be realised.

4.20 After working with HBL to satisfy some conditions, DHBs approved all the business cases by 31 August 2012. This was two months later than the plan set out in the business cases, putting immediate pressure on deadlines and realisation of benefits.

4.21 In our view, HBL's managers and board followed appropriate methods and good practice to arrive at a decision to approve the FPSC indicative case for change and business cases, and to seek DHBs' approval of those cases.

2 See paragraph 1.7.

Quality assurance

4.22 The programme had several independent quality assurance (IQA) reviews. The first, in December 2012, was a Gateway Review process. From October 2013, a third consultancy firm carried out IQA reviews every quarter. In general, managers acted on IQA recommendations. However, the consultancy firm suggested that HBL could have acted on some recommendations more quickly.

Relationship management and the FPSC programme

4.23 Good communication and engagement with the sector is important for a programme such as FPSC. Putting the FPSC into effect requires the involvement of a range of personnel and organisations, including DHB managers, other staff, and unions.

4.24 HBL used a range of channels to communicate and manage relationships with the health sector in all of its programmes, including the FPSC programme. These included a Change and Communication Framework that HBL, DHBs, and unions agreed, and the FPSC Communication and Engagement Plan.

4.25 Although HBL followed good practice in having communications policies and plans in place, some problems with HBL's relationships and communications with the sector negatively affected the FPSC programme. The main problems were:

- **Communication from HBL was one way.** DHBs felt that HBL used the forums it attended to disseminate information about the FPSC programme and did not take the opportunity to hear DHBs' views.
- **HBL told DHBs what to do.** Although the success of the FPSC programme was based on partnering with DHBs, DHBs felt that HBL was directing them what to do rather than letting them help to plan or develop the programme.
- **HBL had no dedicated mechanism for getting clinicians' input to the programme until after the business case had been approved.** HBL set up a Clinical Council in March 2013, months after the last DHB had approved the business case. Input from the Clinical Council resulted in several changes to the FPSC, suggesting that setting it up earlier could have resulted in a better business case and smoother progress.
- **DHBs lacked information about the programme's progress.** DHBs felt that they were not getting adequate information about the progress of the FPSC programme after they had already begun to restructure in anticipation of putting the programme into effect.

4.26 DHBs' chief financial officers were concerned about the difficulty they were experiencing in getting information about progress on the programme from HBL,

the FPSC Steering Committee, and the programme team through formal and informal channels. Some chief financial officers raised their concerns with their chief executives and HBL through the Steering Committee. On 7 March 2014, the chairperson of the DHB Chief Financial Officer Forum wrote to the chairperson of the DHB Chief Executive Forum expressing concern at the risks the programme posed and the lack of transparent and timely information.

4.27 In early 2014, HBL made organisational changes to engage better with the sector. These included:

- changes in HBL's executive management;
- getting stakeholders more involved in programme planning;
- changing the leadership and membership of the Steering Committee; and
- improvements within HBL's communication team.

4.28 HBL's changes improved the relationship and communication with stakeholders about the FPSC programme, and DHBs had greater input into the planning and governance of the programme. However, we are aware that some stakeholders remained concerned about the accuracy of information that they received about the programme while it was being re-planned. Because of the difficulties they had in the past, it is understandable that some DHBs are sceptical about information on the future of the programme.

Programme governance and management

4.29 Problems with the programme's management and governance contributed to it not achieving as much as it could have.

Governance

4.30 A Steering Committee oversaw the governance of the FPSC programme. The Steering Committee's main responsibilities included ensuring that the FPSC programme was delivered within the agreed parameters and resolving strategic and directional matters that needed the input of senior stakeholders.

4.31 The membership of the Steering Committee was:

- HBL's chief executive, who chaired the committee;
- senior FPSC programme team members from HBL;
- a representative each from Pharmac, the Ministry of Health, healthAlliance, and MBIE; and
- one representative from each of the DHB regions (not necessarily the DHB's chief executive or chief financial officer).

4.32 Weaknesses with the composition of the first Steering Committee that contributed to difficulties with the programme included:

- The Steering Committee did not have the right DHB representation required to get commitment from DHBs.
- Having HBL's chief executive chairing the Steering Committee meant that the management of the FPSC programme was placed in a governance position.
- The roles of the members of the Steering Committee were not well defined and it was not clear in what capacity they were contributing to the Steering Committee. For example, it was unclear whether DHB representatives were there because of their governance skills or because they were representing their DHB.

4.33 A Change Advisory Board might have improved governance. This could have controlled changes made to the FPSC programme so that implications of the changes could be assessed throughout the sector and then communicated if they were to be put into effect.

4.34 One of the consequences of the structure and composition of the Steering Committee is that the HBL board, which had ultimate governance responsibility for the programme, received overly optimistic reports on progress. In October 2013, the board received information that the programme was running to plan, albeit to a revised plan. At the end of 2013, it was clear that there were serious problems with meeting deadlines.

4.35 In April 2014, the Steering Committee's terms of reference were reviewed and the membership revised. Changes included:

- ensuring that both a DHB chief executive and a chief financial officer represented each DHB region;
- appointing a DHB chief executive as chairperson; and
- improving communications between DHBs, HBL, and healthAlliance.

4.36 The effectiveness of the governance of the FPSC programme improved after these changes. Since then, a substantial part of the FPSC programme was paused and re-planned. There was more involvement from DHBs in planning the programme and better communication with the sector about progress. However, we are aware that some stakeholders still have concerns about the role of the Steering Committee, including the timeliness of papers being provided to the Committee, and papers that are presented as reporting a decision rather than as matters to be discussed and decided.

Managing the programme

4.37 We found problems with the programme management of the FPSC, which contributed to delays in the programme and to a substantial part of the programme being paused and re-planned:

- There was no project management office or similar function within HBL. IQA reviews identified this gap as a problem for the programme. The role of the project management office would have been to maintain standards of project management. The lack of project management disciplines were reflected in a lack of programme documents, deadlines missed, and changes made to the programme without enough control or communication.
- The capability of the programme team did not change to meet the different needs as the programme moved from design to implementation. This hampered efforts to secure necessary engagement with DHBs as the skills needed moved from technical to communication and relationship management.
- An associated problem was that not enough time and emphasis was allocated to recruitment, meaning that key resources in some work streams were not in place early enough.
- Information did not flow adequately from the programme team to HBL management and the sector. This could be traced back to the lack of a project management office function to monitor information flows. This could also have contributed to the programme's governors and HBL's managers not understanding the true state of the FPSC programme.

Our observations

4.38 The FPSC programme is an ambitious, complex programme with many risks. The desire to achieve HBL's savings target led to an overly ambitious drive to put into place the finance, procurement, and supply chain work streams at the same time.

4.39 HBL did not successfully communicate with DHBs and get input and support for the programme. This slowed both the delivery of necessary information from DHBs into the programme and DHBs' approving the business case and other milestones.

4.40 Weaknesses in programme governance and management contributed to an inadequate and over-optimistic assessment of the position of the programme, which in turn made it more difficult for decision-makers to take early action to correct deficiencies or change direction if necessary.

4.41 HBL did make some changes to programme governance and management in early 2014, including a stronger role for DHB management in the programme steering group. This led to improvements in communication with the sector and programme processes.

4.42 Governance of the FPSC programme would have benefited from the outset by HBL:

- ensuring that the Steering Committee had appropriate members, particularly from DHBs – the consumers of the services being introduced;
- ensuring that the Steering Committee's governance was separate from the operational delivery of the programme – appointing HBL's chief executive as chairman of the Steering Committee compromised the first version of the Steering Committee; and
- clearly defining the role of members of the Steering Committee.

4.43 Although DHBs approved the FPSC business case, commitment to the programme by at least some DHBs appears to have been limited. This is reflected in difficulties HBL had at times in getting information from DHBs, and DHB staff involved in the programme lacking sufficient authority. Although the way that HBL managed relationships contributed to this situation, DHBs shared responsibility for the programme and could have more actively worked for a successful outcome.

5 Banking and insurance

5.1 HBL provided banking and insurance services directly to DHBs and some other entities. HBL dealt with providers on behalf of DHBs to achieve savings through bulk discounts and efficiencies. We looked in detail at the banking service to assess HBL's effectiveness in delivering services directly.

Shared banking

5.2 Shared banking refers to the arrangement where HBL acts as a centralised cash manager for the shared banking entities – the DHBs and HealthShare Limited, healthAlliance, and healthAlliance (FPSC) Limited. The objectives were to maximise investment returns and reduce administration costs.

5.3 HBL inherited shared banking from the Crown Health Funding Agency (CHFA) when it was disestablished in July 2012. CHFA had progressed the programme to the point where DHBs were committed and a bank had been chosen as preferred provider. HBL had to manage the implementation process (including transferring DHBs that were not the new bank's customers to the new bank) and the problems arising from disestablishment of CHFA, such as formalising arrangements through new legal documents and improving the relationship with the bank. HBL was responsible for the ongoing operation of the service.

5.4 HBL moved shared banking entities' cash balances to or from a centralised HBL account. The available balance in the centralised account attracted on-call interest at a rate negotiated with the bank. HBL also invested funds using term deposits for the shared banking entities. From 1 January 2015, HBL was able to place on-call funds with banks other than the preferred provider bank.

5.5 To provide oversight for the process, HBL set up a Chief Financial Officer Reference Group made up of a chief financial officer from each region, two DHB finance managers, and an HBL representative.

5.6 The original forecast gross savings for the programme were $3.6 million a year. The programme saved $4.6 million in 2013 and $4.5 million in 2014, at a cost for both years of $0.7 million. The net savings for these years were marginally higher than forecast.

5.7 Shared banking's success can be attributed to:

- having a narrow and well-defined scope;
- affecting only a few people in each DHB;
- having good leaders that DHBs trusted;
- being able to show benefits from the start; and
- the Chief Financial Officer Reference Group structure, meaning that DHBs helped make decisions, giving them a sense of ownership of the initiative.

Lessons for public entities dealing with significant change agendas

6

6.1 **Ensure that programme governance and management are effective.** Weaknesses in programme governance and management contributed to the inadequate and over-optimistic assessment of the position of programmes, particularly the FPSC programme. Effective programme governance and management are both essential to keeping a programme on track. Just as importantly, they enable a quick response, including making difficult decisions such as reconsidering choices or plans, when projects are not going well.

6.2 **Establish a clear and efficient decision-making process,** particularly when delivering multi-entity programmes. HBL relied on existing structures, such as the CEO and CFO Forums, to communicate with and secure decisions from DHBs. Establishing separate, programme-dedicated forums could have led to faster decisions and reduced programme delays.

6.3 **Governance boards need good-quality information before making significant decisions** and must be confident that they have enough information before making a decision to proceed with a programme. From that point, they need to provide full support for the programme, including senior-level participation and monitoring.

6.4 **Integrate design and planning.** FPSC work streams managed their plans independently, while co-ordinating with other work streams. There should have been more focus on having one integrated plan, which identified critical paths and dependencies. This would have facilitated making decisions when milestones were under threat and trade-offs between timeliness, costs, and benefits needed to be considered.

6.5 **Adhere strictly to project control standards.** Small slippages were accepted and accommodated in HBL's plans, but eventually the co-ordination between parallel work streams could not be sustained and milestones were not achieved. Having a project management office operating effectively, and including more, smaller milestones and confidence points in the plan to enable closer monitoring of the programme, could have addressed this.

6.6 **Do not underestimate the scale of change management effort required** to effect sector-wide initiatives as significant as the programmes led by HBL. Programmes such as the FPSC programme have a significant technology component, but ultimately their success depends on how well the changes individual entities need to make are understood and embraced. This starts with planning and continues throughout the programme, through elements such as communication and monitoring. One aspect that appeared to hamper HBL's progress was securing the full agreement and support of the decision-makers in DHBs, who ultimately would have to put in the work needed to make the programmes successful.

6.7 **Allow enough time and emphasis for programme recruitment.** HBL did not have key resources in some work streams in place early enough. Capacity planning for key resources needs constant monitoring.

6.8 **Have trained staff in place and ready when starting a change programme.** A corollary to the previous point is that all parties in the HBL-led change programmes needed to have staff in place with the capability to engage with the programme. Some of the DHB staff involved with the programme did not have sufficient authority to fully engage at key points, such as development of the FPSC business case.

6.9 **Ensure that communication between parties is open and two way.** Any change programme will struggle to achieve its objectives if all the parties do not have access to timely and reliable information. Establishing channels early on for communicating with the appropriate audience for the message to be conveyed is essential.

6.10 **Ensure that sector solutions are scalable.** Systems being applied across a sector need to be able to be scaled up or down to meet the different needs of different-sized entities. Smaller DHBs are unlikely to need the full range of functions that enterprise systems provide, and ideally should not be expected to pay for unneeded functionality. Equally, solutions should deliver benefits for larger entities with more demanding requirements.

6.11 **Consider fully all tools, including legislative powers, available to achieve successful results.** An option that was available but not requested was for the Minister to exercise powers in the Public Health and Disability Act 2000 to direct DHBs. For example, section 33A provides for the Minister to give directions in relation to administrative, support, and procurement services. This could have resolved situations where HBL had reached an impasse with one or more DHBs, acting in what they saw as the best interests of their district but causing a delay in the programme.