CONTROLLER AND AUDITOR-GENERAL
Tumuaki o te Mana Arotake

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Inquiry into Waikato District Health Board's procurement of services from HealthTap

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Auditor-General's overview

District Health Boards (DHBs) play an essential role in ensuring that New Zealanders have access to high-quality health and disability services. They are also stewards of significant public funds. Faced with funding constraints and increasing demand for services, DHBs are looking for innovative ways to provide more or better healthcare for their communities with the resources available to them.

This report outlines the findings of our inquiry into the decision of Waikato District Health Board (Waikato DHB), in 2015, to enter into a contract with the United States-based company HealthTap Inc (HealthTap) to provide "virtual care" services through an online service. Virtual care uses various communication and information technologies to improve patient access to care, health engagement, and health outcomes. The services were available as a web-based service and as a downloadable application (an app) for cell phones.

In entering into the contract with HealthTap, Waikato DHB was seeking to find an innovative way to deal with some of the pressures it was facing – in particular, the challenge of providing health services to remote and rural communities.

Waikato DHB's contract with HealthTap required Waikato DHB to pay about $16 million in licence fees over two years. The contract was pitched as a two-year trial of virtual care. Waikato DHB then intended to go back to the market using what it had learned during the trial phase to formulate a more detailed analysis of its needs, followed by a formal tender process.

On the evidence available to us, Waikato DHB did not carry out any formal market testing or any form of competitive tender process when selecting HealthTap as a provider.

Towards the end of the two-year term of the contract, Waikato DHB commissioned a review of the project. That review concluded that virtual care represented an important strategic direction for health organisations in Waikato and New Zealand and that, where the services met a particular clinical need, HealthTap performed well. However, it also identified issues with the implementation of the service – including a lack of collaboration with internal and external stakeholders. The review found that the overall cost to Waikato DHB was about $26 million.

When the review was released by Waikato DHB, it said that it considered that the platform was introduced too quickly and without proper collaboration with staff. Waikato DHB also said that the community, its staff, and the organisation were not ready for this change.

In March 2018, Waikato DHB decided that it would not renew its contract with HealthTap when it expired later that year. It stated its intention of continuing to invest in virtual care "on a basis to be determined". That remains the situation at the time of writing this report.

Our findings

Our decision to inquire into the procurement of the HealthTap platform was prompted by concerns about the procurement that my appointed auditor identified as part of our annual audit of Waikato DHB for 2016/17. Those concerns included the lack of an open market procurement process, compliance with the *Government Rules of Sourcing* (the Rules), and Waikato DHB's inability to demonstrate value for money.

The work we have done during our inquiry shows that all of these concerns were justified and that, overall, the procurement process Waikato DHB carried out fell well below the standards expected of a public organisation. The failure in the procurement process meant that Waikato DHB could not prove that it obtained the best value from public money.

Fundamental aspects of good procurement that we would expect to see in a procurement of this type, and that were missing, defective, or carried out too late in the process to be effective, include the following:

- There was no formal planning for the procurement before HealthTap was approached. That meant there was no formal identification of business needs, no risk analysis, and no identification of internal or external stakeholders. There was also no documented analysis of the market and what other options might be available. Waikato DHB's former Chief Executive (the Chief Executive) told us that he performed comprehensive market testing at the time of the procurement and that "there were no other credible platforms that met the criteria". We have not been provided with any documentary records of the market testing or of the selection criteria at the time.
- The Chief Executive made the initial approach to HealthTap about potentially using its services in New Zealand at the request of the Chair of the Board. This followed a discussion between the Chair of the Board and HealthTap's Chief Executive. Early discussions about a possible agreement with HealthTap appear to have been primarily carried out by the Chief Executive. There was no evidence of governance or oversight at this point of the process. No advice was sought from Waikato DHB's legal or procurement teams until after a draft contract had been prepared.
- There is no evidence that, before approaching HealthTap, any consideration was given to the Rules, the specific rules DHBs were required to follow at the time, or Waikato DHB's own procurement policy. In particular, there is no evidence that those initiating the discussions with HealthTap thought about whether Waikato DHB was permitted to carry out a selective procurement process (that is, whether it was permitted to approach a single provider without opening up the procurement to other potential suppliers). Despite eventually seeking advice on this matter, Waikato DHB never formally recorded its response to that

advice and proceeded with a selective procurement anyway. There was some apparent resistance to that advice. The apparent resistance might have been based on a desire to move quickly with the procurement.

- The business case was deficient. A business case was eventually prepared, but only after negotiations had taken place and a draft contract with HealthTap drawn up. There appears to have been no input into the business case from anyone in Waikato DHB's legal or procurement teams. In addition, the business case was written primarily as a strategic business case for virtual care, rather than as a business case explaining and justifying the rationale for entering into a contract with HealthTap. Therefore, it outlined a rationale for adopting virtual care but included little discussion about how the services Waikato DHB would acquire from HealthTap would align with that rationale or about the costs, benefits, or risks of selecting HealthTap as a provider rather than any other party.
- The procurement plan was also a problem. Like the business case, a procurement plan was not written until after a draft contract had been drawn up. The information it contained on market analysis and the chosen procurement approach (that is, selective procurement) was, in our view, unconvincing. The procurement plan was also never finalised. The sense we got is of a plan written after the fact, largely to justify a decision that had already been made.

There are some obvious problems with this approach. Lack of proper planning in the early stages of a procurement means that all subsequent decisions might end up being built on shaky ground. Expert legal and procurement advice came too late. Not getting expert advice at the outset means you risk failing to identify issues that might be fundamental to how you need to carry out the procurement. Writing your business case and procurement plan after you are already in contract negotiations with a potential provider means you risk writing to justify a decision you have effectively already made, rather than one that – viewed objectively – can be seen to be in the best interests of the organisation.

Our concern is not just about "not following the Rules". It is about the apparent disregard shown for the principles underlying those Rules – namely, the importance of fair practice, sound decision-making, and being able to show value for money when making procurement decisions.

There are other problems with Waikato DHB's approach that are perhaps less obvious but that, in our view, contributed to the problems that were encountered after the contract with HealthTap was signed.

- The first problem is the lack of collaboration with other parts of the health sector.

  Each DHB is an independent entity, with its own responsibilities and interests that it needs to attend to. However, there is also an expectation and, in some situations, a legal requirement for DHBs to collaborate when planning, funding, and providing health services.

  In this instance, given the nature and scope of what Waikato DHB was trying to do, its potential to fundamentally alter the way services would be provided, and the need to get buy-in from clinicians and others who would be expected to use the service, it is unclear why Waikato DHB did not seek to engage with other DHBs, providers of health and disability services, clinicians, and the National Health IT Board much sooner.

- The second problem is the lack of clarity about what Waikato DHB was trying to achieve and how the associated costs and benefits would be measured.

  The proposed contract with HealthTap was presented to the Board as a two-year trial. It was intended to help Waikato DHB improve service delivery and to achieve cost savings, with a view to paying for itself.

  However, it was also pitched as part of a bigger plan to establish Waikato DHB as a "virtual health care hub" for Australia and New Zealand. That would have included setting up a partnership with universities to create a new model of study based on virtual care and some form of academic research that would guide and validate the change to a virtual care model.

  These other aspects of the plan did not eventuate. For reasons explained in this report, a formal evaluation process requested by the National Health IT Board – specifically, to ensure that, at the end of the trial, the advantages and disadvantages of the initiative could be objectively determined – also never eventuated.

  The end result is that Waikato DHB cannot show that the desired improvements in service delivery or cost savings were achieved. It is also unclear what benefits it can show from implementing HealthTap as a trial of virtual care in New Zealand.

- The third problem concerns the lack of oversight of the project after the contract was signed.

  We acknowledge that, from the perspective of Waikato DHB's overall budget, the amounts involved in this procurement might appear small, and that the Board of a DHB cannot be expected to have direct oversight of all projects and activities going on in their DHB at any one time.

However, this procurement was a strategically important initiative for Waikato DHB and one that, in the Chief Executive's words, was intended to be a "step change" for the way it went about providing services.

When giving approval to the project, the Board asked several questions about matters that still needed to be resolved, including substantive matters such as the proposed implementation strategy and engagement with the Medical Council, clinicians, and staff. The Board also wanted confirmation that the legislative framework in New Zealand would allow the service to be established as envisaged. It specifically asked for reporting on these matters.

During our inquiry, we did not see evidence of reporting to the Board on any of the issues it had raised when approving the contract or of the Board seeking to follow up on these matters. The high-level governance structure that was proposed to provide oversight of the project was never implemented.

Given the nature of the project and the Board's own questions and concerns about it, we consider that greater oversight of the project, whether at Board level or through some other form of governance structure, was warranted.

Why good procurement is important

A good procurement process supports responsible and fair spending of public money. It also helps manage the risks associated with obtaining and providing public services and promotes accountability and increases transparency. As set out in the Rules, important principles provide the overarching values for procurement by public organisations. Those principles are:

- plan and manage for great results, including identifying your needs, understanding the market, and choosing the right process;
- be fair to all suppliers, which creates competition and gives all providers a chance to participate;
- get the right supplier, which includes selecting one that can deliver what is needed at a fair price and on time, and where risks are identified and managed by the right person;
- get the best deal for everyone, which includes getting value for money, considering the social and economic effects, being able to monitor and measure the outcomes, and being accountable for the results; and
- play by the rules, which includes being accountable and transparent, and all parties acting responsibly.

These principles and the rules that support them are not simply requirements for their own sake. They help guide an organisation to make good procurement decisions that provide the best outcome for the public. It is important that New Zealanders have trust and confidence that the public sector makes good decisions on their behalf and is being a good steward of its resources. Being able to demonstrate through a good procurement process that those decisions have been well made supports that trust and confidence.

Good procurement practice includes properly documenting your decisions. A major concern for us with our inquiry, and a factor that contributed to the amount of time it took, was the lack of documentation for significant parts of the procurement process.

Final comment

The events described in this report are now in many ways historical. However, there are important lessons about a good procurement process that can be learned and applied to other procurements in the public sector – in particular, when seeking to be innovative.

Innovation in the public sector is important. It can lead to new and better services for the public and more efficient ways to deliver current services. However, when public organisations seek to innovate, it is all the more important to respect the disciplines of good procurement. Innovative service delivery and good procurement practice are not mutually exclusive.

Respecting good procurement disciplines helps a public organisation have assurance that its procurement will deliver value for money, and that valuable public resources will not be wasted regardless of the innovative nature of what is being procured. Without enough assurance that its procurement will deliver value for money, there is a greater risk of the procurement wasting valuable public resources.

Nāku noa, nā John

John Ryan
Controller and Auditor-General

20 September 2019

1 Introduction

1.1 In September 2015, Waikato District Health Board (Waikato DHB) entered into a two-year contract with a company based in California, HealthTap Inc (HealthTap), to provide information technology services (the HealthTap platform) to support Waikato DHB's delivery of what became known as its "SmartHealth service".

1.2 The SmartHealth service enabled patients and clinicians to access and deliver healthcare "virtually" rather than in face-to-face consultations. The HealthTap platform behind the SmartHealth service offered a range of modules and services (such as video technology, messaging facilities, appointment scheduling, and health records). It was available as a web-based service and as a downloadable application (an app) for cell phones.

1.3 As part of our annual audit of Waikato DHB for 2016/17, our appointed auditor identified several concerns with the procurement of the HealthTap platform. Those concerns included the lack of an open market procurement process, compliance with the *Government Rules of Sourcing* (the Rules), and an inability on the part of Waikato DHB to demonstrate value for money.

1.4 In November 2017, the State Services Commissioner wrote to us asking us to investigate the procurement process Waikato DHB followed with HealthTap. He made this request because of concerns about the procurement that had arisen in the context of an investigation the State Services Commission was carrying out at that time into expenses claimed by Waikato DHB's former Chief Executive (the Chief Executive). The Chief Executive was closely involved in the procurement of the HealthTap platform.

1.5 In December 2017, we decided to carry out an inquiry into Waikato DHB's procurement of the HealthTap platform.

How we carried out this work

What we looked at

1.6 In our terms of reference, we said that we would examine:

- Waikato DHB's procurement of information technology services from HealthTap to deliver the SmartHealth service;
- Waikato DHB's management of the contract entered into with HealthTap; and
- any other related matters that we considered it desirable to report on.

1.7 In February 2018, after our inquiry was already under way, Waikato DHB decided to commission its own investigation into the SmartHealth service. It engaged the professional services firm Ernst & Young (EY) to provide an independent assessment of the "functionality, implementation, costs and benefits of the technology platform HealthTap, in the context of its SmartHealth initiative". Waikato DHB made that report public in May 2018.

1.8 EY's report covers some of the ground we intended to cover as part of our inquiry. Therefore, we decided to focus our inquiry on the sourcing phase of the procurement process, rather than on contract implementation.

1.9 For the sake of completeness, we have included a summary of some aspects of EY's report in Part 8. However, EY noted in its report that the Chief Executive was not among the stakeholders interviewed for its work.[1] The Chief Executive told us that there are aspects of the EY report that he does not agree with.

What we did

1.10 We reviewed more than 7000 documents Waikato DHB provided to us.

1.11 We spoke with several current and former DHB staff who were involved in the procurement or implementation of the HealthTap platform, including the Chief Executive at the time of the procurement. We also spoke with several current and former Board members.

1.12 HealthTap and the Chair of the Waikato DHB Board at the time of the procurement provided responses to written questions that we submitted to them.

1.13 We talked to several people from other organisations Waikato DHB interacted with during the implementation of the SmartHealth service, including from the Ministry of Health and two health organisations in the Waikato region. We also reviewed documents provided by those organisations and the work our appointed auditor carried out on the procurement as part of the annual audit work.

What we did not do

1.14 As well as our normal audit work and our inquiry, there have been other investigations or reviews of Waikato DHB. We have been mindful not to duplicate that work or consider the issues they have covered.

1.15 As already mentioned:

- The State Services Commissioner has investigated expenditure and other matters related to the Chief Executive during his time with Waikato DHB. A report on that investigation was issued in March 2018. The State Services Commissioner's investigation did not look the procurement of the HealthTap platform. Similarly, we have not considered any of the related travel or other expenses that investigation might have been covered.
- We have not duplicated the work carried out by EY during its review.

1.16 The Serious Fraud Office also carried out an investigation relating to the Chief Executive at the same time as we were performing our inquiry. The Serious Fraud Office announced the closure of its investigation on 4 July 2019.

1 Ernst & Young (17 May 2018), *Waikato District Health Board Assessment of Implementation of the HealthTap Solution*, page ii.

The timing of this report

1.17 Our inquiry has taken longer than we anticipated. There are several reasons for this. They include a lack of documentation about some important aspects of the procurement, which meant we had to interview more people to try to fill the gaps in information.

1.18 There were also issues relating to our need to access, use, and share legally privileged information with some interviewees and the legal processes that had to be followed to support that. As part of our inquiry, Waikato DHB gave us access to legally privileged information without any waiver of privilege. We asked Waikato DHB whether it would waive privilege over that information for the purposes of this report. Waikato DHB has decided not to waive privilege, which it is entitled to do. Therefore, we have not included that information.

1.19 Most importantly, we considered it essential to interview the Chief Executive, who was instrumental in initiating and driving the procurement of the HealthTap platform. He was not available for an interview until January 2019, which was more than a year after we began our inquiry work.

How this report is structured

1.20 Part 2 provides information on virtual care, the reasons for Waikato DHB's interest in virtual care, HealthTap, and the HealthTap platform.

1.21 Part 3 explains the context in which DHBs operate and the procurement processes they are required to follow.

1.22 Part 4 describes the initial stage of the procurement process, from the point when HealthTap was first approached to the first draft of a contract.

1.23 Part 5 outlines the advice from DHB staff that was provided about the draft contract and the procurement process.

1.24 Part 6 describes the involvement of the Board up to when it gave in-principle approval to the contract.

1.25 Part 7 describes changes that were made to the contract after that in-principle Board approval and summarises what the final contract said.

1.26 Part 8 describes some aspects of EY's report that we consider relevant to our inquiry.

1.27 Part 9 sets out our views on Waikato DHB's procurement process.

2 Background information

2.1 This Part provides background information that is helpful to understanding Waikato DHB's decision to purchase the HealthTap platform. It describes:

- what virtual care is;
- why Waikato DHB was interested in virtual care;
- what HealthTap is; and
- how the HealthTap platform works.

What is virtual care?

2.2 Virtual care is the use of various communication and information technologies to improve patient access to care, health engagement, and health outcomes. Waikato DHB anticipated that using virtual care would give patients more control over their healthcare, reduce the need for patients to physically travel to clinics, and give patients access to credible online health information.

Why Waikato District Health Board was interested in virtual care

2.3 Waikato DHB's interest in virtual care was driven by a need to find a way of delivering healthcare in a more cost-effective and patient-centred way.

2.4 Particular drivers for change were described in Waikato DHB's strategic business case for virtual care:

> *A synopsis of the major drivers is given below:*
>
> - *Impending demand for health services created by the health needs of the baby-boomer generation.*
> - *Increasing burden-of-lifestyle illness such as obesity and chronic disease management.*
> - *The increasing depopulation of rural centres with the concomitant reduction in the supply of medical services.*
> - *Overreliance on treatment-based medical services rather than proactive patient-based public health activities.*
> - *Demographic change in our current healthcare workforce will constrict supply of suitable qualified personnel over the next 15 to 20 years.*
> - *Reducing real funding available to public health care as a component of national GDP.*

2.5 Before it implemented the SmartHealth service, Waikato DHB was already using "telehealth" services to perform virtual ward rounds in its hospitals. A virtual ward round involved a nurse taking a telehealth cart (similar to a computer on wheels) to the patient's bedside and the patient and specialist then communicating through a video screen.

2.6 About the same time, Pinnacle Healthcare, the largest primary health organisation in the Waikato region, was developing its own patient portal. Patient portals are secure websites that allow people to access their personal health information and interact with their doctor. Through patient portals, people can send secure messages to their doctor, order repeat prescriptions, and, in some patient portals, view lab results and doctors' notes.

2.7 However, our understanding is that implementing a comprehensive virtual care approach to the delivery of health services had not been attempted by any other DHB or healthcare provider in New Zealand at the time.

What is HealthTap Inc?

2.8 HealthTap is a company based in the United States that developed the HealthTap platform. It provides software that connects patients with doctors and clinicians online using video-conferencing and audio and text messaging.

2.9 The Chief Executive told us that, when he first approached HealthTap to discuss its virtual care services and products, the company was still in its start-up phase. Its Board included its investors and representatives, and HealthTap's main business at the time was with small to medium-sized practices in the United States. The Chief Executive told us that, although HealthTap had clients in almost 50 states, it was still on the cusp of preparing for larger "enterprise" customers, such as Waikato DHB.

How does the HealthTap platform work?

2.10 The HealthTap platform is an online package of modules made available through an app. There are two versions – one for consumers and one for providers. Both versions are available through Apple and Google Play's app stores. It is also available through a web-based interface.

2.11 The HealthTap platform enables patients to communicate with clinicians through video conferencing and audio and text messaging, and to access health information. The HealthTap platform also enables clinicians to create medical records of those consultations.

2.12 The HealthTap platform is a form of "software as a service", meaning that those purchasing it do not own and install the software locally but access it online. The components include:

- a health profile that records a patient's demographic and health history information;
- a consultation platform through which a patient and clinician can talk to each other by text, audio, or video, and the HealthTap platform also supports the exchanging of messages and attachments; and
- a healthcare team component that enables patients to invite clinicians to join the team looking after them and that gives those clinicians access to the patient's health profile.

3 District health boards and their procurement processes

3.1 In this Part, we describe:

- the context in which DHBs operate; and
- the rules DHBs are required to follow when procuring goods and services.

The context in which district health boards operate

Requirement for collaboration

3.2 DHBs are Crown entities. Their activities are governed by the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000, and associated Regulations, including Regulations about planning.

3.3 DHBs receive public funding to plan, fund, and provide health and disability services for the population of a district. To carry out these functions, they are required to collaborate with, or purchase services from, other providers of health and disability services, such as primary health organisations, general medical practices, and other DHBs.

3.4 Collaboration requirements include working with other DHBs in their region to develop a regional services plan. A regional services plan ensures that DHBs providing services in the same region align their service and capacity planning.

3.5 Waikato DHB operates in the Midland region, so it is expected to work with the other DHBs in the Midland region. When planning services and major information technology projects, Waikato DHB has to plan alongside the Lakes, Tairawhiti, Bay of Plenty, and Taranaki DHBs in relation to their regional services plan.

3.6 Each DHB is governed by a Board comprising a mix of ministerial appointees and publicly elected members. In this report, we refer to the governing body of Waikato DHB as "the Board".

Information services and information technology

3.7 Information technology (IT) presents a particular challenge for the health sector. In 2009, the National Health IT Board was established as a subcommittee of the National Health Board. One of its tasks was creating a national IT plan for the health sector to help address barriers to sharing information between different parts of the health sector and what was seen as a fragmented, organisation-centric approach to health IT investments.

3.8 Both the National Health IT Board and the National Health Board were disestablished in March 2016, and their functions were incorporated into the Ministry of Health. However, at the time of this procurement, DHBs were required to actively support the national IT plan by collaborating on a regional IT plan. DHBs were also required to follow guidelines and advice provided by the National Health IT Board.

3.9 Specific matters for which DHBs needed to get approval from the National Health IT Board were:

- any capital expenditure on information technology for amounts more than $500,000; and
- storing any "personally identifiable health information" offshore.

The rules that apply to procurement

3.10 When purchasing goods and services, DHBs are required to comply with the Rules.

3.11 The Rules are government standards of good practice for government procurement and incorporate New Zealand's international commitments on government procurement. When the Rules were first introduced, they were not mandatory for DHBs. They became mandatory for DHBs in February 2015, which was during the early stages of the HealthTap procurement.[2]

3.12 The Rules include a mixture of rules and principles. Combined, the rules and principles are intended to:

- guide public organisations to procure responsibly and to achieve public value; and
- provide consistent and transparent standards to give everyone confidence in the integrity of government procurement.

3.13 Agencies can be audited for compliance with the Rules, and suppliers have a right to complain if they consider that an agency has not complied with the Rules.

3.14 For the purposes of this report, the main points to note about the Rules are:

- As a general rule, the Rules applied to all goods and services purchased by DHBs except for "certain types of health services" (which are defined in the Rules).
- The Rules applied to any procurement by a DHB if the value exceeded $100,000.
- There was a requirement to openly advertise procurement opportunities, unless one of the specified exemptions applied.
- For certain types of procurement, including any type of procurement with an estimated value over the whole-of-life of the contract of $5 million or more, DHBs were required to submit a procurement plan to the Ministry of Business, Innovation and Employment to review and to have regard to any advice or feedback provided by that Ministry on the plan.

2 The version of the Rules that applied to Waikato DHB at the time was the third edition. A fourth edition of the Rules will officially come into force on 1 October 2019. These are to be called the *Government Procurement Rules* rather than the *Government Rules of Sourcing*. The fourth edition requires public organisations to have policies in place that incorporate the same principles as the third edition but that also incorporate the Government Procurement Charter. The Charter sets out government expectations of how public organisations should conduct their procurement activity to achieve public value.

4 Initial stages of the procurement process

4.1 This Part describes the early stages of the procurement process, from Waikato DHB's initial discussions with HealthTap to the first draft of a contract. It covers events from October 2014 to April 2015.

4.2 The written evidence available for these early interactions between Waikato DHB and HealthTap is limited because few records were available from Waikato DHB. This Part is based largely on the recollections of people we interviewed.

October 2014: The Chair and the Chief Executive first hear about HealthTap

4.3 In October 2014, the Chair and the Chief Executive attended a meeting at the University of Waikato with a professor from Harvard University's School of Public Health.

4.4 Our understanding is that, at the time, Waikato DHB was actively working on a virtual care strategy and had already embarked on some aspects of virtual care. However, the Board had not yet formally approved or endorsed a virtual care strategy.

4.5 The Chair told us that, at the meeting, he mentioned to the professor the challenges Waikato DHB faced in adequately servicing a remote rural population and that the Professor suggested Waikato DHB look at HealthTap as a service that might be able to help.

October/November 2014: The Chair's meeting with HealthTap in the United States

4.6 At some point after this conversation with the professor, in either October or November 2014, the Chair travelled to the United States and, during that trip, met with the Chief Executive of HealthTap. The Chair told us that his meeting with the HealthTap Chief Executive lasted about 45 minutes and that they discussed what HealthTap was doing and what it had achieved.

4.7 The Chair told us that, on his return from the United States, he reported to the Board about his trip, including his visit to HealthTap. He said that this would have been at either the last Board meeting of 2014 or the first meeting of 2015. There were no records of this in the minutes of Board meetings. However, it is possible the Board was briefed informally.

4.8 The Chair also told us that he asked the Chief Executive to "have a look at HealthTap" to see whether it would work for Waikato DHB.

4.9 The Chief Executive was relatively new at the time. He started his role in July 2014 and told us that there was a great sense of urgency at Board level at the time about the problems that needed addressing, such as the growing population, poor access to health services, and Waikato DHB's struggling financial performance. He said he was employed by the Board to make "radical changes" at Waikato DHB. He saw virtual care as one of the tools that could be deployed to bring about the radical change he believed the Board was seeking.

March 2015: The Chief Executive's meeting with HealthTap in the United States

4.10 In early February 2015, the Chair emailed the Chief Executive of HealthTap and proposed a more in-depth discussion between HealthTap and Waikato DHB's Chief Executive. In March 2015, the Chief Executive visited HealthTap's offices in Palo Alto, California.

4.11 We were told that the purpose of this visit was to discuss a potential partnership between Waikato DHB and HealthTap, and to see HealthTap's business culture. This was considered necessary because HealthTap was a start-up company and any deal with Waikato DHB would be the first time that HealthTap had done business with a customer of this size.

4.12 After the Chief Executive's visit, discussions began between HealthTap and Waikato DHB, covering matters such as HealthTap's business model, how HealthTap interacted with its clinicians, and its pricing model. Those discussions were led by the Chief Executive and continued to the point where the parties agreed an in-principle deal, under which Waikato DHB would purchase a license for 2500 users of the HealthTap platform for two years. The cost was US$2,000 for each of the 2500 users.

4.13 The Chief Executive told us that the marketplace for virtual care was not well developed at the time. He said that what he believed was needed was an existing platform that had an established track record and substantial clinical buy-in, and that included:

- multi-organisational capability that could integrate into consumer-based technology, such as general practitioner clinical practice systems, as well as Waikato DHB's own system, "Health Views";
- interoperability with local and national health platforms, such as those of the Ministry of Health;
- the ability to operate on broadband and 4G networks, to be deployed rapidly, and to evolve quickly to meet New Zealand and local conditions;

- peer review functions;
- compliance with New Zealand Government IT and information security standards relating to privacy and security of information stored in the cloud; and
- exit features that would enable Waikato DHB to transfer to another provider if necessary.

4.14 The Chief Executive told us that, in scanning the market, the only supplier that could meet most of these requirements was HealthTap. He said that his expectation at this point was that Waikato DHB would enter into an initial contract with HealthTap for a fixed term of two years. Those two years would be an "exploratory stage", during which Waikato DHB would learn more about what its needs were and what barriers it might face in implementing virtual care.

4.15 The two-year exploratory stage was also intended to give the market time to mature. The intention was to then go back to the market to test what else might have become available in the interim and to "stimulate the market" to respond in a way that would give Waikato DHB more options in the longer term.

Late March 2015: Draft letter of intent

4.16 By late March 2015, a draft letter of intent had been developed. It set out the following terms:

- The HealthTap platform would be available to be used by Waikato DHB's more than 2500 doctors and affiliated general practitioners.
- There would be a "full-scale rollout" of the platform from 1 January 2016.
- Waikato DHB was intended to become the "innovation hub" for Australia and New Zealand for delivering end-to-end virtual care, taking advantage of its early adoption of the HealthTap platform.
- It was anticipated the parties would enter into a formal agreement some time before 11 May 2015 and likely on 10 April 2015.

4.17 HealthTap emailed a copy of the draft letter of intent to the Chief Executive, who forwarded it to the Chair. Waikato DHB was unable to find a copy of the final signed version in its files. It appears that Waikato DHB never signed the letter of intent. The Chief Executive told us that Waikato DHB never intended to sign the letter.

April 2015: A draft contract

4.18 After the letter of intent was drafted, the chief executives of Waikato DHB and HealthTap met for about three hours at Auckland airport, together with the Chair and Waikato DHB's Chief Information Officer. We have some evidence that they

met to discuss the terms of a possible contract and to agree a price in principle. This was sometime in early April 2015.

4.19 On 11 April 2015, HealthTap sent a copy of a draft contract to Waikato DHB. We understand the draft contract was based on HealthTap's standard customer agreement. It included the following key terms:

- HealthTap would licence Waikato DHB to use the HealthTap platform through the web and mobile apps.
- The licence would include the right to use some or all of the following components:
  - **Scheduling**: for use with virtual consultations;
  - **Content**: which would be used to educate and engage patients;
  - **Communication**: which would provide a platform for virtual consultations delivered by clinicians;
  - **Services**: for use with virtual care services (such as medications and diagnostics);
  - **Support**: which would have patient follow-up and engagement capabilities; and
  - **Personal Health Record**: which would be integrated with Waikato DHB's health-delivery system.
- The HealthTap platform would be provided through cloud-based computing and data storage devices specified by HealthTap.
- HealthTap agreed that it would not supply any other healthcare provider in Australia or New Zealand with the HealthTap platform for a period of six months, which could be extended by negotiation. The granting of this exclusivity period was said to be in support of Waikato DHB's goal of becoming "the innovation hub of the Australia and New Zealand region for the delivery of end-to-end virtual care, and to ensure a well-executed and fully resourced rollout." The exclusivity period did not give Waikato DHB the right to act as a reseller or broker of the HealthTap platform.
- Waikato DHB would pay a license fee of US$5,250,000 each year of the two-year term of the contract. In the first year of the contract, the licence fee was payable in three instalments, coinciding with three project milestones. The license fee is described as being based on a proxy of US$2100 for each authorised user each year and assumed there would be 2500 "authorised users", meaning general practitioners, clinicians, and other health service providers.
- A "usage fee" of US$10 was also payable for each completed virtual consultation.
- These fees did not include any customisation and integration services, which would be billed separately.

4.20 The draft contract records that Waikato DHB asked HealthTap to integrate information from Waikato DHB's electronic health record system into the Personal Health Record part of the HealthTap platform for use by authorised users during virtual consultations with patients. It was noted that this work would require a separate agreement and scope of paid work.

4.21 The draft contract gave Waikato DHB no warranties and no termination rights, and was subject to the laws of the State of California in the United States.

4.22 Correspondence between Waikato DHB and HealthTap at this time shows there was an expectation on the part of HealthTap that the contract would be signed by late April 2015. HealthTap was apparently interested in the idea of announcing its deal with Waikato DHB at a telemedicine conference in Australia at that time, and the Chief Executive of HealthTap had arranged to come to New Zealand to execute the documents at the same time.

Our observations about the initial development of the arrangement with HealthTap

There was a lack of written records of the early stages of the procurement

4.23 Few records were available about the early discussions between Waikato DHB and HealthTap, and how they reached the point of a draft contract.

When HealthTap was first approached, it was unclear how well developed the virtual care strategy was

4.24 From the evidence we have seen, it is not clear when Waikato DHB first approached HealthTap; how well developed Waikato DHB's virtual care strategy was; how widely Waikato DHB had discussed the strategy with other DHBs, clinicians, or primary health providers; or whether the Board had formally endorsed it.

No legal, procurement, or other specialist legal staff were involved in the initial discussions or negotiations with HealthTap

4.25 The early discussions and negotiations about a possible agreement with HealthTap, as described in this Part, were led by the Chair and Chief Executive with some input from the Chief Information Officer. No legal, procurement, or other specialist staff at Waikato DHB were involved.

There was no evidence of any formal planning or risk analysis in the early stages of the procurement process

4.26 Up to this stage of the process:

- There was little evidence of any of the planning or risk analysis that might typically be expected for a procurement activity of this type and size.
- There was no business case or procurement plan, no documented identification of needs or market analysis, no identification of internal and external stakeholders, and no documented due diligence of HealthTap as a potential supplier.

There was no evidence of consideration being given to Waikato DHB's procurement or consultation obligations

4.27 There was no evidence that those leading the negotiations with HealthTap had considered either the Rules or Waikato DHB's procurement policy. In particular, there was no evidence that they considered:

- whether the Rules or Waikato DHB's policy permitted Waikato DHB to approach a potential supplier without openly advertising the procurement opportunity; or
- whether Waikato DHB needed to consult with any external agencies, such as the Ministry of Business, Innovation and Employment or the National Health IT Board, about the proposed contract with HealthTap.

It was unclear what benefit Waikato DHB would obtain from the exclusivity clause or from having a "first user" advantage

4.28 Both the draft letter of intent and the draft contract included a provision establishing an exclusivity period during which HealthTap agreed that it would not supply any other healthcare provider in Australia or New Zealand with the HealthTap platform. The exclusivity period was stated to be in support of Waikato DHB's goal of becoming "the innovation hub of the Australia and New Zealand region for the delivery of end-to-end virtual care".

4.29 In the documents we were given to review, we did not find any clear explanation of the rationale for the exclusivity period, how this would support Waikato DHB's goal of becoming an innovation hub, or why being an innovation hub was important to the virtual care strategy.

4.30 When we interviewed the Chief Executive, he told us there were three reasons for the exclusivity clause:

- The first reason was to try to prevent HealthTap from "ratcheting prices up" in Australasia.

- The second reason was to prevent HealthTap from talking to other DHBs in New Zealand without his knowledge. He said that this was because of the "unique relationship" between Waikato DHB and HealthTap and because he wanted to ensure that Waikato DHB was in control of it.
- The third reason was because Waikato DHB was already providing services to other DHBs in some areas of virtual care and getting paid for it – for example, in dermatology. The Chief Executive told us that he wanted to make sure that, if other DHBs took up licences to use the HealthTap platform, Waikato DHB – which had paid for the establishment of the HealthTap platform in New Zealand – would get any commercial benefit from other DHBs coming on board.

4.31 Despite this explanation, it remains unclear to us what benefit Waikato DHB was seeking by including the exclusivity clause and whether that benefit was to gain a commercial advantage for itself or to protect the interests of other DHBs that might be interested in the HealthTap platform.

Procurement and legal advice on the draft contract

5

5.1 It was only after Waikato DHB received a copy of the draft contract on 11 April 2015 that its in-house legal and procurement teams became aware of the discussions that had taken place and the proposed contract with HealthTap.

5.2 During the next few days, discussions took place involving Waikato DHB's Corporate Solicitor, the Chief Executive, the Chief Information Officer, and HealthTap executives. Waikato DHB's Corporate Solicitor also sought advice from external specialist legal advisers on the draft contract. Legal advice was provided to the Chief Executive and the Chief Information Officer in April 2015.

5.3 It is evident from these exchanges, and from interactions that followed, that Waikato DHB staff had serious reservations about the terms of the draft contract and the procurement process that had been followed to date. As a result, it became clear that signing a contract before the end of April 2015 was not going to be feasible.

5.4 In this Part, we outline:

- the requirements of Waikato DHB's procurement policy;
- what Waikato DHB's normal practice was for a procurement of this type;
- why Waikato DHB staff were so concerned about the terms of the draft contract and the procurement process that had been used; and
- some of the steps taken in response to those concerns.

Waikato District Health Board's procurement policy

5.5 Waikato DHB's procurement policy required:

- a business case for any procurement greater than $500,000 in total value that had significant strategic implications or that carried significant risk;
- an assessment of the market conditions and business needs in the short term and long term;
- a clearly documented rationale for the proposed procurement approach;
- a planned and documented approach for deciding which supplier has the best capability to deliver and provide value for money before approaching the market;
- a procurement plan for procurement more than $100,000 before any approach to the market; and
- a due diligence process to be carried out on potential suppliers to assess their financial ability, technical ability, and capacity to fulfil the contract.

5.6 The policy also included the expectations that, as a general rule, market testing would be carried out through some form of competitive procurement process and that, if a competitive process was not adopted, the justification for not using a competitive process would be recorded in the procurement plan.

Waikato District Health Board's normal procurement practice

5.7 Waikato DHB staff told us that a normal process for procurement involving large expenditure followed the approach set out in Waikato DHB's policy.

5.8 Business requirements would be identified and inform the procurement process that was to be used (that is, whether a competitive process or direct procurement would be used and, if a competitive process was used, what form that would take).

5.9 Staff would then develop a business case and a procurement plan. The procurement plan would cover the procurement objectives, methodology, evaluation (including criteria and panel members), and reporting and monitoring arrangements, among other matters.

5.10 The procurement process used was usually driven by how clear the business requirements were. In some instances, the business requirements would be more fully developed after running a process to request expressions of interest. A request-for-proposal process would then follow.

5.11 We were told that, in nearly all instances where Waikato DHB was purchasing something unique, staff would run a request-for-proposal process. We were also told that Waikato DHB would generally carry out due diligence checks on the potential provider when it intended to contract with companies for IT services. The due diligence checks would typically include reviewing the provider's financial position and carrying out reference checks, and might include visits to the provider's premises.

Concerns from Waikato District Health Board staff about the procurement process

5.12 As noted in paragraph 5.3, Waikato DHB staff raised concerns about the procurement process and the proposed contract with HealthTap as soon as they became aware of it. Concerns that were raised included:

- that Waikato DHB needed to consider whether the Rules applied and, if so, whether there were any exemptions that would permit Waikato DHB to take a direct sourcing approach rather than openly advertising the procurement;
- that, if the Rules applied and the value of the contract was more than $5 million (as was likely), Waikato DHB was required to submit a procurement plan to the Ministry of Business, Innovation and Employment to review;
- that Waikato DHB needed to consider whether the proposed purchase of the HealthTap platform was a capital investment in information and communications technology, because, if it was, the National Health IT Board needed to approve it;

- that it was not clear from the terms of the contract whether the arrangement was, in fact, a trial, as those leading the negotiations had indicated was the intention; and
- that it was also not clear whether the arrangement could be ended after two years.

5.13 Some of the staff present at the meeting told us that, when concerns were raised about whether a direct sourcing approach was permitted, those leading the HealthTap proposal appeared reluctant to contemplate seeking expressions of interest from other potential providers at that point in the process. We understand that this was because of the time it would take and a view that there was the need to move quickly.

5.14 The need to move quickly was because of concerns Waikato DHB would lose control of the idea and the perceived advantage of being first with the HealthTap platform. We understand that this was related to the provision in the draft contract under which HealthTap agreed to an exclusivity period of six months and concerns that, if Waikato DHB then went to market, it would lose the advantage of the exclusivity period it had negotiated with HealthTap.

Concerns about the draft contract

5.15 Waikato DHB's Corporate Solicitor sought specialist external legal advice on the draft contract. A summary of this legal advice was provided to the Chief Executive and the Chief Information Officer in April 2015. The content of the advice is legally privileged. We asked Waikato DHB whether it would waive privilege over this advice for the purposes of this report and it decided not to, which it is entitled to do.

5.16 The outcome of that advice was that the draft contract could not be agreed in its current form. It is nevertheless clear Waikato DHB staff had serious reservations about the terms of the draft contract and the procurement process that had been followed to date.

Steps taken in response to staff advice

5.17 It appears that, between April and June 2015, some steps were taken in response to advice from Waikato DHB staff. These included drafting a procurement plan and a due diligence process.

Draft procurement plan

5.18 We summarise the main points in the draft procurement plan in the paragraphs below. In doing so, we note that the plan was never finalised and that the draft we were shown, dated 21 April 2015, includes some information that was incorrect. This might be because it was written in anticipation of steps that needed to be taken or matters that needed to be approved, rather than as a record of these

things having been done. However, the plan does provide some evidence of how the rationale for the procurement was being developed and presented at the time.

5.19 The plan describes how Waikato DHB had adopted a new strategic objective to make more of its virtual care services. One of the three cornerstones of this initiative was a two-year trial that would "build the knowledge of how to create sustainable virtual clinical services".

5.20 The plan said that the main objective of the virtual care initiative was to place "patient/whanau/citizen at the centre of the healthcare continuum" and to "rebalance the clinician patient relationship by increasing patient authority". It was noted that close integration would be needed with researchers from international universities to ensure that the clinical practice that was created was safe for patients and clinicians delivering the service.

5.21 The plan goes on to describe how the proposed innovation of personal virtual care using the HealthTap platform needed to be seen in the context of the need for change – such as the lack of medical services in rural areas and the "overreliance on treatment-based medical services rather than proactive patient-based public health services".

5.22 The plan also refers to the need for Waikato DHB to respond to the "disruptive pressure for change" that was being driven by the increasing use by patients of non-accredited, online medical services.

5.23 The main points recorded in the plan as at 21 April 2015 were:

- The proposal was for an initial contract for two years, followed by a full request-for-proposal process. The contract was stated to have been negotiated by the "Waikato legal team" and its expected value was US$10 million over two years.
- A budget had been presented to, and approved by, the Board.
- Stakeholders were identified as being "all service units within the provider arm of Waikato DHB". The plan stated that these stakeholders would be part of a two-year study and would have representatives on the governance boards.
- An exemption from the Rules was being sought – we assume from the requirement to openly advertise – on the grounds that Waikato DHB was carrying out a two-year study programme and that the identified system was needed to define the new clinical service after that programme.
- The plan included a heading for "Market analysis & procurement strategy", under which was written the following statement:

  The review of the market and engagement with Harvard school of population health identified that at the present time only one vendor has the capability to provide the services required.

- The plan also included a heading for "Procurement Method", under which was written:

  The process to select the supplier will be a closed procurement with a single provider given the unique nature of the work to be undertaken. It will be a fixed 2-year term of engagement after which a RFP process will be undertaken once the exact scope and need of the system to support virtual care is defined.

- Risk management was described as part of the business case.

5.24 As noted above, the plan was never finalised.

Due diligence on HealthTap

5.25 We were told that a due diligence process was carried out on HealthTap. This included the following steps:

- Staff at Waikato DHB reviewed media coverage of HealthTap.
- They also got in touch with a lawyer based in Silicon Valley, who provided them with some suggestions about how to do due diligence checks in the United States. That lawyer provided some high-level information on the investment funding HealthTap had received in recent years and on some of its investors. He suggested that staff ask to speak to a HealthTap Board member and/or investor, and ask them about the financial position of the company. He also suggested that they ask to see a copy of HealthTap's financial accounts.
- The Chief Information Officer called HealthTap's Chief Executive and asked to speak to a Board member or investor and to see a copy of their financial accounts. HealthTap's Chief Executive declined to provide this information.
- The Chair subsequently telephoned a HealthTap Board member who represented one of HealthTap's main investors. The Chair told us that they spoke for more than an hour and that he was "reassured that they [the investor] were committed for the long haul". The only record relating to that conversation we have seen is an email from the Chair indicating that the conversation had occurred. It did not specifically record what was said during the conversation.
- Waikato DHB's Chief Executive told us that he had discussions with doctors in the United States and Canada who used HealthTap's services and with a representative from the Mayo Clinic about the opportunities for capital reduction. He also told us that the due diligence process included face-to-face discussions with people in Australia, Canada, and the United States, including his visit to HealthTap in March 2015 to observe HealthTap's business culture. We have not been provided with any documentary records of those discussions.

Our observations about advice from Waikato District Health Board staff and the response to it

Waikato DHB's legal and procurement staff had no input until after HealthTap provided a draft contract for Waikato DHB's consideration

5.26 Waikato DHB's legal and procurement staff had no input into the procurement process until HealthTap provided a draft contract to Waikato DHB. We are concerned that Waikato DHB progressed so far with the proposed procurement without consulting its own legal and procurement staff.

Significant problems were identified with both the draft contract and the procurement process

5.27 Once key advisers became aware of the draft contract, they immediately identified several problems with the procurement process that had been followed to date, including potential non-compliance with the Rules and Waikato DHB's own procurement policy and significant problems with the draft contract.

Advice should have been sought on the procurement before HealthTap was approached

5.28 By approaching HealthTap and progressing discussions without understanding all the issues and risks that needed to be considered, Waikato DHB put itself in a difficult negotiating position. It also meant that, instead of enabling its staff to work in a proactive manner to help prepare a well-considered business case, procurement plan, and contract negotiation strategy, the legal and procurement teams were effectively required to operate in "damage limitation mode".

The procurement plan was drafted too late to be meaningful as a procurement plan

5.29 A procurement plan was subsequently drafted. However, this was several weeks after the draft contract was provided, the plan was never finalised, and it included information that might well have been inaccurate at the time it was written – for example, that Waikato DHB had adopted a new strategic objective to make more of its health services virtual health services, that a budget had been presented to and approved by the Board, and that the draft contract had been negotiated by Waikato DHB's legal team.

5.30 In any event, the procurement plan was written too late to be of any genuine help in guiding an effective procurement process. The sense we got is of a plan written after the fact, largely to justify a decision that had already been made, rather

than as a genuine and well-considered analysis of Waikato DHB's needs, risks, and rationale for contracting with HealthTap.

The due diligence carried out on HealthTap was not well documented or as timely as we would have expected

5.31 The due diligence process that was carried out, in our view, was not well documented or as timely as we would have expected. The documentation that does exist does not generally record the specific details of the results of the due diligence work.

Fear of losing a "first user" advantage did not justify non-compliance with the Rules

5.32 We are particularly concerned about the apparent resistance Waikato DHB's advisers struck when they pointed out that a direct sourcing approach might not be permitted under the Rules or Waikato DHB's own procurement policy.

5.33 Our concern is not just about "not following the Rules". It is about the apparent disregard shown for the principles underlying those Rules – namely, the importance of fair practice, sound decision-making, and being able to show value for money when making procurement decisions.

5.34 Our concern is amplified by the resistance to reconsidering the direct-sourcing approach appearing to have been, at least in part, because of fear of losing a so-called "first user" advantage. For reasons explained in Part 3, given the context in which DHBs operate, the motivation for wanting to be seen to be first to implement the HealthTap platform in New Zealand is not clear to us.

5.35 Therefore, we are all the more concerned at the suggestion that protecting a "first user" advantage might have been considered justification for not complying with the Rules, Waikato DHB's own procurement policy, or good procurement practice generally.

6 The Board's involvement in the procurement process

6.1 The Chief Executive had delegated authority to negotiate and sign a clinical service contract up to $10 million and to approve capital expenditure up to $1 million with input from the finance and procurement teams in Waikato DHB. Because the proposed contract with HealthTap would exceed the Chief Executive's financial delegation, it needed the Board's approval.

6.2 The Chair of the Board had visited HealthTap on an information-gathering exercise and participated in a face-to-face meeting at Auckland airport involving Waikato DHB's and HealthTap's chief executives. He was also provided with copies of the legal advice received on the draft contract. However, it is not clear how much the rest of the Board knew at this point about the proposed virtual care strategy or the specific arrangements with HealthTap.

6.3 In this Part, we explain how the Board was made aware of the arrangement and how it responded to it.

24 June 2015: Memorandum on virtual care provided to the Board

6.4 A memorandum on virtual care was provided to the Board for discussion at its meeting on 24 June 2015. The memorandum had been prepared by the Chief Executive, which includes a note at the top to explain that the memorandum:

- was not on the agenda for the meeting but had been included as a supplementary paper because it had not been "worked up" sufficiently at the point the agenda was compiled; and
- could not be held over until a subsequent meeting as there was an expectation of speed on the part of other interested parties.

6.5 The memorandum set out the case for virtual care, including outlining the challenges facing Waikato DHB, the need for an urgent "step change" in service delivery to prepare Waikato DHB for the health needs of the population, and delivery challenges in the next three to five years. The memorandum said that virtual care could:

- "encourage, enable and enforce greater accountability for health outcomes on to the patients themselves"; and
- let Waikato DHB "do a great deal more with a great deal less via our current health care delivery capability".

6.6 The memorandum explained that:

- the change required for virtual care had an exploratory stage that would take six months to refine and a further 18 months to embed as a new way of working;

- there would be a phased approach in which the first six months would be used to refine how to target the change and "drive out the benefits required", and the following 18 months would involve the roll-out of virtual care throughout Waikato DHB "where it is clinically appropriate";
- the estimated cost of the proposal would be $8.5 million each year for two years ($1 million for clinical change, to be funded by "capital and reprioritisation of operational funding", and $7.5 million for enabling clinical practice and technology);
- during the first six months, there would be "engagement with medical colleges and the Ministry of Health ... to ensure all required wider consultation is completed and any concerns nominated are addressed and resolved"; and
- after six months, any outstanding issues with the contract or implementing the services would be identified and addressed, and a plan made to roll out virtual care in Waikato DHB.

6.7 The memorandum identifies several activities needed to ensure success with the roll-out of virtual care. These were:

- the need to review and possibly make changes to legislation, both to give assurance to medical staff and to address any medico-legal concerns about practice standards;
- the need to ensure that the cost savings envisaged as a result of introducing virtual care could be demonstrated (the memorandum states that the cost model would be part of the academic research to guide and validate the change to a virtual care model);
- the establishment of a partnership with Waikato and Auckland universities to create a new model of study based on virtual care, to ensure that academic rigour was applied to any review of the virtual care model, and to ensure that the new way of working was applicable across clinical practice in New Zealand; and
- the need to manage issues related to storing patient data on offshore servers.

6.8 The memorandum recommended that the Board:

- note the need to move with urgency to manage the coming clinical delivery challenges for Waikato DHB; and
- approve the establishment of virtual care as outlined in the memorandum.

6.9 Notably, the memorandum does not mention that Waikato DHB had already approached the proposed supplier and a draft contract had been developed.

6.10 The memorandum was not discussed at the meeting. However, the minutes of the meeting record:

- that the Board's views were sought on mobile/virtual care technology and whether Waikato DHB should adopt this delivery model; and
- that, in response, the Board raised several questions about clinical change management, how the virtual care plan linked with Waikato DHB's strategic plan and priorities, and the urgency to form a relationship with HealthTap.

6.11 The Board resolved to receive the memorandum and that an electronic version be provided to Board members for their feedback. It requested that a comprehensive business case be produced.

6.12 The minutes do not record whether the Board's decisions were unanimous or whether individual Board members objected.

9 July 2015: The Board held a workshop to discuss virtual care

6.13 A few days after the 24 June Board meeting, the Chair emailed Board members to ask them to attend a workshop to discuss virtual care further. He said that the reason for the workshop was to discuss issues and questions that were not addressed by the paper prepared for the 24 June meeting. He also said that, if the Board was to decide to invest in this area, it would need to do so early in the financial year so that there would be time for any savings to be realised and to enable Waikato DHB to meet its budget for the year.

6.14 The workshop was held on 9 July 2015. We understand that at least two Board members were unable to attend the workshop. A discussion paper prepared for it contained similar information and rationale for the proposal to the 24 June 2015 memorandum to the Board.

6.15 There were no minutes from the workshop or other records of what was discussed. As these events are now some time ago, the Board members we spoke with no longer had a clear recollection of the matters discussed. The Chair told us that he believed the workshop indicated support for further investigation into the use of digital technology and the possible fit of HealthTap's services.

22 July 2015: The Board considered a strategic business case for virtual care

6.16 At the next Board meeting on 22 July, the Board was provided with a "Strategic Business Case for Virtual Care".

6.17 The business case contained information about the rationale and need for change similar to that in the memorandum and workshop paper that had been previously provided to the Board. It went on to describe specific success criteria, contractual aspects, expected hard and soft benefits, time frames, resource requirements, and risk analysis. It also briefly outlined the rationale for the procurement process. We summarise the main points below.

Targets

6.18 The targets for the first year included:

- reducing outpatient visits by 5%;
- carrying out 1% of all patient outpatient appointments in the patient's home through video-conference facilities;
- 15% of all identified high-needs patients would be enrolled in the virtual care solution;
- virtual care would be recognised as a routine part of clinical practice in Waikato DHB; and
- 10% reduction in the cost of running Waikato DHB's Meade Clinical Centre to deliver outpatient services in the second year of operation of the virtual care enablement project.

Soft benefits

6.19 The "soft benefits" included effective access to essential clinical advice in a timely manner from more remote locations, improved staff efficiency and productivity by reducing travel requirements, reduced time and costs for patients by reducing their requirement to travel, and increased access to specialty services for rural patients.

Risks

6.20 The risks identified included:

- not achieving the required operational cost savings to fund virtual care;
- failing to obtain any necessary approvals from bodies such as the Medical Council, the Government Chief Information Officer, and National Health IT Board;
- engagement with the primary care sector; and
- unsuccessful change management.

Costs

6.21 The estimated cost for the "establishment of Virtual Care" was $8.4 million in the first year. Of this amount:

- $1 million was the cost of clinical change and was to be funded by capital and "reprioritisation of operational funding"; and
- $7.4 million was for enabling clinical practice and technology to be delivered as a service.

6.22 Similar costs were projected for the second year (2016/17). It was expected that most of the costs would be met by operating cost savings in each year (for example, a reduced demand on the emergency department or outpatient services). The expected savings were:

- $6.9 million in 2015/16; and
- $7.4 million in 2016/17.

6.23 There is no analysis to show how these cost savings were calculated. This differed from the information in the previous papers to the Board, which indicated that operational savings to fund virtual care of $3.5 million would be achieved in 2015/16 and $8.5 million in 2016/17. A small proportion of these costs would be funded from amounts already set aside for telehealth.

The procurement process

6.24 The business case included a very short section called "Procurement Compliance". In response to the question "... have you engaged with Procurement to discuss the Procurement activity required to ensure compliance with the Procurement and Contracts Policy?", it stated "Yes" and said:

> *The process for purchasing the software as a service is based on the fact that for the integrated solution there is one identified supplier, being HealthTap, which has been confirm[ed] by several independent sources such as Forbes.*
>
> *To minimise risk and in recognition of the fast paced market in this service provision the initial agreement will only be for a period of 24 Months. This will allow the opportunity for market maturity to occur and completive* [sic] *pressures to be created when the contract is available for review.*

The Board's decision about virtual care

6.25 According to the minutes of the 22 July meeting, the Board discussed the strategic business case at length and several questions were raised.

6.26 These included questions about:

- whether the legislative framework at that time supported the introduction of the proposed service;

- whether the proposed financial savings noted in the document were realistic;
- whether the expenditure was prudent or affordable given Waikato DHB's present position;
- the effect of foreign currency movements; and
- whether more complete information was needed to make a decision.

6.27 The minutes noted that most of the expenditure would be on "the provision of contracted technology services, presently envisaged to be through a firm known as HealthTap".

6.28 According to the minutes of the meeting, the Board:

- approved "the move towards a virtual care service as a strategic objective of the Waikato DHB";
- supported the Chief Executive establishing a virtual care service;
- confirmed that the Chief Executive's financial delegations covered the proposal;
- supported further negotiations with HealthTap "to determine whether a satisfactory contract could be concluded within the Chief Executive's delegation"; and
- supported the establishment of a virtual care service based on the HealthTap platform if a satisfactory contract could be concluded.

6.29 In providing its approval, the Board requested further detailed reporting on several matters. They were:

- the progress of negotiations;
- the scope, benefits, cost, and risks associated with the establishment of the service as it is implemented, which included reporting about:
  - a clear definition of the implementation strategy, including which services the technology will be rolled out to;
  - key performance indicators and deliverables;
  - engagement with the Medical Council, clinicians, and staff;
  - the monitoring mechanism;
  - how issues raised will be addressed; and
  - financial and budgetary impacts; and
- confirmation that the legislative framework would allow the service to be established as envisaged.

6.30 It is unclear from the wording of the minutes whether the Board was anticipating being updated on these matters before the contract was signed or was simply outlining matters it considered needed to be addressed in subsequent contract negotiations.

6.31 The minutes record that:

> *The Chief Executive noted that it was his intention to work with the Chair in making the final decision as to whether or not to commit to the HealthTap proposal as the centrepiece for implementation of the virtual care strategy.*

6.32 The minutes do not record whether the Board's decisions were unanimous or whether individual Board members objected. We understand from several people that not all of the Board members supported the proposal.

Our observations about the Board's involvement

It is unclear how much the Board knew

6.33 When the Chief Executive presented his memorandum to the Board on 24 June 2015, it is unclear how much the Board already knew about the proposed virtual care strategy or the proposed arrangement with HealthTap.

6.34 Although the Chair had been aware of the discussions with HealthTap, it is unclear how much the rest of the Board members knew about that process. One Board member told us, for example, that they were not aware that HealthTap was in a start-up phase or Waikato DHB staff had concerns with the procurement process and draft contract.

The business case was a strategic business case, not a procurement business case

6.35 For the most part, all of the information provided to the Board – whether in the initial memorandum to the 24 June 2015 Board meeting, the discussion paper prepared for the workshop on 9 July 2015, or the business case presented to the 22 July 2015 Board meeting – focuses on the benefits of virtual care and how a virtual care service would meet the challenges facing Waikato DHB. There is little information in any of the documents provided to the Board about the specific rationale for entering into a contract with HealthTap or the specific services to be acquired from them.

6.36 The business case the Board eventually approved was called *A strategic business case for virtual care*. There is nothing wrong in principle with the business case that was drafted. However, it was a strategic business case written to justify a strategic decision. It was not a business case written to explain and justify a procurement decision.

6.37 Therefore, it did not cover any of the matters we would have expected to see covered in a business case to support a procurement, such as an evaluation of

costs, benefits, and risks of alternative options, a market analysis and evaluation of price drivers, or an estimate of the whole-of-life cost for the project.

There was no legal or procurement input into the business case

6.38 On the evidence we have seen, the legal and procurement specialists at Waikato DHB did not see the business case or have any input into it.

The Board was not fully advised about the contractual and procurement concerns

6.39 There is also little discussion in the documents presented to the Board about the contractual and procurement issues that had been identified and that were yet to be resolved. The information presented to the Board shows that those involved in preparing the business case had taken account of some of the concerns Waikato DHB staff raised. However, there was no reference to the advice that had been received about compliance with the Rules.

The need for speed was not properly explained or justified

6.40 A theme that appears to underlie the information presented to the Board, but that is never clearly articulated, is the need for Waikato DHB to act quickly.

6.41 In his initial memorandum to the Board for the 24 June 2015 Board meeting, for example, the Chief Executive talked about the need for the matter to be considered urgently because there was "an expectation of speed on the part of other interested parties". The memorandum closes by noting the need to "move with urgency to manage the coming clinical delivery challenges for Waikato DHB".

6.42 Similarly, in his email of 29 June 2015, the Chair told his colleagues on the Board that, if the Board were to decide to invest in virtual care, it would need to do so early in the financial year so that there would be time for any savings to be realised and to enable Waikato DHB to meet its budget for the year.

6.43 We acknowledge that speed and momentum are sometimes an important part of a procurement process. However, we do not accept that a general need to fix a problem urgently necessarily translates into a need to carry out a particular procurement quickly. We are concerned about the emphasis that appears to have been placed on the need for speed in this instance without any clear justification as to why.

6.44 In the Chief Executive's memorandum to the Board, it is not clear who the "other interested parties" were, whether their expectation of speed was reasonable, or why that expectation was even relevant to Waikato DHB.

6.45 In relation to the anticipated cost savings referred to in the Chair's email, it seems unlikely to us that any cost savings would be realised in full in HealthTap's first year of operation or that, if they were, they would be a factor in enabling Waikato DHB to meet its budget for that year.

6.46 The minutes of the 24 June 2015 Board meeting show that the Board clearly had doubts about the need for speed and queried the urgency to form a relationship with HealthTap. Questions the Board asked at its 24 June 2015 meeting and its subsequent meeting on 22 July 2015 all point to concerns about substantive matters that still needed to be resolved. The nature of these concerns – for example, about clinical change management, the implementation strategy, and financial and budgetary impacts – and that they had not yet been resolved, was clearly at odds with any notion of speed.

Given the uncertainties, it is questionable whether the Board should have approved a contract with HealthTap

6.47 It is clear from the information provided to the Board that the proposed implementation of virtual care would involve an exploratory stage and that there were some uncertainties and matters that still needed to be resolved, both before a contract was entered into and possibly afterwards. It is likely that this is the reason for the Board's approval being conditional on a satisfactory contract being reached and for the Board requesting reporting on certain matters.

6.48 In our view, the Board was right to decline approval for the virtual care proposal when it was first presented without a comprehensive business case.

6.49 Given the matters that were still to be resolved after the business case had been presented to them, we question whether the Board was right to give its approval subsequently. We acknowledge that approval was given on a conditional basis and that the decision was not unanimous. However, given the nature of some of the unresolved matters, we question whether the Board should have been more forceful in seeking assurance on those matters before giving approval for a contract with HealthTap.

Contract negotiations after Board approval

7

7.1 The Board's in-principle approval of a virtual care strategy and the potential contract with HealthTap was given on 22 July 2015. The contract with HealthTap was signed two months later on 23 September 2015.

7.2 In this Part, we describe:

- the steps Waikato DHB took during this two-month period to resolve the concerns that had been raised about potential non-compliance with the Rules and some of the other matters that Waikato DHB staff had raised; and
- some of the changes made to the draft contract.

Attempts to address compliance with the Government Rules of Sourcing

7.3 Waikato DHB sought to explore the applicability of the Rules and any exemptions under those Rules to the proposed contract. In our view, robust advice was provided to those driving the procurement.

7.4 We did not find any evidence in the documents Waikato DHB gave us explaining what it decided to do in response to the advice it had received about compliance with the Rules. In our view, it is difficult to see how the procurement of the HealthTap platform could be exempt from the requirement for open advertising under the Rules.

Interactions with the National Health IT Board

7.5 One of the issues that Waikato DHB staff had raised when they reviewed the draft contract was whether the contract with HealthTap needed the approval of the National Health IT Board. As explained in Part 3, this was because, at the time of this procurement, all DHBs were required to get approval from the National Health IT Board for:

- any capital expenditure on information technology for amounts more than $500,000; and
- storing any "personally identifiable health information" offshore.

7.6 In this instance, it appears to have been concluded early on that, because Waikato DHB would be purchasing a licence to use HealthTap, rather than assets, the expenditure would be classed as operating expenditure, so the National Health IT Board's approval was not needed.

7.7 However, Waikato DHB did need the National Health IT Board's approval to store "personally identifiable health information" offshore, which would happen using the HealthTap platform because the servers for storing data were located in the United States. Waikato DHB applied for an exemption on 3 December 2015. It was

granted on 13 March 2016, subject to several conditions, including that Waikato DHB maintained a copy or back-up of the relevant information in New Zealand.

7.8 Although the National Health IT Board's approval was not needed for the contract, the Chair, Chief Executive, and Chief Information Officer of Waikato DHB met with the National Health IT Board in February 2016 to discuss the virtual care strategy and the procurement of the HealthTap platform.

7.9 After that meeting, the National Health IT Board wrote to the Chair confirming its ongoing interest in Waikato DHB's virtual care strategy and outlining certain expectations it had with regard to the strategy and Waikato DHB's implementation of the HealthTap platform.

7.10 These expectations included:

- The HealthTap platform would be a trial programme aimed at rural and underserved communities within Waikato DHB's district.
- A comprehensive evaluation process would be set up to ensure that, at the end of the trial, advantages and disadvantages could be objectively determined, including model of care implications and benefits to patients and general practice, and whether there had been or was likely to be a positive return on investment.
- The project was a collaborative initiative between Waikato DHB, primary health organisations, general practices, and community services, and the evaluation approach needed to reflect that collaboration.
- Co-design and co-implementation with community consumer groups, including Māori. This would be a key element of this application.
- After the trial period, a wider roll-out or further progression of the HealthTap platform would require a business case to be endorsed by the National Health IT Board and approved by central agencies.

7.11 The National Health IT Board told Waikato DHB it should provide its first evaluation report by 30 August 2016. This report should include a detailed description of the evaluation criteria, as well as progress to date against selected criteria, followed by updated reports every six months.

7.12 However, the National Health IT Board was disestablished shortly afterwards and its functions were absorbed into the Ministry of Health. We were told that the proposed evaluation and reporting on the HealthTap platform did not proceed.

24 September 2015: Contract signed with HealthTap Inc

7.13 Waikato DHB and HealthTap entered into a HealthTap License Agreement for the HealthTap Platform as a Service on 24 September 2015. The Chief Executive signed the contract for Waikato DHB.

7.14 The final contract included several provisions that appear to have been included to provide greater assurance to Waikato DHB about the standard of service it would receive from HealthTap and to strengthen its rights to enforce performance. These include:

- a requirement for HealthTap to provide the services in accordance with all applicable New Zealand laws and regulations, and to meet certain service levels documented in a Service Level Agreement;
- a requirement for HealthTap to ensure that the products and services it provided to Waikato DHB, authorised users, and patients under the contract would be of no less quality and operate with the same functionality as the equivalent commercially available versions of those products and services in the United States;
- provisions to protect the security of confidential information and Waikato DHB's data, including patient information, and provisions for an annual audit of those measures by an independent party;
- a "most favoured customer" provision – that is, if HealthTap provided more favourable terms to any other party purchasing equivalent services, HealthTap would match those terms for Waikato DHB;
- a right for Waikato DHB to terminate the contract immediately if:
  - HealthTap failed to meet the agreed service level for service availability;
  - HealthTap failed to materially meet milestones for the implementation of the SmartHealth service;
  - the services failed to meet standards such that, as a result of HealthTap's failure, any patient was, or was reasonably likely to be, harmed;
  - in certain circumstances, the requirements about data security were not met; and
  - in certain circumstances, by paying an early termination fee; and
- a requirement for HealthTap, on termination of the contract, to provide reasonable assistance with exit or disengagement as Waikato DHB reasonably requested and, if requested by Waikato DHB during the term of the contract, to work with Waikato DHB to establish, maintain, and test procedures and capabilities to ensure that Waikato DHB's data could be transferred to an alternate service provider if the contract was terminated or expired.

7.15 However, it appears that several issues that Waikato DHB staff had raised were not resolved. They were effectively left to be resolved or agreed after the contract was signed. The issues included whether there were any legal or policy impediments to using HealthTap's services in New Zealand.

7.16 For example, the contract provided that the parties would work together to further define and document the "clinical service components and requirements relating to the Services", in order to provide further detail and specificity to the health and clinical objectives that the parties wished to achieve under the contract. These clinical service objectives were to be finalised within four weeks of signing the contract. We understand that this did not happen.

7.17 The contract also made provision for a 60-day implementation period during which the parties would:

- investigate and assess the proposed use of the products by patients, including the use of particular project modules and virtual consultation services with non-New Zealand clinicians, taking into consideration compliance with New Zealand laws and health policy; and
- consider and discuss any practical, operational, or cost implications that might arise as a result of any legal and/or policy considerations.

7.18 Waikato DHB was required to notify HealthTap before the end of the implementation period of any services or products it did not, for the time being, wish to activate for patients.

Our observations about the contract negotiations

Some of the concerns about the procurement process and proposed contract were addressed, but some significant areas of risk remained unresolved

7.19 As already noted, we consider that those driving this procurement involved Waikato DHB's legal and procurement staff far too late in the process. That said, once advice was received, attempts were made to address the concerns about the procurement process and proposed contract.

Waikato DHB's efforts to justify non-compliance with the Rules were concerning

7.20 It appears that Waikato DHB made several attempts to argue that the Rules did not apply or that, if they did apply, an exemption from the open advertising requirement was justified. By not involving the right people early enough, Waikato

DHB appears to have got into a difficult situation where it did not want to have to withdraw from a deal it had invested time in negotiating and was close to signing.

7.21 However, we are concerned about the amount of effort those in Waikato DHB driving the procurement appear to have gone to try to justify non-compliance with the Rules. Given what the Rules represent – the government's commitment to best practice, and fair and transparent procurement processes – and the aims they are trying to achieve – an effective procurement process, accountability, and value for money – we do not consider it appropriate for a public organisation to attempt to circumvent the Rules or to find reasons not to comply, unless such reasons genuinely exist.

Waikato DHB does not appear to have resolved whether the Rules applied

7.22 Despite eventually seeking relevant external advice, Waikato DHB does not appear to have formally resolved whether its decision to directly source the HealthTap platform was permitted under the Rules or, for that matter, whether direct sourcing complied with its own procurement policy. We found no record that it did so. In our view, not only should this matter have been resolved and documented before the contract was signed but it should have been resolved and documented before HealthTap was ever approached.

Waikato DHB's discussion with the National Health IT Board suggests some inconsistencies in the parties' understanding of the project

7.23 The National Health IT Board's letter to Waikato DHB after their meeting in February 2016 is of interest in that it shows how the implementation of the HealthTap platform was being presented to and/or seen by an external stakeholder at that time.

7.24 Some of the National Health IT Board's observations, as recorded in that letter, are consistent with how the project was presented to the Board – for example, that it was intended to operate initially as a trial and that it was aimed at rural and underserved communities within Waikato DHB's district.

7.25 However, others seem inconsistent with what looks like, to this point at least, Waikato DHB's "go it alone" approach – for example, the statement that HealthTap was a "collaborative initiative" between Waikato DHB, primary health organisations, general practices, and community services, and that there would be co-design and co-implementation with community consumer groups, including Māori.

The proposed evaluation process was never established

7.26 Waikato DHB's meeting with the National Health IT Board is also of interest because of the recognition it gives to the importance of establishing some form of evaluation process during the trial phase and because of the requirement for Waikato DHB to prepare a further business case, to be endorsed by the National Health IT Board, after the trial period and before any wider roll-out or further progression of the HealthTap platform.

7.27 These requirements are consistent with what the Board had been told was the general intention when it gave its in-principle approval to the virtual care strategy and the contract with HealthTap. There are references in the documents presented to the Board to various evaluation-related activities – for example, stakeholders being part of a two-year study, the need for "close integration" with researchers from international universities to ensure safe clinical practice, and the establishment of a partnership with Waikato and Auckland universities to create a new model of study based on virtual care, to ensure that "academic rigour" was applied to any review of the virtual care model, and that the "... new way of working was applicable across clinical practices in New Zealand".

7.28 It is unfortunate that, after the National Health IT Board's functions were absorbed into the Ministry of Health, the evaluation process it recommended was not established. Without this, or some other form of evaluation process, the value of HealthTap as a trial of virtual care in New Zealand is difficult to assess.

Ernst & Young's report: Assessment of implementation of the HealthTap Solution

8

8.1 After the contract was signed between Waikato DHB and HealthTap, staff in both organisations worked hard during the 60-day implementation period and subsequently to implement the HealthTap platform.

8.2 Eventually, through an iterative process, Waikato DHB reached the point where it considered that it had obtained a minimum viable product. That is the position where enough of the core features of the HealthTap platform had been implemented to enable them to be used and to support feedback for future development.

8.3 As we noted in Part 1, the terms of reference for our inquiry considered looking at Waikato DHB's management of its contract with HealthTap. That would have included looking at aspects of how Waikato DHB implemented the HealthTap platform. However, in February 2018, after our inquiry was already under way, Waikato DHB decided to commission its own investigation into the SmartHealth service that it was providing through the HealthTap platform.

8.4 It engaged the professional services firm EY to provide an independent assessment of the "functionality, implementation, costs and benefits of the technology platform HealthTap, in the context of its SmartHealth initiative". Waikato DHB had contemplated a review at the end of the two-year contract period and that is the work EY was commissioned to perform. Waikato DHB made EY's report public in May 2018.

8.5 We decided that, given that public resources had been used to review the implementation of the HealthTap platform and to identify options and recommendations about virtual care, it would have not been sensible for our work to also cover implementation. Therefore, we decided to focus our inquiry on the sourcing phase of the procurement process, rather than on the implementation and management of the contract after it had been signed.

8.6 For the sake of completeness, in this Part, we summarise some aspects of EY's report that we consider relevant to our inquiry.

Summary of aspects of Ernst & Young's report

8.7 Virtual care represented an important strategic direction for health organisations in the Waikato and New Zealand.

8.8 Where the service offered through the HealthTap platform met a particular clinical need, it performed well.

8.9 Waikato DHB's decision-making about the HealthTap platform's implementation was influenced to a considerable extent by the pricing arrangement in the HealthTap contract.

8.10 Pricing was through a fixed annual licensing fee rather than progressive increases in consumer and clinician registrations or use. This meant that Waikato DHB was under immediate pressure to achieve volume through a "big bang" approach, rather than a progressive and staged roll-out with interim evaluation phases.

8.11 The change management team in Waikato DHB became involved in the HealthTap platform implementation in November 2015, only after the contract was signed. Programme reports produced by the change team told of a multitude of issues with the technology and the unwillingness of Waikato DHB clinical staff to change their model of care.

8.12 As doctors and consumers reported to EY, a prime trigger for patients to register for the SmartHealth service was their doctors' promotion of it. However, doctor advocacy for the SmartHealth service was not strong because of the HealthTap platform's reputation inside Waikato DHB and an unclear implementation plan. A particular cause of its poor reputation was HealthTap's design for the United States' healthcare market, which meant that it had attributes that were at odds with Waikato DHB's clinical culture and ways of working.

8.13 A considerable period was spent reorienting the HealthTap platform to better fit the Waikato DHB operating environment. However, by this time many clinicians had formed negative views of it. Users also experienced major issues with data and connection availability in rural areas. This was not tool related but added to the negative perception of the HealthTap platform.

8.14 HealthTap's operating model did not fit well with the New Zealand healthcare context, and the application had usability issues in the Waikato DHB operating environment. This meant that:

- the "off-the-shelf" HealthTap platform was very United States-focused when it went live in the Waikato, which alienated local clinicians and consumers seeking to use it; and
- considerable unanticipated time and expense was put into tailoring the platform to Waikato's outpatient model and IT requirements, and tailoring the content and functions for New Zealand users.

8.15 EY's work identified the main capabilities that the HealthTap platform had. EY also identified the capabilities that it expected to see in a virtual care application but that were not available in Waikato DHB's implementation of the HealthTap platform.

8.16 The implementation of the HealthTap platform lacked a clear direction, transparency, or open communication, which was a significant barrier for organisational and sector support of it:

- There was an absence of clear and unified leadership direction and communication, combined with a similar absence of pre-defined functional requirements developed through stakeholder engagement and of an explicit implementation plan.
- Together, these factors meant that there was no organisational alignment on the desired model of care that would support virtual consultations, which in turn damaged the credibility of the HealthTap platform with Waikato DHB staff.
- Medical stakeholders, in particular, reported feeling alienated from a technology platform that was imposed on them without consultation.

8.17 The way the HealthTap platform was introduced undermined existing service and technology initiatives, preventing a collaborative inter-organisational approach:

- Other health organisations in the Waikato and wider Midland region were surprised by Waikato DHB's introduction of the HealthTap platform. Organisational relationships suffered as a result.
- Primary care providers felt that the introduction of a DHB-funded after-hours primary care service using the HealthTap platform was a unilateral action at odds with the existing after-hours service agreed with, and funded by, Waikato DHB and that a better outcome could have been achieved through collaboration.
- The largest primary care network in the Waikato region also had work under way on a practice management system with some virtual care capability. It reported feeling "blind-sided" by Waikato DHB's adoption of the HealthTap platform.
- Waikato DHB stakeholders interviewed and surveyed by EY unanimously acknowledged that Waikato DHB as an organisation was not ready for the change. There was no recognition of a "burning platform" for virtual care and a strong sense that the HealthTap platform was being imposed on a sector that did not recognise the need for it.

8.18 Using reports on Māori engagement together with EY's interviews, EY identified that there were some barriers to the uptake of HealthTap by Māori stakeholders. Despite those barriers, Māori stakeholders were generally clear that there was a place for virtual care solutions in their communities.

8.19 Consumers interviewed by EY viewed HealthTap as a good option to counteract some of the perceived access issues with Waikato's health services and was a positive step towards the future. Consumers also used HealthTap as a medical reference library containing credible information. Consumers also identified areas where HealthTap could not replace face-to-face service delivery or could be improved to better suit the consumer's needs.

8.20 Although a governance structure was set up for implementing the HealthTap platform, this was reported by stakeholders to be only loosely used in practice:

- It was intended that there would be a whole-of-system governance body established to ensure that virtual care was integrated with the wider Waikato health system. However, this leadership group did not eventuate, meaning that the only point of project governance lay with Waikato DHB's Board.
- Although a Virtual Health Service Change Steering Committee was established, it "did not have overall ownership of the programme".

Uptake and usage of the services

8.21 EY assessed the uptake and usage of the HealthTap platform. It found:

- a total of 10,031 unique patient profiles were registered from 1 December 2015 to 6 March 2018 (2.3% of the Waikato resident population);
- most patients (87%) activated HealthTap after registering for it;
- 3125 unique clinicians registered with HealthTap during the study period;
- 50% of clinicians activated their HealthTap account after registering for it; and
- 80% of clinicians did not complete the online training tool.

8.22 EY determined that the overall numbers of consumers using the HealthTap platform was lower than the aspirations in Waikato DHB's strategic business case. However, in the context of a two-year trial testing a new way for consumers to interact with health services, EY considered the uptake to be encouraging and a recognition of the potential for virtual care to be a viable mode of service delivery.

The costs

8.23 EY also assessed the costs of the HealthTap platform as a service and its implementation. It was difficult for EY to confirm that Waikato DHB's spending records were complete. EY concluded that the amount Waikato DHB paid HealthTap for the use of the HealthTap platform was about $15.4 million. In comparison, EY concluded that the strategic business case request was for $14.8 million for that purpose.

8.24 Waikato DHB incurred other costs in delivering its SmartHealth service. EY concluded that, in total, Waikato DHB spent about $26 million on the SmartHealth service, including the costs of the HealthTap platform. The other costs included the costs of devices and staff time.

9 Our views on the procurement

9.1 In this Part, we set out our views on Waikato DHB's procurement process. In summary, we have concerns that many of the important elements of procurement we expect to see from a public organisation were missing or carried out too late in the process. Specifically, we consider that:

- The business case that went to the Board was a strategic business case for virtual care, rather than a business case justifying the procurement of a specific service from HealthTap.
- There was no final procurement plan setting out Waikato DHB's objectives and how it intended to achieve them or setting out an intended procurement process.
- What procurement planning was done was done too late – both the business case and the draft procurement plan were prepared after Waikato DHB had received a draft contract from HealthTap for its consideration.
- Expert legal and procurement advice was not sought until too late into the procurement process.
- Given the nature and scope of what Waikato DHB was trying to achieve, it did not collaborate enough with other DHBs, other providers of health and disability services, or clinicians.
- The lack of proper procurement planning and evaluation process makes it difficult to assess whether any intended benefits were realised or whether the HealthTap platform represented value for money.
- Greater oversight of the project was warranted in the circumstances.

9.2 We are also concerned about the lack of documentation for the early stages of this procurement. Although we were provided with many documents from Waikato DHB's files, many of the details about the procurement had to be obtained from personal recollections of those involved or of staff and Board members who became involved later in the process. Not only does this make a subsequent review or inquiry challenging but it also means that Waikato DHB cannot rely on its records to enable public trust and confidence in its processes.

Procurement rules that district health boards must follow

9.3 Like other organisations in the public sector, when DHBs carry out a procurement process, they are spending public funds. As a result, they must operate within the procurement framework that the Government has put in place to ensure effective, fair, and transparent procurement processes that support accountability and ensure value for money. They must also comply with their own procurement policy.

9.4 The Government's procurement framework is broadly made up of:

- a set of procurement principles that underpin how public organisations will go about sourcing the goods and services it needs and how it will engage with the suppliers it contracts with;
- the Rules, which are designed to support good practice for procurement planning and good market engagement, leading to better outcomes for agencies, suppliers, and taxpayers; and
- a range of information and guidance, including a toolkit of resources (including templates for preparing business cases and procurement plans).

9.5 The Rules are mandatory for a large part of the public sector, including DHBs from February 2015. Public organisations can be audited for compliance with the Rules, and suppliers have a right to complain if they consider that an agency has not complied with the Rules.

9.6 Waikato DHB also had its own procurement policy that, consistent with the Rules, required:

- a business case for any procurement that was more than $500,000 in total value, had significant strategic implications, or carried significant risk;
- an assessment of the market conditions and business needs in the short term and long term;
- a clearly documented rationale for the proposed procurement approach;
- a planned and documented evaluation approach before approaching the market;
- a procurement plan for procurements with a value of $100,000 or more before any approach to the market;
- a due diligence process to be carried out on potential suppliers to assess their financial ability, technical ability, and capacity to fulfil the contract; and
- a written record of any decision to depart from the usual market testing requirements.

The business case was deficient

9.7 A business case is not required for every procurement. However, it is generally advisable when a procurement is of higher value or risk. The Rules state that:

> *... all procurement covered by the Rules should be supported by a business case or procurement plan that has a level of detail reflecting the size, value and complexity of the procurement*.

9.8 Also, Waikato DHB's own procurement policy required a business case to be prepared because the proposed procurement was likely to be more than $500,000 in total, had significant strategic implications, and carried significant risk.

9.9 A good business case will provide the justification for a project. It will evaluate the costs, benefits, and risks of alternative options and present a recommendation for a preferred approach. A business case should set out the business need, describe how critical the services are, and how the services will deliver the strategic business objectives. It should also demonstrate an understanding of the market and price drivers, and estimate the whole-of-life cost for the project.

9.10 Waikato DHB prepared a business case that went to the Board in July 2015. However, it was (and was presented as) a strategic business case for implementing virtual care. As we have explained earlier, the business case set out the challenges facing Waikato DHB at the time, argued for a need to make a significant change in service delivery to address those challenges, and set out the rationale for a move to virtual care. The business case did set out some targets, identified risks, and estimated costs – however, the discussion of these issues in the paper was focused on the implementation of virtual care generally, rather than on a specific proposed option for delivering it.

9.11 The business case included a short section on "Procurement Compliance" that stated that there was only "one identified supplier, being Health Tap, which has been confirm[ed] by several independent sources such as Forbes". It also noted that:

> *[t]o minimise risk and in recognition of the fast paced market in this service provision the initial agreement will only be for a period of 24 months. This will allow the opportunity for market maturity to occur and completive* [sic] *pressures to be created when the contract is available for review.*

9.12 The business case presented a rationale to the Board for adopting a virtual care approach at Waikato DHB. However, it did not provide a full and comprehensive description of the market at the time. It did not set out all the possible options that could be considered, and it did not explain why the HealthTap platform was considered the preferred option.

9.13 As a result, there was no discussion in the business case of how the services proposed to be purchased from HealthTap aligned with the strategy to move to a virtual care model. Nor is there any discussion about any of the costs, benefits, or risks of selecting HealthTap as a provider. As we have outlined above, an organisation following a good procurement process will first identify its strategic objectives and priorities, and *then* plan a procurement approach designed to achieve those objectives.

9.14 Even more importantly, the business case was presented to the Board in July 2015, after discussions had been had with HealthTap, a letter of intent had been proposed, and a draft contract had been provided from HealthTap that included an in-principle agreement about the services to be provided and a proposed contract price.

9.15 It was described to us that the business case was informed by what the contract said. This is the wrong way around. Creating a business case at such a late stage in the process risks the rationale for the procurement being written to reflect a deal that has already been done, rather than setting out a proposal for a deal that meets an organisation's business objectives and priorities.

9.16 In our view, the business case that went to the Board did not meet good practice in many respects. Overall, it lacked evidence and authority for the decisions it was seeking to justify.

The procurement plan was also a problem

9.17 A separate procurement plan is not always needed for every procurement. In some instances, it can make sense to combine a procurement plan with a business case. For high-value or high-risk procurements, a procurement plan is a good discipline because it will (ideally) outline the entire proposed procurement process, from a sourcing plan to a contract team and exit strategy.

9.18 As noted above, the Rules require a robust business case or procurement plan to be completed for all procurement subject to the Rules. Waikato DHB's procurement policy required a procurement plan for procurements with a value of more than $100,000 before any approach to the market.

9.19 A good procurement plan will build on a business case, setting out an organisation's objectives and how it intends to achieve them, as well as an outline of what is being procured and the cost involved. The plan should include a proposed strategy for engaging the market and a description of the type of procurement approach to be used. It should also record how the procurement complies with an organisation's procurement policy and the Rules. Where an exclusion or exemption is proposed, the rationale should be clearly outlined in the procurement plan.

9.20 During our inquiry, we were provided with a draft procurement plan that was prepared at some point between April and June 2015. Again, importantly, the plan was prepared after discussions with HealthTap had progressed to the point that a draft contract had been prepared. The plan was never finalised.

9.21 As a result, the plan did not cover all the matters we expect to see in a robust procurement plan. The draft plan included a cursory reference to a review of the market and a direct closed procurement method, but no analysis was provided to support the proposed approach on either of these issues.

9.22 There was a brief reference to the fact that an exemption from the Rules was requested, and we assume that this related to the requirement to use an open

competitive procurement process unless a specific exemption applied. The plan did not make clear what the exemption was, state why the exemption would apply, or record whether a final view had been reached on whether the direct procurement approach to HealthTap was consistent with the Rules.

9.23 In summary, the plan did not contain a robust description of the matters we expect to see set out in such a plan. It was created too late in the process to be effective as a procurement plan, and it was never completed. Its main purpose appears to have been to try to show that good practice had been followed rather than because it actually had.

Expert procurement and legal advice came too late

9.24 The planning phase of a good procurement process will consider the skills and experience required in a procurement team. Importantly, the right expert advice (including legal and procurement advice) should be sought at the very beginning of the process.

9.25 From the evidence we have seen, it does not appear that either the procurement team or the internal legal advisers at Waikato DHB were aware of the proposed procurement with HealthTap until after a draft contract was provided in April 2015.

9.26 At that point, several procurement issues were raised, including:

- whether the Rules applied to the procurement;
- if so, whether there were any exemptions to the requirement to advertise openly;
- whether Waikato DHB was required to submit a procurement plan to the Ministry of Business, Innovation and Employment; and
- whether approval was required from the National Health IT Board.

9.27 At that stage, Waikato DHB's Corporate Solicitor also sought external specialist legal advice.

9.28 We have not taken a view on the accuracy of any of the advice. However, it is clear that, once Waikato DHB's legal and procurement staff became aware of the draft contract with HealthTap, they took appropriate steps to ensure that robust advice was provided.

9.29 Once again, the advice was sought too late in the process. Waikato DHB's advisers were providing advice on which rules related to the procurement process after discussions between Waikato DHB and HealthTap had already progressed to the stage of a draft contract. Not only is this far from good practice but it also created

significant risk for Waikato DHB. In essence, regardless of the quality of the advice, it came too late to help shape a good procurement process, to ensure compliance with relevant procurement requirements, and to sufficiently manage any risks associated with the terms negotiated with the provider.

9.30 Further, the evidence we have seen does not make it clear whether Waikato DHB ever reached a final view on many of the matters its staff raised. There is no record of a final decision about whether any of the exemptions in the Rules applied that would allow it to carry out a direct procurement approach with a single supplier. Waikato DHB did not submit a procurement plan to the Ministry of Business, Innovation and Employment as required by the Rules. We did not see any evidence to indicate why this did not occur.

Waikato District Health Board did not collaborate sufficiently

9.31 DHBs receive public funding to plan, fund, and provide health and disability services for the population of a district. To fulfil those functions, they cannot work in isolation. They have to work with other providers of health and disability services, their communities, and other DHBs.

9.32 The New Zealand Public Health and Disability Act 2000 (the Act) requires DHBs to collaborate with relevant organisations and to foster community participation in health improvement. Waikato DHB is expected to work with the other DHBs in the Midland region, which includes the Lakes, Tairawhiti, Bay of Plenty, and Taranaki DHBs, on a regional services plan (with some information technology context) and a regional IT plan.

9.33 DHBs have an annual funding agreement with the Minister of Health. Part of that funding agreement is the Operational Policy Framework. As well as requiring Waikato DHB to prepare an annual plan, the Operational Policy Framework requires Waikato DHB to prepare a regional services plan, to follow certain processes if making significant changes to services, and to work with other DHBs in the region to develop, maintain, and implement a regional IT service plan.

9.34 The Act also outlines requirements for DHBs to consult on specific matters (such as strategic planning changes, on proposals for a significant change to policies, outputs, or funding for outputs stated in an annual plan, and on land sales). DHBs also have general consultation requirements under the Act, which means that consultation might be required in a variety of circumstances and on other issues.

9.35 There is some uncertainty about whether Waikato DHB's use of the HealthTap platform would have triggered the process requirements related to making a significant service change – but we saw no evidence that Waikato DHB considered

this. We also saw no mention in Waikato DHB's annual plan or regional services planning of its intention to use the HealthTap platform.

9.36 It was not until 19 February 2016 that the Chief Executive emailed the Midland region DHB chairs and chief executives with information about Waikato DHB's virtual care developments. This was about 12 months after Waikato DHB began exploring HealthTap's services. It is also about five months after the contract with HealthTap was signed and well after the strategic business case was approved. As EY noted in its report:

> *The DHB's business case did not position virtual care within a context of either Midland Regional collaborative information system and service planning, or primary health care model of care development – both of which were (and remain today) important factors in the operating environment.*[3]

9.37 Given the strategic importance of the initiative and its implications beyond the hospital setting, it is not unreasonable to expect that, to some extent, Waikato DHB might have signalled the initiative to other DHBs earlier and through the relevant planning mechanisms, as well as consider whether it was a significant service change. It did not do that.

It is unclear what Waikato District Health Board was trying to achieve

9.38 We are left in some doubt about what Waikato DHB was trying to achieve with this procurement. In the evidence we have seen and the interviews we carried out, it was often described as a trial of a platform to learn what virtual care delivered by Waikato DHB might look like. At the end of a two-year trial, Waikato DHB would be in a better position to approach the market and carry out a more competitive process.

9.39 On the other hand, some people, including the Chief Executive, described a desire to make the platform available to other DHBs and obtain a commercial benefit from its initial investment in buying the services from HealthTap.

9.40 This possible commercial benefit is reinforced by the draft letter of intent, which refers to Waikato DHB becoming the "innovation hub" for the delivery of end-to-end healthcare using the HealthTap platform. It is also reflected in the contract, which includes an exclusivity period during which HealthTap would not supply any other healthcare provider in Australia or New Zealand.

3 Ernst & Young (17 May 2018), *Waikato District Health Board Assessment of Implementation of the HealthTap Solution*, page 4.

9.41 The information that went to the Board explained that, after a six-month "exploratory stage", there would be a roll-out of virtual care throughout Waikato DHB and it would be embedded as a new way of working. Virtual care was presented to the Board as providing a "step change" in service capability that would achieve operational savings that would fund it.

9.42 A good procurement process will include a review, so that an organisation can understand whether the anticipated benefits have been received, whether the services achieved value for money, whether there are opportunities for further improvements, and what lessons can be learned for the future.

9.43 In our view, the deficiencies in the procurement planning stages we have identified mean that Waikato DHB did not clearly identify the intended benefits of procuring the HealthTap platform from the start. That makes it very difficult for Waikato DHB to carry out meaningful measurement of those benefits.

Greater governance oversight was warranted

9.44 When the Board approved the strategic business case for virtual care in July 2015, it asked for further detailed reporting on several matters. This included reporting on the negotiations, scope, benefits, cost, risks (including an implementation strategy), key performance indicators and deliverables, engagement with the Medical Council and staff, the monitoring mechanism, financial and budgetary impacts, and confirmation that the legislative framework allowed for the service to be established. Later, in October 2015, the Board asked for future reporting on how the project was tracking against budget, achievements, and a benefits analysis.

9.45 Once the contract with HealthTap was agreed, a separate Virtual Health Change Steering Committee was put in place and was responsible for governance and monitoring of the project. We note that, in its report, EY did not consider that the steering committee, in practice, had overall ownership of the programme.

9.46 Reporting to the Board on progress with the HealthTap platform did not routinely include systematic analysis about the actual progress of the project, its risks, and how those were being managed. We did not see documentary evidence of the Board being provided with reporting on the matters outlined in paragraph 9.45, although we saw evidence that some reporting to the Board was verbal.

9.47 We accept that, in the context of an organisation of the scale and complexity of Waikato DHB, it is not realistic or practical to expect the Board to directly govern and track the progress of every project or initiative. Annual expenditure on the HealthTap platform was less than 1% of Waikato DHB's annual budget, and a separate steering committee was set up to govern and monitor the project.

9.48 Having said that, this initiative was strategically important and had the potential to fundamentally alter the way services were provided in all parts of Waikato DHB. The Board had expressed concerns about several issues and asked for subsequent reporting on them. There is evidence that the Board was given some level of briefing about the progress of the project but not that their specific concerns had been addressed. In light of the significance of the project and the concerns that the Board had raised previously, our view is that greater oversight was warranted.

Appendix
Timeline of key events

October 2014	The Chair and the Chief Executive talk with a professor from the United States who suggests that they look at HealthTap.
October/November 2014	The Chair visits HealthTap in California.
March 2015	The Chief Executive visits HealthTap in California.
28 March 2015	HealthTap sends the Chief Executive and Chair a draft letter of intent to enter into an agreement by April 2015.
11 April 2015	HealthTap sends a draft agreement to Waikato DHB, with an intention that the contract be concluded and signed by the end of April 2015.
April 2015	Waikato DHB's internal and external advisers provide advice about the proposed agreement.
21 April 2015	Waikato DHB prepares a draft procurement plan.
Mid-April/June 2015	Waikato DHB and HealthTap discuss the nature and terms of the contract to address the risks and make the HealthTap platform suitable to New Zealand environment.
4 June 2015	Waikato DHB's Chief Information Officer calls HealthTap's Chief Executive to find out some information for due diligence checks.
22 June 2015	The Board is briefed about discussions between the Chief Executive and the Chief Information Officer with a United States-based organisation about virtual care.
24 June 2015	The Board meeting at which virtual care and a memorandum about virtual care are discussed.
9 July 2015	The Board's workshop about virtual care.
22 July 2015	The Board's meeting at which the Strategic Business Case for Virtual Care is discussed and the Board approves "moving towards a virtual care service as a strategic objective" and supports negotiating a satisfactory contract with HealthTap and, if that was possible, establishing a virtual care service on its platform.
August/September 2015	Negotiations continue about the terms of the contract.
23 September 2015	The Chief Executive reports to the Board that a steering group has been set up and that it will meet weekly.
24 September 2015	An agreement is signed between HealthTap and Waikato DHB, and 60-day implementation period begins.

28 October 2015	The Chief Executive provides the Board with a paper providing an overview and progress of the "virtual care programme". That update includes the fact that a two-year agreement has been signed with HealthTap, discussions have been had with Hauraki Primary Health Organisation and Māori Health Services about using the services, and an Executive Director, Virtual Care and Innovation has been appointed. This paper notes that one of the next steps is the "completion of the business requirements document, service design and privacy impact assessment". The Board requests that future reporting include how the project is tracking against budget, achievements, and a benefits analysis.
25 November 2015	The Chief Executive provides a verbal briefing that a pilot of the programme will start in 2016, a system is in final testing, and the Virtual Care team has visited HealthTap in California.
28 March 2018	The Board resolves not to renew the contract with HealthTap on the expiry of the contract in May 2018.

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