Canterbury DHB

Taskforce Review – Phase 1

31 July 2020

Contents

Executive summary

Scope and objectives

EY was commissioned to provide an independent perspective on Canterbury District Health Board (CDHB)'s financial performance, and actions underway to improve performance. EY was also asked to provide advice on aspects of CDHB's control environment.

Context

CDHB performs well on most measures of population health, access to care and service quality. However, CDHB has struggled to eliminate a persistent financial deficit, which first emerged in 2014/15.

In 2019, alongside the Ministry of Health and EY, CDHB completed an operational review and sustainability plan with the aim to reduce the annual deficit by $62.5m over four years. This would bring the forecast deficit to nil pre-interest, depreciation and capital charge.

In response, CDHB established five taskforces to begin delivery on the sustainability plan in 2019/20, and lay the foundations for outyears.

Sustainability taskforces

2019/20

In 2019/20, the taskforces reported $13m of savings against a target of $15m. While 87% of the planned savings target was achieved, our independent assessment found that there are a number of areas that should be strengthened and improved as initiatives are programmed for 2020/21 and beyond.

Particular areas for improvement relate to how benefits were identified, sized, validated and reported. These include:

- The line-of-sight of accountability from governance to executive to operational leaders, with ambiguity particularly regarding responsibility for delivery of specific initiatives.
- The delivery structures and resourcing to achieve the taskforce objectives and targets.

These areas contributed to some taskforces underperforming against targets, and for initiatives with less success needing to be substituted in-year. Reporting issues also impacted on the confidence of the Board and QFARC in the delivery of the programme. This feedback on the lessons and learnings from 2019/20 is important given the more ambitious targets set for years 2-4 of the taskforces.

2020/21

The planned savings target in 2020/21 is a significant increase on 2019/20, and is greater than included in the 2019 sustainability plan ($55m v. $47m). With the delay in migration to Hagley, savings from insourcing of planned care has materially decreased in 2020/21.

Key findings from our independent assessment of the 2020/21 taskforce programme are:

- The focus areas identified are generally aligned with strategic drivers of the CDHB's deficit.
- 2019/20 flow-on initiatives have been factored into the 2020/21 Annual Plan (Plan), but are not visible in governance reports viewed by EY. These were originally planned to be part of the 2020/21 taskforces, so it is unclear why they have been replaced with a new set of taskforces (rather than added to).

Executive summary (cont'd)

- The initiative workup process appears less developed than in 2019/20, and CDHB has started the financial year with a material level of initiatives and benefits yet to be fully designed and / or validated.
- There is significant pressure on delivering in Q3 and Q4, in which ~$40m (70%) of the savings programme is phased.
- There is limited visibility of the impact of Hagley on CDHB's cost profile, and the assumed savings that have been built into the Plan.
- There remains tensions in tracking and reporting progress to a level of specificity that is appropriate for the Board and QFARC, and reporting being timely and transparent enough to enable effective assurance and decision-making.
- The establishment of a dedicated programme management office (PMO) to support taskforce delivery is a positive step, so long as there is sufficient involvement of frontline leaders, and they have clear accountability for realising savings.

Overall, the pace of delivery on the 2020/21 taskforce programme needs to be accelerated, and the structural and process issues with the 2019/20 approach need to be further strengthened, for QFARC to have confidence of achievability of planning savings.

Other observations

CDHB has recorded significant growth in personnel costs over the past two financial years largely due to above Plan FTE growth, putting pressure on the ability to meet Plan, and achieve longer-term financial sustainability. While some of the growth has been driven by compliance, and recruitment in advance of migration to Hagley, there has been sustained growth in the underlying FTE base.

CDHB currently has 135 vacant unplaced positions (160 FTE), which is equivalent to ~$16.3m. Nearly 115 of these vacant positions were advertised between 2 June and 17 July 2020. [redacted]

In 2020/21, CDHB will be delivering the largest migration of hospital services in NZ's recent history at the same time as planning for and delivering a substantial savings plan. Governance and management of these major work programmes need to be aligned, to ensure coherence and the successful delivery of both programmes.

Our recommendations are provided overleaf.

Recommendations

Urgent recommendations

In order to move forward with the 2020/21 Plan and accelerate delivery of savings, it is recommended that QFARC seek the following pieces of work for their September meeting:

- If it has not already been provided to QFARC, phasing of the 2020/21 Plan should be provided as early as possible. This should include phasing for benefit realisation as a result of taskforce savings initiatives (visibility of both phasing for the 2020/21 taskforces and how the gains from the 2019/20 taskforces, such as Leave Care, have been built into the base of the Plan). When phasing has been finalised, QFARC should seek an assessment of the reasonableness and achievability of the phasing.
- Evidence of how the migration to Hagley will support the planned expenditure profile of the Provider Arm, and how benefits from the migration will be tracked and reported.
- Progress report on developing and quantifying initiatives to achieve the taskforce programme targets, and the associated action plans, costs and impacts of the initiatives.
- A description of how the necessary operational management controls will be achieved through the financial year, and how this will remain visible to QFARC.

Ongoing reporting to QFARC

Given the scale of the two major programmes of change (taskforce programme and Hagley migration) planned for 2020/21, active governance will be required from QFARC. To achieve this, the following regular reporting to QFARC is recommended:

FTE movement

- Movements should be monitored against the Plan, and should include outsourced personnel.
- This should include the benefits of the process adopted in December 2019 regarding testing and challenging vacancies, and replacement of leaving staff - at least within personnel groups where efficiencies are planned and expected.
- All current vacancies should be examined for necessity and alternative solutions (using the DHB's well-considered new or replacement FTE sign-off process), and redeploy existing FTE wherever possible.

Taskforce programme and Hagley migration

- For the Hagley migration, reporting should include a clear map of the critical path and dependencies, high visibility of risks and issues and escalation, and tracking progress against expected changes in the expenditure profile (including clear KPIs and understanding of drivers of variance that can be addressed).
- For the taskforce program, reporting should include tracking costs of initiatives, benefits delivery progress, key risks and issues, and key decision points (for example, a decision to cease pursuing an initiative).

Recommendations (cont'd)

Progressing the longer term focus

A key learning from the development of the 2020/21 Plan is that the lead time to fully develop initiatives to a point where they are implementation ready is longer than anticipated, and needs to occur well in advance of the beginning of the relevant financial year. In line with high maturity savings programmes, initiatives in future Plans should become more strategic in nature, which will require more time to develop.

For this reason it is recommended that QFARC commission a revised multi year savings programme, including:

- Scenarios for achieving break-even, including what would be required under each scenario to achieve the associated savings targets, and associated risks.
- Strategic initiatives to achieve sustainable and ongoing efficiencies that could be further developed in 2020/21 for implementation in 2021/22.
- Focus areas for sustainable ongoing efficiencies, which should include:
  - An independent review of bed planning and resource deployment processes to identify areas (specific services or wards) where planned resource can be better matched to demand. This will contribute to identifying areas where reprioritisation can occur, and setting in place a planned and structured approach to managing to this year's Plan.
  - Identifying which Provider Arm services are loss-making or have higher costs per output compared to other similar DHBs, and leading benchmarks. For these services, performance improvement plans and model of care changes to align with the DHB's funding parameters should be developed. Equivalently, a focus on those services where financial performance can be improved should be considered.

Assurance and support

- Support for further developing initiatives and quantifying expected benefits should be prioritised. The time to complete this task will impact how much time is available to implement the initiatives and realise savings, and must be completed at pace. Support for this work will enable a structured approach to be taken, which can support greater visibility of the initiatives, certainty and risks for QFARC.
- It is recommended that independent reporting to QFARC continues for the foreseeable future. The immediate focus should be an assessment on the likelihood of achieving the 2020/21 savings target and areas of shortfall, and the reasonableness and achievability of how savings and expenditure have been phased.
- The need for a robust migration plan for Hagley is a critical area where support and expertise is recommended. In particular, assessments of any go / no go frameworks and PMO structures, with a focus on rapidly supporting further development of these.
- The development of longer term strategic initiatives, and a revised multi-year savings plan will require experience with savings programmes in peer DHBs, and the ability to apply global learnings on models of care and transformational change.

Background and scope of work

Taskforce programme context

In 2019, alongside the Ministry of Health and EY, CDHB completed an operational review and sustainability plan with the aim to reduce the annual deficit by $62.5m over four years. This would bring the forecast deficit to nil pre-interest, depreciation and capital charge.

The outcomes of the review pointed to five key drivers of the deficit:

- Transition costs (earthquake and infrastructure related)
- FTE growth above Plan
- Staff sickness
- Resourcing (notably forecasting/deployment of resource relative to demand)
- Annual leave management.

In response, CDHB established five taskforces, each being responsible for specific areas where savings can be made. The taskforces include:

- Absenteeism
- Continuous improvement
- Resource optimisation
- Planning and funding contracts
- Revenue optimisation.

Each taskforce has identified key areas of focus and developed savings targets for each financial year until 2022/23 (inclusive).

Scope of work

In March 2020, the CDHB Board (Board) commissioned EY to undertake an independent assessment of CDHB's taskforces, their progress to date, and opportunities to enhance the taskforce approach to support longer-term financial sustainability.

The scope of the assessment included:

- Savings already claimed, whether the savings can be realised against DHB's deficit including an assessment of the longevity and sustainability of each savings initiative.
- Current structure in place for the identification, implementation and the ongoing tracking of initiatives contained within each taskforce.
- Internal structures and coordinating mechanisms to deliver initiatives, with clear lines of accountability.
- Alignment of savings initiatives and the underlying drivers of cost, including the identification of areas of opportunity where CDHBs costs are disproportionately high.
- Further opportunities for savings and service improvement.
- Understanding the impact of the taskforce streams for projected expenditure, with clear tracking of expected benefits for longer term financial sustainability.

The Board also requested an independent assessments of:

- The use of EQ revenue, and balance remaining
- Financial delegations policy
- Impact of the COVID-19 pandemic.

The detailed scope is outlined in Appendix A.

Features of high maturity savings programmes

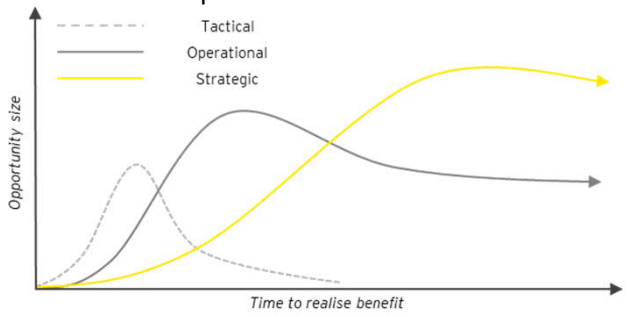
A mix of strategies is critical to success

A number of healthcare provider organisations that EY has worked with have typically focused too much on tactical strategies to resolve a financial shortfall, at the expense of long-term strategic re-design and reconfiguration which are the root causes of the financial position. The composition of savings portfolios is therefore a critical consideration in providing for long-term sustainability.

As a guide, in our experience an indicative ratio of 4:4:2 mix (tactical : operational : strategic) would be the ideal for a multi year programme of financial improvement, which over time shifts towards operational and strategic initiatives rather than a high proportion of tactical responses. It is expected that tactical opportunities will be identified each year, although they will diminish in frequency and importance.

Across the DHBs in New Zealand we have worked with, we have generally found that DHBs do not embed cost improvement into core business, reducing the effectiveness of their programmes.

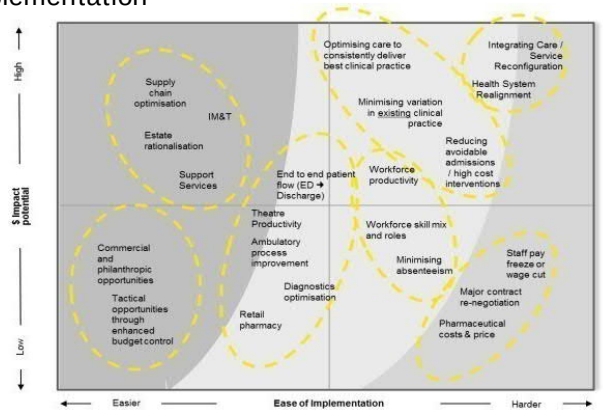
Figure 1: Relationship between return and time to realise benefit



Understanding the ease of implementation and trade offs

EY's international experience in health care cost and performance improvement suggests that savings usually come from similar areas, with trade-offs between the level of financial impact delivered and ease of implementation. Figure 2 illustrates these savings areas based on typical financial impact and ease of implementation as observed across our international portfolios of work.

Figure 2: Relationship between financial impact and ease of implementation



Risk weighted initiatives and more benefits planned than the target

Successful savings programmes have higher benefits planned than what is necessary to meet the target, as a way to manage risk of individual initiatives not progressing as planned, as well as good monitoring of initiatives, particularly higher risk initiatives.

In addition, good programmes have the right process to action a change, either to the initiative or by pulling forward another initiative to make up the shortfall.

Features of high maturity savings programmes (cont'd)

High maturity savings programmes also have the following features across the end-to-end process (from project governance, set up, initiatives identification, execution to close-out). We have assessed CDHB against each of these domains – for detailed criteria and assessment, please see Appendix B.

Governance and accountability

- There is strong board leadership, and the Board has clear visibility over decision making.
- The organisation is committed to change and change management strategies are in place.
- The problem (and the drivers of the problem) are clearly articulated.
- Programme planning is clear and the business case / return on investment for initiatives are understood.
- Accountability is clear and aligned, and SROs have appropriate authority to make changes needed.

Initiatives and benefits identification

- A formal idea intake (involving all stakeholders), idea validation (including evidence for benefits quantification and likelihood of success), and initiative prioritisation process is followed.
- An appropriate mix of tactical, operational and longer-term strategic initiatives are selected, and initiatives are connected to cost growth drivers.

Benefits realisation

- Stakeholder messaging (using appropriate communications channels) is in place for all impacted stakeholders, and stakeholders are incentivised to contribute to benefits realisation.
- Teams responsible for implementing initiatives have the capability and capacity to deliver targeted benefits.

Reporting and monitoring

- Clear progress reporting is available, including KPIs, risk reporting and contingency planning.
- Reporting is available in a timely manner to support key decision making points.

Programme evaluation

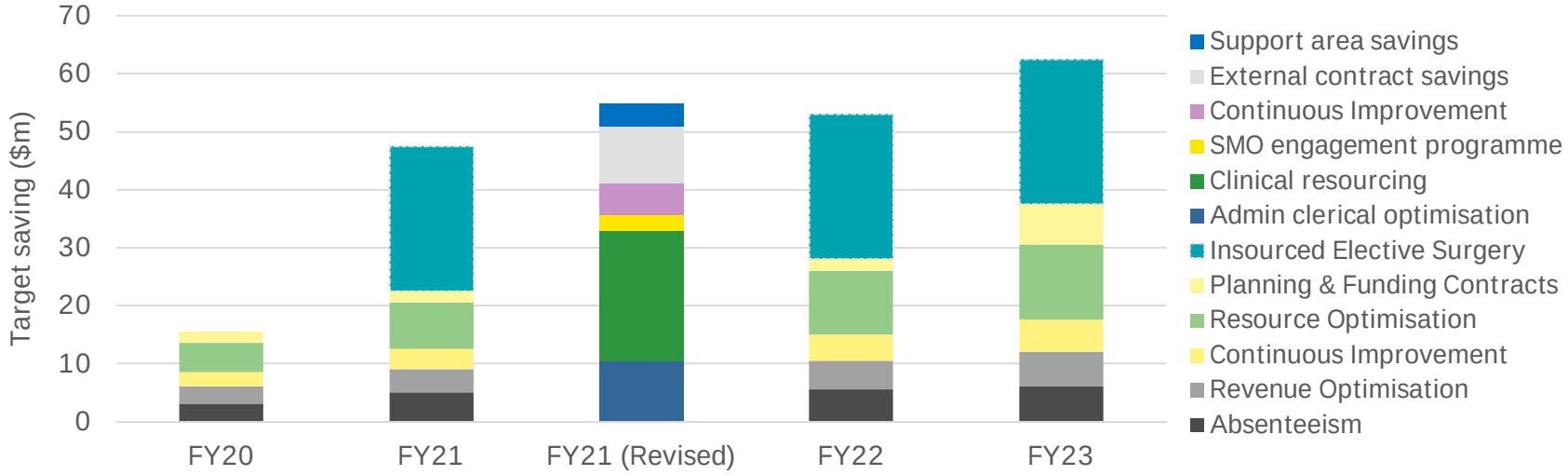
- There is a clear check out process to identify when savings have been realised and removed from budget lines (including a distinction between recurrent and non-recurrent savings).
- Structured learnings are used to improve planning of future initiatives.

Context: CDHB financial performance and 2020/21 Plan

2020/21 Plan evolution – savings target

- The 2019/20 taskforce savings target was $15m. The 2020/21 target was planned to be $47.5m in-line with the 2019 Review's objective of the DHB breaking-even by FY23.
- Despite a favourable uplift in Ministry of Health funding, continued cost growth has resulted in the need for the 2020/21 savings target to increase to $55m. Learnings from 2019/20, alongside delays in migration to Hagley, have resulted in changes to the composition of the taskforce programme – compared to that identified through the 2019 Review (Figure 3).
- The most notable difference is that planned savings from insourcing elective surgery have not been scaled back, and more emphasis is on optimising clinical resourcing – a key recommendation of EY's Operational Review.
- Some of the taskforce areas and initiatives that were planned for 2020/21 are not included in the $55m programme. However, the DHB has advised they are factored into the 2020/21 Plan. For example, resource optimisation and leave care / absenteeism are no longer line items within the programme. They are reported as included in the Plan, but the underlying assumptions are not visible to EY. On review of the Plan, the annual leave liability appears to have increased materially.
- While these savings initiatives are reported to have been factored into the Plan, EY recommends the visibility of underpinning assumptions, and how savings will be monitored and reported to QFARC needs to be clarified. This will provide greater confidence as to the appropriateness of the savings (in terms of quantum), their achievability, and tracking of their realisation.

Figure 3: Taskforce work programme savings composition compared to 2020/21 Plan[1]



[1]The revised 2020/21 target for the taskforce programme is taken from the Funding 20/21 paper, CDHB Board, 18 June 2020.

Context: CDHB financial performance

Table 1: Financial performance trends

Financial Performance ($'000)	2018/19 Actuals	2019/20 Actuals	2020/21 Plan (v6)
Total Revenue	1,834,263	1,974,505	2,069,235
Personnel Costs*	829,946	912,834	947,983
Outsourced Personnel & Services	31,126	33,232	29,739
Clinical Supplies (incl depreciation)	134,853	154,268	162,506
Infrastructure & Non-Clinical Supplies (incl depreciation)	198,130	240,020	259,672
External Providers	752,788	810,045	814,341
Total Expenditure	1,946,843	2,150,399	2,214,241
Net Surplus / (Deficit)	(112,580)	(175,894)	(145,006)
Interest and financing charges	24,753	38,538	50,062
Depreciation expense	54,085	77,973	85,108
Total Capital Costs / IDCC	78,838	116,511	135,776
Net Surplus / (Deficit) [Before Capital Costs / IDCC]	(33,742)	(59,383)	(9,836)
FTE (#s)	8,640	9,124	9,259
Year-on-year growth	N/A	5.6%	1.5%
Personnel Costs / FTE ($)	96,055	99,212	102,385
Year-on-year growth	N/A	3.3%	3.2%

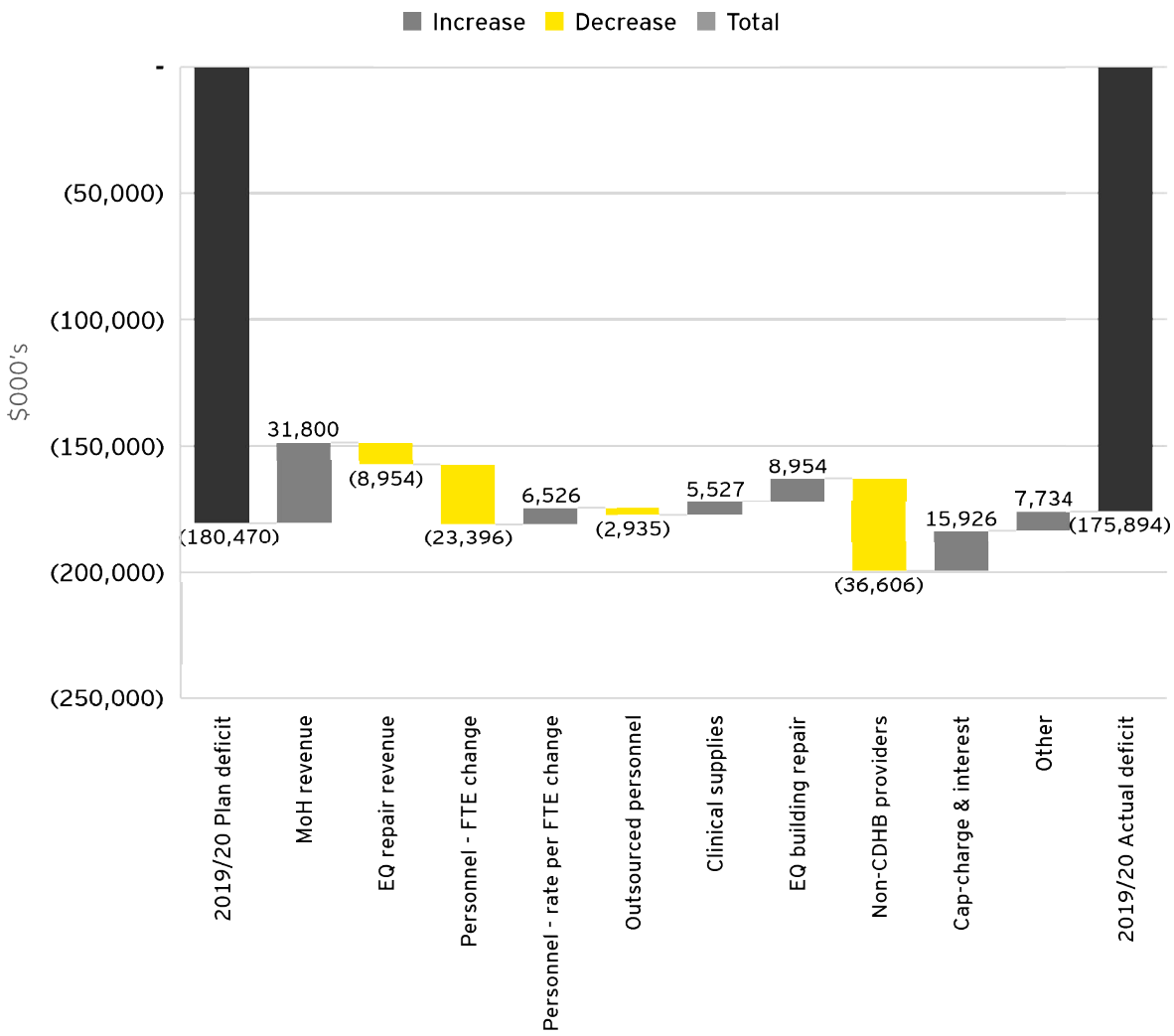
Key trends and planning parameters are:

- In 2018/19, the net deficit was $113m. The deficit increased by $63m in 2019/20 due to a 10% ($204m) increase in expenditure relative to a 8% ($140m) increase in revenue.
- Of the $204m increase in expenditure, $82m was a result of an increase in personnel costs which is primarily due to an increase of 484 FTE (5.6%).
- External provider costs also increased by $57m (7.7%) in 2019/20, with a significant proportion of this related to outsourced clinical services.
- Personnel costs and expenditure on external providers is expected to increase again in 2020/21 albeit at a much lower rate.
- In 2020/21, CDHB are planning to decrease the deficit position by $21m – to $145m. This is in the context of revenue increasing by $95m (including a favourable movement in Ministry of Health revenue of $22.6m above previously expected based on pre funding package advice).
- CDHB is planning on significant constraint in expenditure growth compared to prior years. The primary driver for the increase in expenditure is personnel costs [redacted]

* Note: 2018/19 excludes a provision for Holiday Pay of $69m and 2020/21 excludes a provision for Holiday Pay of $31m.

2019/20 Plan vs Actual

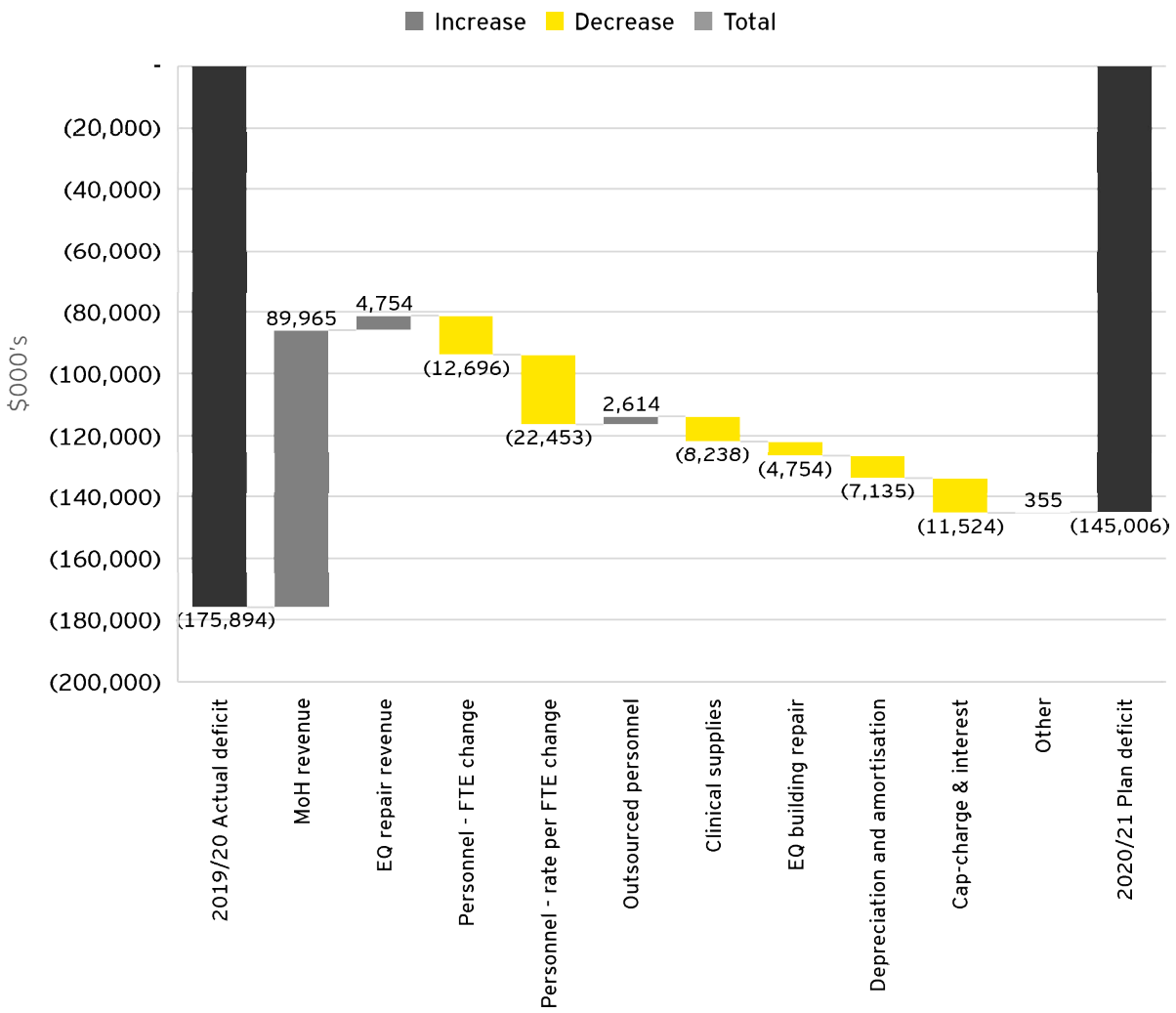
Figure 4: 2019/20 Plan against 2019/20 Actual



- In 2019/20, the CDHB deficit was $5m less than Plan, supported by the taskforce $13m savings, and favourable movements in revenue and capital charge and interest.
- Personnel costs and payments to non-CDHB providers exceeded Plan by $54m. These are the two largest expenditure categories that must be targeted for savings to be achieved in 2020/21 and outyears.
- FTE increased by 234 accrued FTE ($23.4m), although this was offset by a lower than planned cost rate per FTE ($6.5m). Outsourced personnel were $2.9m higher than the 2019/20 Plan. Above Plan FTE growth has occurred over the past two financial years, and impacts on the DHB's financial position in 2020/21, as salary inflation applies to a larger workforce.

2019/20 Actual vs 2020/21 Plan

Figure 5: 2019/20 Actual against 2020/21 Plan



- The DHB has had a favourable uplift in revenue, ($90m) exceeding the $82m planned for pre funding package advice. This materially contributes to an improved deficit position.
- Insourced personnel costs are expected to increase by $35m. This is comprised of a cost per FTE uplift ($2.5k, to a total of $22.5m), and an FTE uplift ($12.7m). [redacted] Outsourced personnel are planned to decrease by $2.6m.
- CDHB will need to carefully monitor revenue and cost to achieve the improved deficit. The increase in planned expenditure is much lower than achieved in previous years which will require a robust strategy to identify and monitor opportunities for efficiency.

Taskforce programme

Observations and lessons learned from 2019/20

The taskforce work programme in 2019/20 delivered ~$13m of its $15m savings target. While the taskforces achieved 87% of their collective target, our independent assessment is that the structure and processes of the taskforces were less developed than we would expect. Whist these issues were manageable in a savings programme of $15m, the learnings from this review need incorporating for future program delivery, as they could become major vulnerabilities in a programme the scale of 2020/21 ($55m). The introduction of a dedicated PMO could be supportive of managing these issues, but there needs to be a clear acceptance that current ways of working are not optimal. The specific issues include:

Benefits identification

- Benefits identification was at very high level for each taskforce, rather than being identified by initiative. This makes risk of under-delivery significant, and tracking and reporting of realisation difficult. In many cases, there was little evidence behind the quantum of expected benefits. There does not appear to have been a robust benefits quantification or prioritisation process at the inception of taskforce initiatives.

Project planning and monitoring

- There were several instances where initiatives that were being pursued at the start of the financial year were discontinued, and other initiatives took their place (see Appendix B). Whilst identifying and introducing new initiatives demonstrates responsiveness to changing circumstances, oversight and accountability of initiatives originally identified appears to have been lost. In many cases, the decision-making process and the strength of evidence as to why to not pursue ceased initiatives is unclear.
- Project planning at an initiative level appears to have been very high-level. We would expect to see a greater level of detail, including key actions required, an assessment of likelihood of achieving expected benefits, and risks and issues tracked at a greater level of detail during the implementation phase.

Taskforce governance

- The accountability structure at a taskforce programme level was clear (each had an ELT lead) but some ambiguity existed between the programme and initiatives. For many initiatives, the line of sight between the initiative and the expenditure line reduction (or alternatively, additional cost avoided) appears unclear.

Given the increased scale of the 2020/21 programme, the following learnings should be considered to provide the Board and QFARC confidence in the ability of the programme to achieve its target:

- As a priority, introducing a more robust benefits identification and quantification process.
- Rapidly assessing and refocussing effort whilst still keeping the Board and QFARC appraised of when and why these changes might occur.
- More robust project planning and monitoring is in place, to provide appropriate oversight of progress and risk management. The PMO resource is a good step towards supporting this.
- Line of sight between initiative and expenditure line reduction to provide visibility and assurance to the Board that benefits have been realised.

Sustainability of 2019/20 savings

- In many cases, there is not enough detail to determine with certainty the quantum of savings that are sustainable into the future. Some initiatives should have created a permanent change to cost, which will embed the savings (e.g. [redacted] but this is dependent on the management control environment - i.e. many of these savings could slip over time due to operational decision-making.
- Some of the initiatives intended to optimise revenue will have ongoing benefits (e.g. [redacted] however others are more likely to have one-off benefits (e.g. [redacted].
- However, some initiatives generated savings by reducing volumes of a contracted service (e.g. [redacted].
- We expect that many initiatives will have had a positive impact on expenditure in the 2020/21 Plan and out-years (particularly in the Leave Care and Resource Optimisation taskforces). To provide QFARC with clarity of which initiatives are expected to have recurring benefits, there should be more detailed information available regarding how these have been built into the 2020/21 Plan. For example, how much a line item has been reduced by due to ongoing benefits from these initiatives.
- Initiatives worked up for the 2020/21 taskforces should have recurring benefits in out-years clearly stated (alongside risks to achieving out-year benefits).
- CDHB has stated that some of the taskforces pursued in 2019/20 will be continued into 2020/21 (e.g. [redacted]). However, the planning documentation we have seen does not provide details quantifying the potential benefits of continuing action on these taskforces.

Observations on the 2020/21 taskforces

The increased scale of the savings targets for 2020/21 (~$55m) represents a major step change for CDHB, and in the DHB sector this target is at the upper reaches of the level of savings achieved in the past decade.

Our observations regarding the planned 2020/21 taskforces include:

Benefits identification and stage-gating

- The taskforce focus areas and initiatives are generally aligned with strategic drivers of CDHB's deficit. The focus is largely on the Provider Arm, although a range of savings are expected in commissioned community services.
- The composition of the taskforce programme has changed compared to that identified in the 2019 Operational Review. There needs to be more visibility about how initiatives such as leave care have been factored into the 2020/21 Plan.
- A clearer stage-gating process to properly scope and validate initiatives is needed. There remains a lot more work to clarify the specific actions that are required to deliver a substantial proportion of the benefits in the current programme (beyond strategic concepts of savings potential). Methodical identification of costs and benefits of each initiative needs to be completed, with the rationale and analysis visible to QFARC. For example, identifying specific actions in specific wards or services, the costs associated with these actions, and which line item expenditure reduction will be reconciled to.
- CDHB is adopting an agile approach to this year's taskforce programme, commencing with discovery phases for a range of the initiatives. Discovery phases are intended to finalise initiative design and benefit identification, and are to be completed within Q1. While some tactical initiatives are expected to be undertaken during discovery phases, the majority of savings are phased in Q3 and Q4. Where they are required, discovery phases need to be efficient so that lower probability savings initiatives can be discounted quickly, and alternatives found, to avoid more pressure being loaded onto later quarters of the financial year.
- The stated benefits expected from the initiatives comprising the 2020/21 savings programme are annualised figures. Given benefit realisation is largely set for the latter half of the year, there is a risk that these initiatives will not achieve the full annualised figure, and other initiatives will be required alongside these to achieve the $55m target within 2020/21.
- The lack of specificity of the initiatives makes it difficult to categorise into high, medium and low benefits realisation risk. Some of the initiatives proposed will likely require consultation with the Ministry of Health, employees or unions (see details in Appendix C). The time required to complete this work could put pressure on achieving targets within 2020/21 and presents a risk of slippage if approvals are delayed.
- While a process to fully develop and assess benefits is needed, the impact of delaying benefits realisation until at least Q2 means CDHB will need to save approx. $6m per month (October – June) in order to stay on track against Plan. This means that tactical savings need to be made as a priority – including making difficult, but important, decisions about the unplaced vacant positions.

Observations on the 2020/21 taskforces (cont'd)

Programme management

- The DHB has introduced a PMO to run the taskforces in 2020/21, and is following an agile approach to working up and executing initiatives. The next step will be to identify targets and goals for smaller sprint cycles, and to surface indicators that can be used to monitor whether the programme is on track. An agile approach does offer opportunity to produce benefits quickly, but requires a high degree of rigour to successfully implement. There is a risk, which has been seen in other organisations, that an agile approach results in frequent changes to focus and initiatives when decisions become hard or more complex at the cost of meeting overall savings targets. Robust reporting to governance and management sponsors can mitigate this risk.

Programme monitoring and controls

- If most savings are realised in Q3 and Q4, benefit validation needs to be completed as early as possible in Q1 and Q2. Monitoring controls that allow for weekly tracking of benefit realisation will need to be place to ensure that remedial actions are timely given the compressed timeframes to find alternative savings before year-end.
- Given the 2019/20 learnings, reporting to QFARC of progress against Plan, and the intention for the majority of savings to not be realised until Q3 and Q4, ongoing risk assessment needs to be strengthened. This is to ensure the right governance processes are in place to ensure successful delivery of the Plan. QFARC will also need to be provided clear decision points to enable the pace of delivery required.

Long-term programme planning

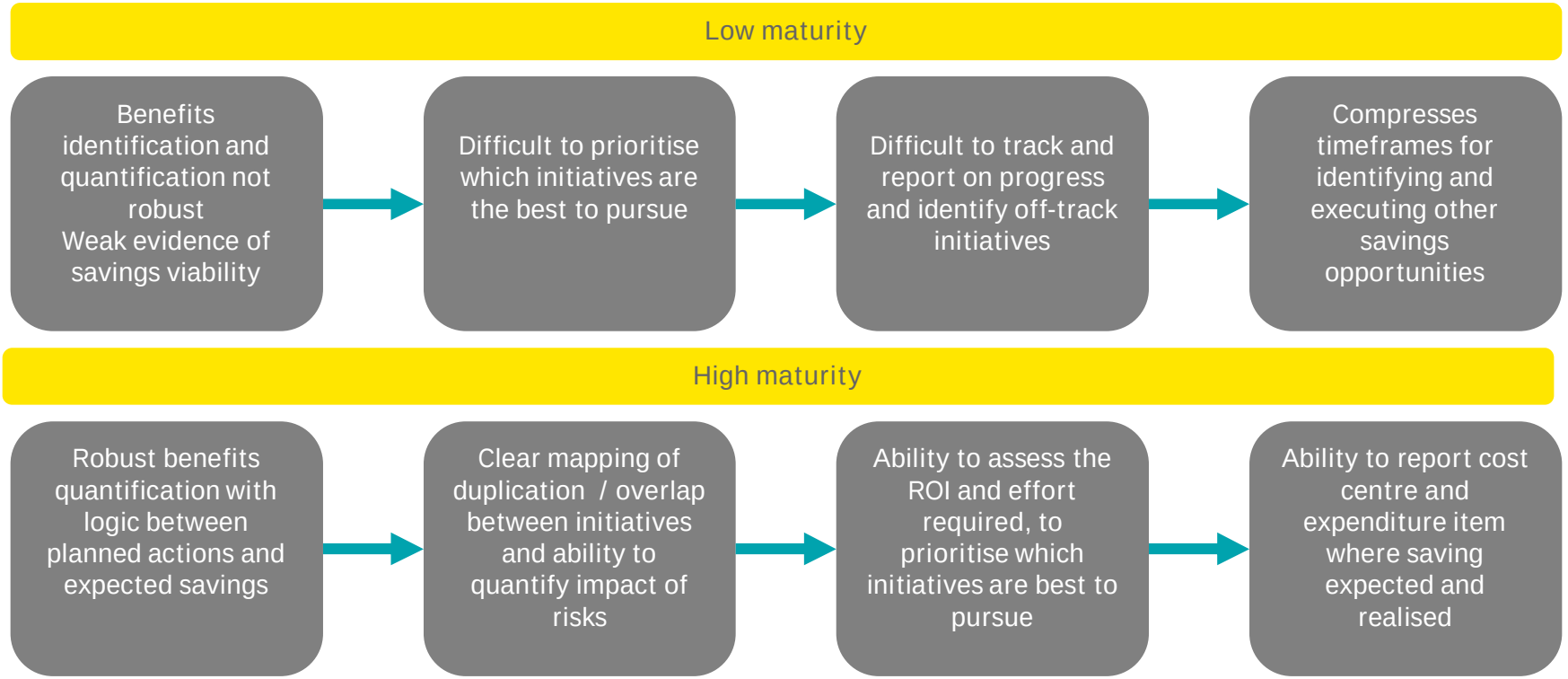
- A multi-year view of the savings programme needs to be developed urgently. The sustainability and unintended consequences of initiatives planned for 2020/21 have not yet been worked through. Furthermore, the requirement to ramp up savings efforts again in 2021/22 means longer term, strategic initiatives which will deliver long lasting efficiencies need to be developed now so they can be delivered early in 2021/22.
- We note that many of the 2020/21 taskforce programme initiatives still require detailed workup, even though the financial year has started. Good practice is that the bulk of initiatives are implementation ready leading into the start of the financial year.

Key finding: there needs to be greater transparency between actions identified, benefits to be realised, and reporting of realisation

A key finding of our assessment of the 2019/20 taskforce programme is that the lines of sight from an initiative to activities to expected benefits were unclear. This was particularly noticeable where multiple initiatives were expected to achieve shared benefits, and the contribution of individual initiatives to these benefits was not clear.

Given this, we assess the taskforce programme as low maturity in this domain compared to leading practice. Line of sight in the work-up of initiatives in 2020/21 also require strengthening, although it is understood that many of the initiatives are still in early stages of planning. A full maturity assessment of the taskforce programme is contained in Appendix B.

Figure 6: End-to-end process for benefit identification to benefit realisation



Monitoring and reporting

As mentioned earlier, CDHB is currently in the process of establishing a PMO to identify, execute and monitor the savings initiatives that have been identified. Given the scale and urgency associated with the required savings, this appears to be an appropriate starting point. We note however, that the following will need to be considered to ensure that progress is reported to management and QFARC:

2020/21

- Based on our assessment of the 2019/20 taskforce approach, governance of the taskforce savings programme should be standardised with improved oversight of progress reporting against targets. Risk identification, alongside clear accountability for delivery, must be clearly articulated and agreed.
- The teams responsible for driving savings delivery must be suitably resourced to prepare robust analysis and seek appropriate approvals from Management and QFARC when required.
- Reporting for QFARC, as well as any taskforce oversight committees, must include savings timelines, evidence of delivery and expected future impact of interventions. QFARC should also receive clear and concise reporting of other key operational trends to ensure visibility, and opportunity for governance action where necessary. This should include reporting of FTE movements (including outsourced) against Plan, vacancy management and revenue.
- Most savings are planned to be realised in Q3 and Q4, with a discovery phase for a range of initiatives in Q1. QFARC should receive progress reports on the discovery phase to ensure that it is operated efficiently to identify the most promising savings opportunities and discounting opportunities with low likelihood of success.
- As savings initiatives ramp up, monitoring controls that allow for weekly tracking of benefit realisation will need to be place to ensure that remedial actions are timely given the compressed timeframes (delivery in Q3 and Q4).

2021/22 and beyond

- Given the required savings in 2021/22 and beyond, when reporting on progress associated with savings initiatives, the longer term implications need to be captured and reported.
- QFARC should be provided with scenarios for achieving break-even, including what would be required under each scenario to achieve the associated savings targets, and associated risks. This will need to be updated periodically to capture operational changes over time.

Control environment

Operating management and processes

Tightly managed and monitored operations are critical for achieving the 2020/21 Plan

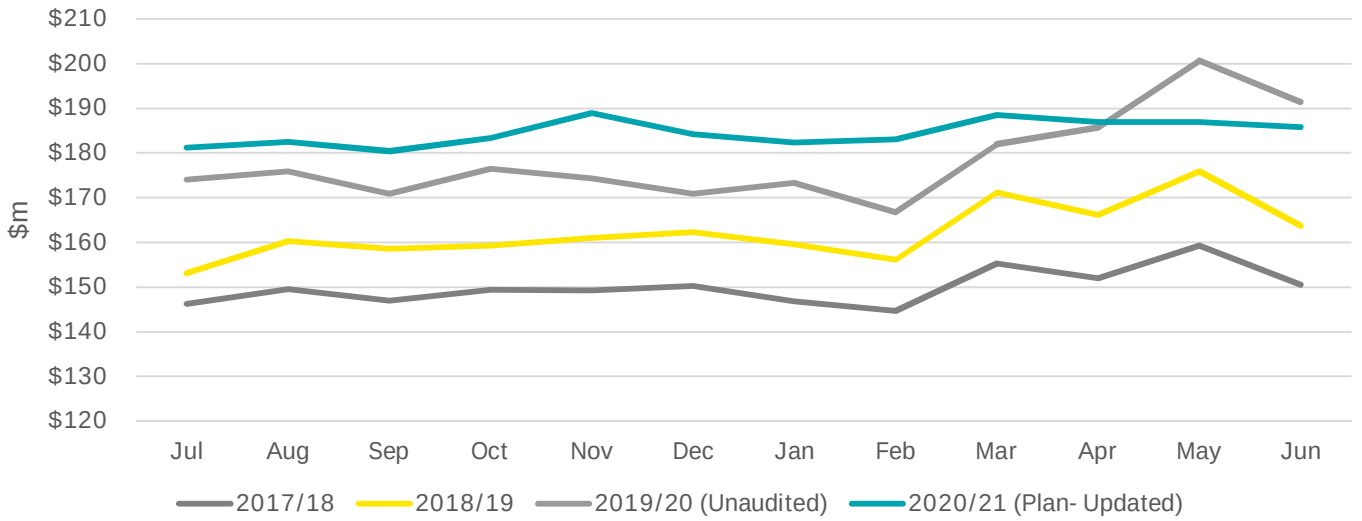
At the time of developing this report, the savings initiatives still in the process of being fully developed, and taskforce phasing information shows that most savings are expected to be realised in Q3 and Q4.

The need to track expenditure to (or better than) Plan will be critical throughout the year to ensure that no unexpected cost are generated in Q1 and Q2 and planned savings in Q3 and Q4 are achieved. Any delays to savings initiatives or unplanned expenditure will put increased pressure on CDHB in Q3 and Q4, when expenditure tends to be higher.

CDHB expenditure has grown year on year

In 2018/19 and 2019/20, operating expenditure (excluding depreciation and financing costs) increased by 9% - with an underlying deficit of $60m in 2019/20. The Plan for 2020/21 forecasts operating expenditure to grow at 2%. With personnel costs and payments to external providers contributing the majority of the operating costs, these two areas require additional attention and scrutiny when setting targets and monitoring performance.

Figure 7: Phasing of expenditure across the financial year, 2017/18 – 2020/21



FTE movements

FTE movements

Historically, recruitment has been above Plan. Figure 8 shows the pattern of FTE growth above Plan year on year. As the largest expenditure line for CDHB (approximately 50% of total annual expenditure), adherence with the FTE Plan set for 2020/21 will be critical.

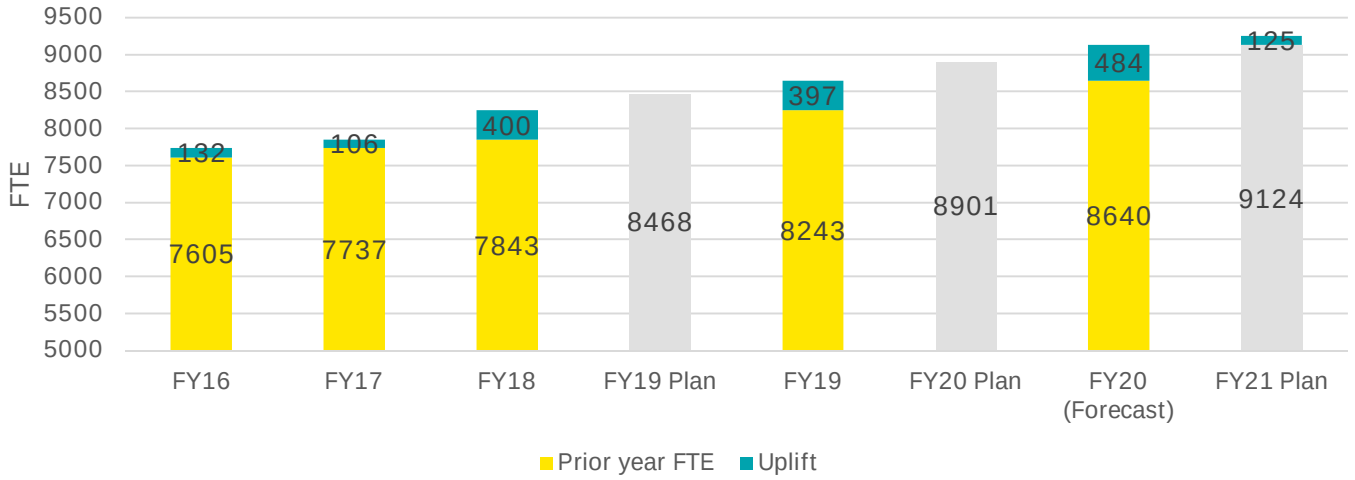
CDHB has established processes to ensure executive oversight for all recruitment and personnel growth decisions. Chief Executive approval is required for all new positions (with supporting business case), while replacement of staff requires sign-off of the relevant General Manager, and Executives. While these mechanisms are in place, they have not enabled management to planned FTE establishments, with growth excluding Hagley migration, compliance, and insourcing of services, being ~200 FTE over the past two financial years (~$20m).

Redeploying existing personnel to fill vacant positions and challenging vacancies

As of July 17, CDHB reported 135 vacant unplaced positions (160 FTE) [1], of which nearly 115 were new vacancies introduced between 2 June and 17 July. Only 3.8 FTE vacancies were over six months old, most of which were vacancies for SMOs.

Going forward, CDHB will need to seek to minimise total FTE growth, where additional FTEs are not funded from other revenue sources (e.g. Ministry of Health side-contracts). A key way to achieve this will be to challenge the need to fill or create new positions, and redeploy resources to assume former tasks of vacated positions wherever possible.

Figure 8: Key FTE movements 2015/16 to 2020/21 Plan



1. CDHB provided vacancy data as of 17 July 2020.

Resource deployment

There are opportunities to better match resource allocation of nursing personnel with demand

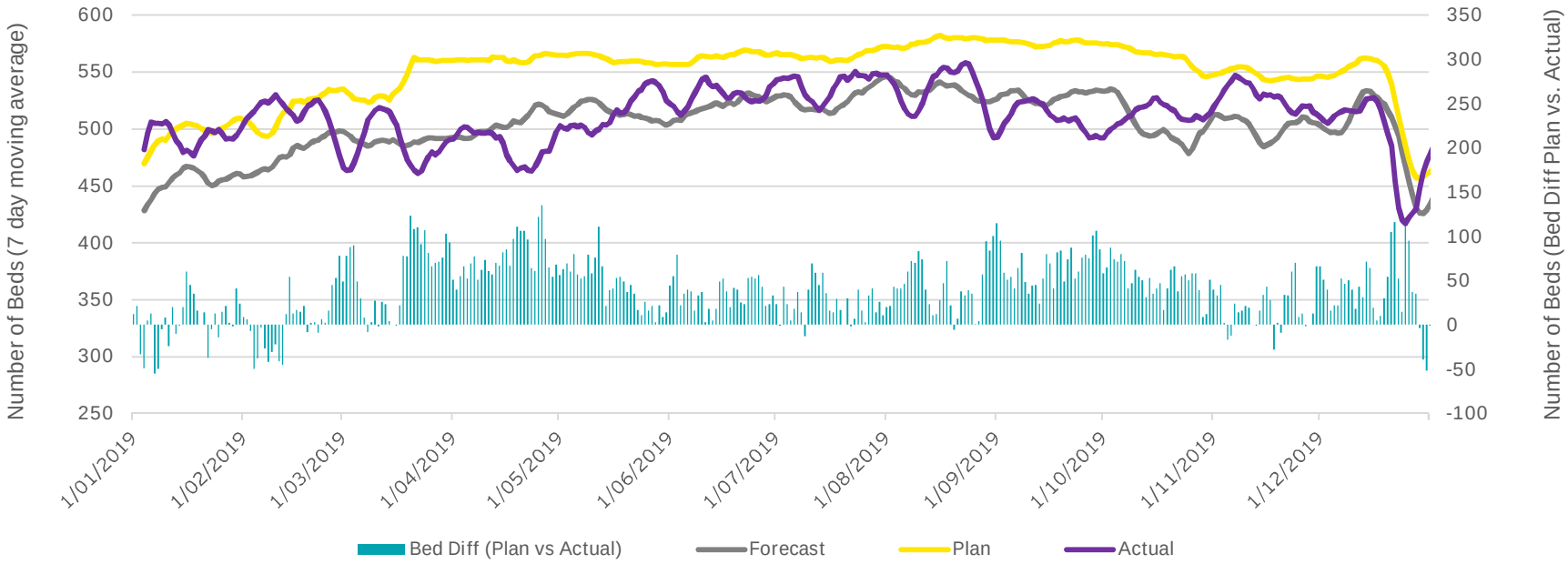
The bed planning process for Christchurch Hospital is central to the effective and efficient allocation of resources at CDHB. With daily personnel expenditure across the DHB between $2.3m - $2.8m, tight controls on resource deployment as well as daily challenge of resource requirements are crucial.

On average, the Christchurch hospital bed plan is set at 46 beds greater than forecasted demand. [redacted]

Rebasing bed planning to forecast demand could produce cost savings

[redacted]

Figure 9: Forecast vs planned vs actual beds (7 day moving average) at peak occupancy (10am) for Christchurch Hospital January 2019 – December 2019



Resource deployment (cont'd)

[redacted]

Figure 10: Bed days per nursing FTE FY13 – FY20 Dec YTD (annualised)[1]

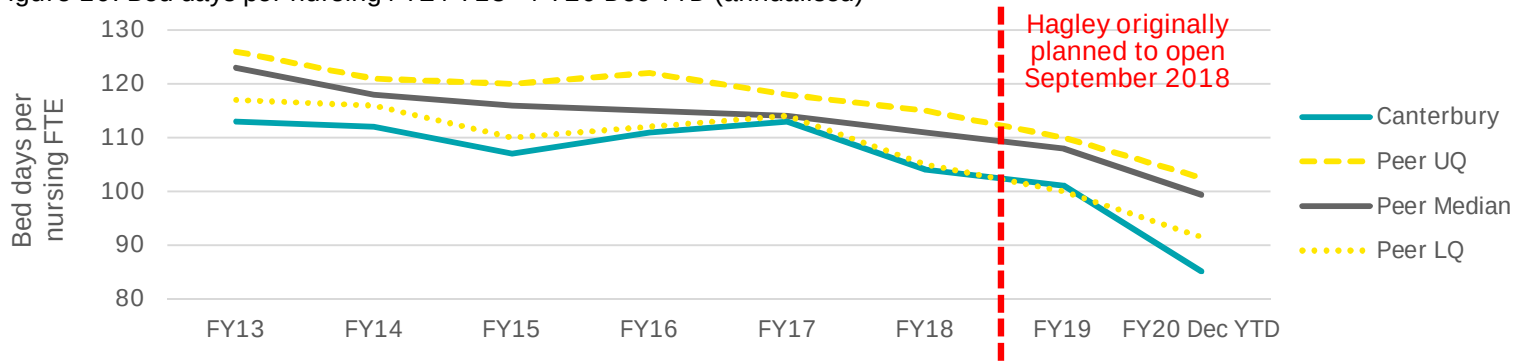
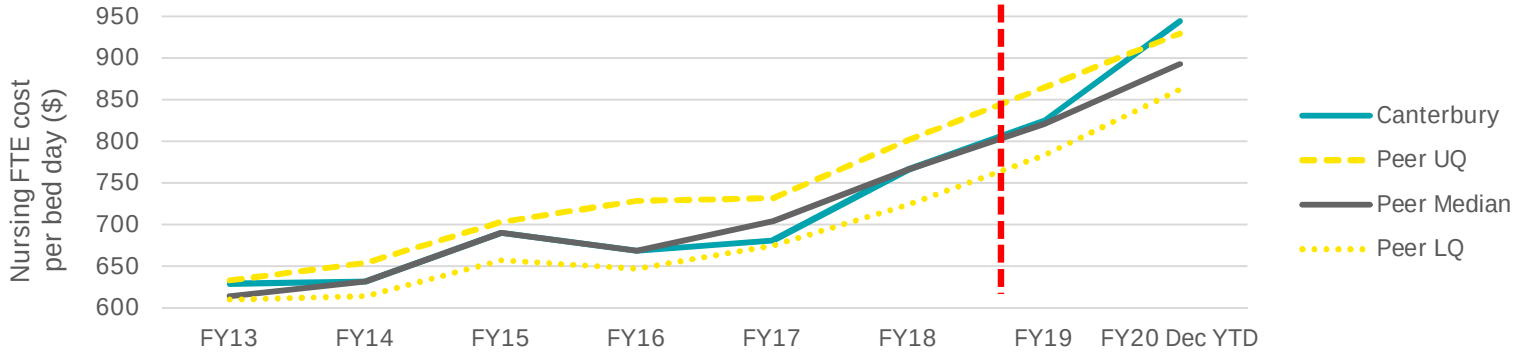


Figure 11: Nursing FTE costs per bed day FY13 – FY20 Dec YTD[1,2]



[1]FY20 YTD (Dec) based on extract from NMDS on 25 May 2020. This data may not yet capture all CWDs or bed days. The MoH have confirmed that the issue regarding SIPICs should be resolved and they were not aware of any outstanding coding issues.
[2]Cost per nursing FTE is lower at CDHB. In FY19, costs per nursing FTE stood at $82.6k, compared with $84.5k to $90.2k amongst other large DHBs.

Financial delegations

Financial delegations

Comparison to peer DHBs

EY has compared key categories of financial delegations to other DHBs of variable size (where information is available) for the Chief Executive.

CDHB's delegated financial authority is not tied to the Annual Plan, as is the case for some peer DHBs.

Compliance with policy is high

The CDHB Internal Audit report – Follow-up Review of Compliance with CDHB Delegated Authorities as issued August 2019 noted a 96% compliance with prescribed delegated authorities, although the scope of this review did not include payroll or payroll related expenditure.

Table 2: Comparison of financial delegations policies across DHBs

Category	CDHB	Large DHB 1	Large DHB 2	Large DHB 3
Capital Expenditure	$1m per asset/event	$500k (if included in Annual Plan)	$500k	$500k
Purchase of goods and services	Up to $3m/transaction	Up to $3m	<$250k (if outside of Annual Plan)	Up to $3m per annum
Payroll and Payroll related expenditure	Full Authority	Up to $2m		
OPEX			$500k	$1.5m per purchase order
Staff Travel	Full Authority		Up to $10k (Non CME) Up to $25k (CME)	
New FTE	No limit		No limit for unbudgeted FTE [1]	If within Budget

[1] For FTE appointments within budget over $150k, Level 2 (Executive Members) have authority to approve. The Chief Executive's authority applies to unbudgeted FTE only.

EQ Revenue

EQ revenue

Table 3: EQ fund reporting

EQ Fund – Reported to the Ministry of Health	June 2020
Opening balance	$290.0m
Less:	
Drawdowns as at June 2014	$20.0m
Revenue draw-down	$43.2m
Equity draw-down	$60.9m
Approved expenditure	$57.0m
Funds available (held by the Ministry)	$108.9m
Ring-fenced for Energy Centre	$44.9m
Ring-fenced for Tunnel	$14.7m
Balance available to draw-down	$49.4m
Cost to complete approved projects	$38.6m
Balance available	$10.7m

As shown in the table above, as at June 2020, the uncommitted balance remaining in the earthquake insurance fund held by the Ministry of Health is $11m (not adjusting for underspend on approved projects), however the undrawn amount is circa $109m.

To calculate the funds available, the undrawn amount must be adjusted for:

- Approximately $60m set-aside for the energy centre and tunnel which are being managed by HRPG.
- $39m set-aside for projects that have been approved however the funding has not been drawn down.

The presentation of the balance available appears to be inconsistent between the different reporting methods. Some reports state the funds available and others state the balance that is uncommitted. This appears to be a communication issue rather than a calculation error. We recommend a standard reporting structure be agreed that identifies the funds available and uncommitted balance.

Approval process

The supporting documentation associated with six projects was reviewed to understand the approval process followed prior to expenditure being authorised. Of the projects reviewed, all had business cases to support the funding requests, and we did not identify any irregularities in respect of the approval of expenditure. The approvals for each project are summarised below:

Table 4: Approvals for selected projects

Project	Management approval	CE approval	Board approval
Birthing Unit	Yes	No*	Yes
Hillmorton Food Services	Yes	Yes	N/A - <$1m
Home Dialysis Fitout	Yes	Yes	Yes
Rangiora Health Hub	Yes	Yes	Yes
BWD Boiler House	Yes	Yes	Yes
St Asaph St Substation	Yes	Yes	Yes

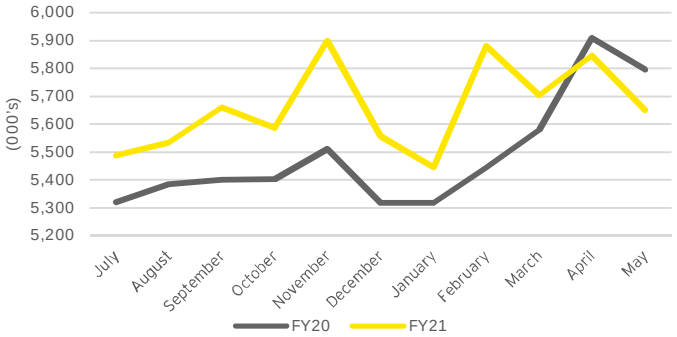
*Approved by Justine White (Executive Director, Finance and Corporate Services at the time).

Impact of COVID-19

Impact of COVID-19

The daily expenditure at CDHB has increased significantly during the COVID-19 pandemic. Total daily average expenditure (without interest, depreciation and capital charge) grew by 6.9% in March – May 2020 compared to the previous 8 months.

Figure 12: Total daily average expenditure (without IDCC) 2019/20 actuals and 2020/21 Plan



Month	Average	July	August	September	October	November	December	January	February	March	April	May
Total expenses LESS IDCC (FY20) Daily Average Spend (000's)	5,490	5,320	5,385	5,400	5,403	5,512	5,319	5,318	5,445	5,580	5,909	5,796
Total expenses LESS IDCC (FY21) Daily Average Spend (000's)	5,659	5,487	5,535	5,660	5,586	5,899	5,557	5,446	5,881	5,703	5,846	5,652
Movement (000's)		167	151	260	183	387	237	129	437	123	-62	-144

Daily average expenditure on personnel also grew throughout 2019/20. Daily personnel expenditure rose by 8.1% from $2.4m (July – February) to $2.6m (March – May), despite an average of 67 fewer open beds (507 vs 440) at Christchurch Hospital. Fewer open beds had a marked impact on clinical supplies expenditure, as expected.

Figure 13: Total daily average personnel expenditure 2019/20 actuals and 2020/21 Plan

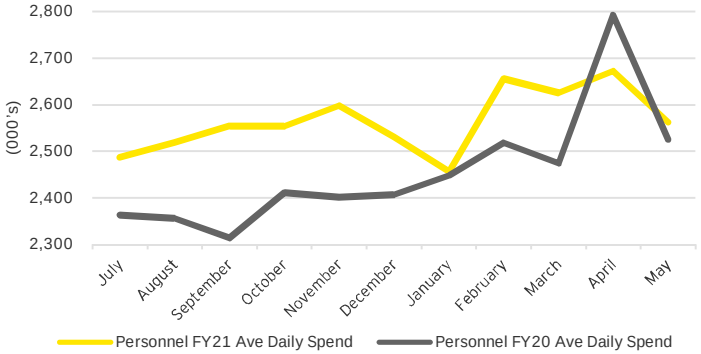
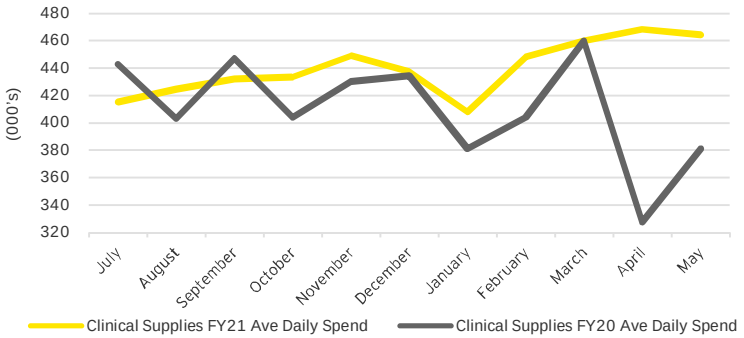


Figure 14: Total daily average clinical supplies expenditure 2019/20 actuals and 2019/21 Plan



Opportunities following lessons from COVID-19

Innovations in models of care (most notably virtual care) have been accelerated by the COVID-19 pandemic. As the immediate crisis of the pandemic abates, there is the opportunity to 're-set' models of care, service delivery and performance expectations as the 'new normal'.

In many jurisdictions, COVID-19 has forced the rapid transition to a 'digital-first' model of care to protect service users and the healthcare workforce. This has occurred in New Zealand, but with perhaps less impetus since the suspension of the lockdown / Alert Level 4.

Using the emerging evidence from Australia and the Regional Planning tool co-commissioned by South Island DHBs, the potential benefits to CDHB could be[1]:

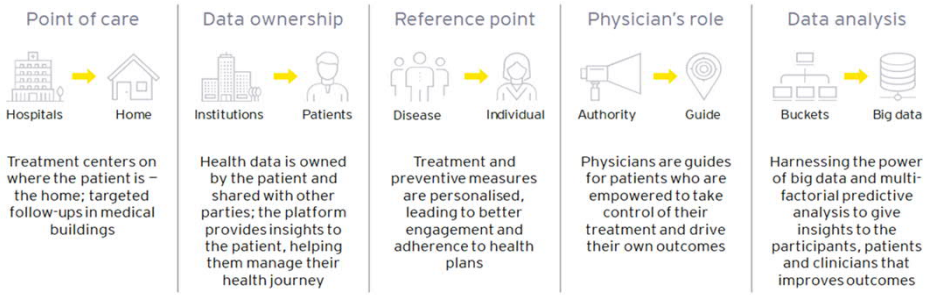
Potential economic benefits - 5-10 year outlook[2]
Depending on health agency coordination for acceleration

7%	of hospital admissions avoided due to virtual care (among which 5% for acute, 30% for non-acute and for mental health)
-22%	decrease in total patient hospital days in bed due to avoided admissions through virtual care and shorter average LOS
10%	of emergency department attendances avoided due to virtual care (among which 5% for urgent, 40% for non-urgent)

Virtual health capabilities across the continuum of care:

Wellness Self monitoring through wearables and sensors	**Virtual triage** Self triage through chat bots, nurse lines	**Virtual visits** Live consultation through apps/video
Virtual urgent care Unscheduled live consultation through apps	**Remote monitoring** Assessment/monitoring of patient condition through data collected using digital technology	
Hospital at home Post discharge care via apps/video and monitoring	**Acute telehealth** Mobile carts, robots & tablets to support patient and clinicians	**Virtual ICU** Physiological and EHR data monitoring of critically ill

The opportunities accelerated by COVID-19 can support transformation across the Canterbury health system. This is not limited to virtual care as shown above. The full spectrum of digital technologies can be used to create a more personalised and person centred health system. EY's simulation models can be used to estimate the impacts of these emerging models of care on patient outcomes and resources.



[1]Virtual Care economic model (May 2020), [2]eHealth NSW – Proposed future ICT projects (2020), [3]Telehealth literature desktop research.

[2]SIAPO regional planning tool population view with CDHB as the DHB of service. Impacts quoted for CDHB should be considered as indicative only.

Appendix A – Project scope

Independent review of the taskforce work programme

In March 2020, the following scope of work was agreed with the Board

To provide confidence of taskforce work programmes are delivering the expected benefits for long-term financial sustainability at Canterbury DHB and progress against targets, it is proposed that a review cover the following areas:

1. An assessment of the savings already claimed, whether the savings can be realised against DHB's deficit including an assessment of the longevity and sustainability of each savings initiative.
2. An assessment of the current structure in place for the identification, implementation and the ongoing tracking of initiatives contained within each taskforce. The assessment would recognise interdependencies in the delivery of initiatives, indicate trade-offs and highlight the risks both clinical and financial, in a standardised approach. This assessment would be made in the context of the ease of implementation for savings initiatives and their potential financial benefit.
3. An assessment of the alignment of initiatives contained within each taskforce and the underlying drivers of cost, including the identification of areas of opportunity where the DHBs costs are disproportionately high.
4. An assessment of further opportunities for savings and service improvement and whether opportunities exist where variation in performance is greater than expected across the DHB.
5. Understanding the impact of the taskforce streams for projected expenditure, with clear tracking of expected benefits for longer term financial sustainability.

Alongside an independent review of the taskforce work programme, it was agreed that the following work is necessary to support an understanding of both the decisions and circumstances that have led to CDHB's current financial position. The additional work includes a review of:

EQ revenue

- Receipt and allocation of EQ revenue, including an assessment of the allocation of funding.
- Approval process for each allocation.
- Remaining revenue available for projects.

Financial delegations

- Financial delegations covering operating and capital expenditure, including a comparison to other large DHBs pre- and during the COVID-19 pandemic.
- Major capital decisions against the financial delegations policy to assess whether there have been discrepancies.

Impact of the COVID-19 pandemic

- COVID-19 related activity and associated operating and capital spending to test whether expenditure is proportionate to the level of care and preparedness involved.
- Impact of COVID-19 related activity on CDHB's financial position and progress made in the taskforce Work Programme.

Appendix B – Taskforce assessment

Continuous improvement

Table 5: Continuous improvement savings target vs. achieved 2019/20

Taskforce Group	Initiative	FY20 Savings target	Savings achieved @ 15.06.2020[1]
Continuous Improvement	Radiology - In-Provider	$2.5m	-
	Radiology - Community		-
	Hospital Acquired conditions		-
	Pharmaceuticals		-
	Service Capacity Release		$4.7m
	Choosing Wisely		-

- It appears that only one of the original initiatives has delivered savings. The Service Capacity Release initiative was intended to focus on reducing ED admissions and LOS, and improving theatre utilisation through trialling abscess surgery as a day case.
- However, the $4.7m saved through this taskforce work programme was instead realised from a reduction in outsourcing ($3.59m), aged-residential care price and volume uplifts ($0.84m) and non-renewal of a cleaning contract ($0.40m).
- It is unclear what the process was for exploring the original initiatives and determining that there was limited opportunities for savings.

[1]KeyedIn - CDHB Taskforce Savings and Impact data, 15 June 2020.

Absenteeism / Leave management

Table 6: Absenteeism savings target vs. achieved 2019/20

Taskforce Group	Initiative	FY20 Savings target	Savings achieved @ 15.06.2020[1]
Absenteeism	Capability Development & Delivery	$3m	$2.09m
	Process, Analytics & Tool Development		
	Service Delivery		

- The use of analytics to support action taken to improve the management of annual leave and sick leave is robust and the communication strategy to provide support across the organisation is well considered.
- We note that no savings have been delivered since March, although the taskforce work programme and each initiative is being assessed as 'on track' in KeyedIn (15 June).

[1]KeyedIn - CDHB Taskforce Savings and Impact data, 15 June 2020.

Resource optimisation

Table 7: Resource optimisation savings target vs. achieved 2019/20

Taskforce Group	Initiative	FY20 Savings target	Savings achieved @ 15.06.2020[1]
Resource Optimisation	Establishment and Optimisation	$5m	$0.84m
	Common Framework Alignment		$0.26m
	People Resource Definitions		
	Unique Enduring Position Development		

- From the documentation, it is unclear which departments, rosters or workforce groups were being reviewed for optimisation.
- We would recommend that to improve planning and likelihood of success in 2020/21, clear logic should link specific actions to expected benefits as the initiative planning passes the early stages of idea-gathering and identification. We understand that the identification phase is agile, however a level of benefit and risk quantification will be needed to track progress appropriately.
- As was highlighted in the 2019 Operational Review, there are opportunities to better ensure oversight of organisational deployment and recruitment as well as supporting oversight of department resourcing and accountability to budget.
- We note that no savings have been delivered since March 2020, although the taskforce work programme and its initiatives assessed as 'on track' (15 June).
- In 2019/20, many initiatives were delayed due to the postponed Hagley migration. Because further delays could potentially occur in 2020/21, reporting of the impact of this risk could be improved. For example, the impact on all benefits identified, quantified and the interdependencies between the risk and impact should be made explicit.

[1]KeyedIn - CDHB Taskforce Savings and Impact data, 15 June 2020.

Revenue optimisation

Table 8: Revenue optimisation savings target vs. achieved 2019/20

Taskforce Group	Initiative	FY20 Savings target	Savings achieved @ 15.06.2020[1]
Revenue Optimisation	Coding enhancement project	$6m	$0.07m
	Costing system review		$1.41m
	Wellfood Revenue targets		
	Labs external revenue optimisation		
	CLS external revenue		

- It appears that only one of the original initiatives has delivered savings (the coding enhancement project).
- The additional $1.41m saved appears to have been driven by initiatives other than those identified as part of an initial identification process - increasing commercial revenue following an InterRAI host consolidation ($0.88m), an ISG project ($0.31m) and a shared data warehouse ($0.12m). It is unclear what the process was for exploring the original initiatives and determining that there was limited opportunities for savings.

[1]KeyedIn - CDHB Taskforce Savings and Impact data, 15 June 2020.

Planning and funding contracts

Table 9: Planning and funding contracts savings target vs. achieved 2019/20

Taskforce Group	Initiative	FY20 Savings target	Savings achieved @ 15.06.2020[1]
Planning and funding contracts	Review of Current Agreements with emphasis on discretionary contracts	$2m	$3.26m
	Identification of alterative pathways for outcome		$0.11m

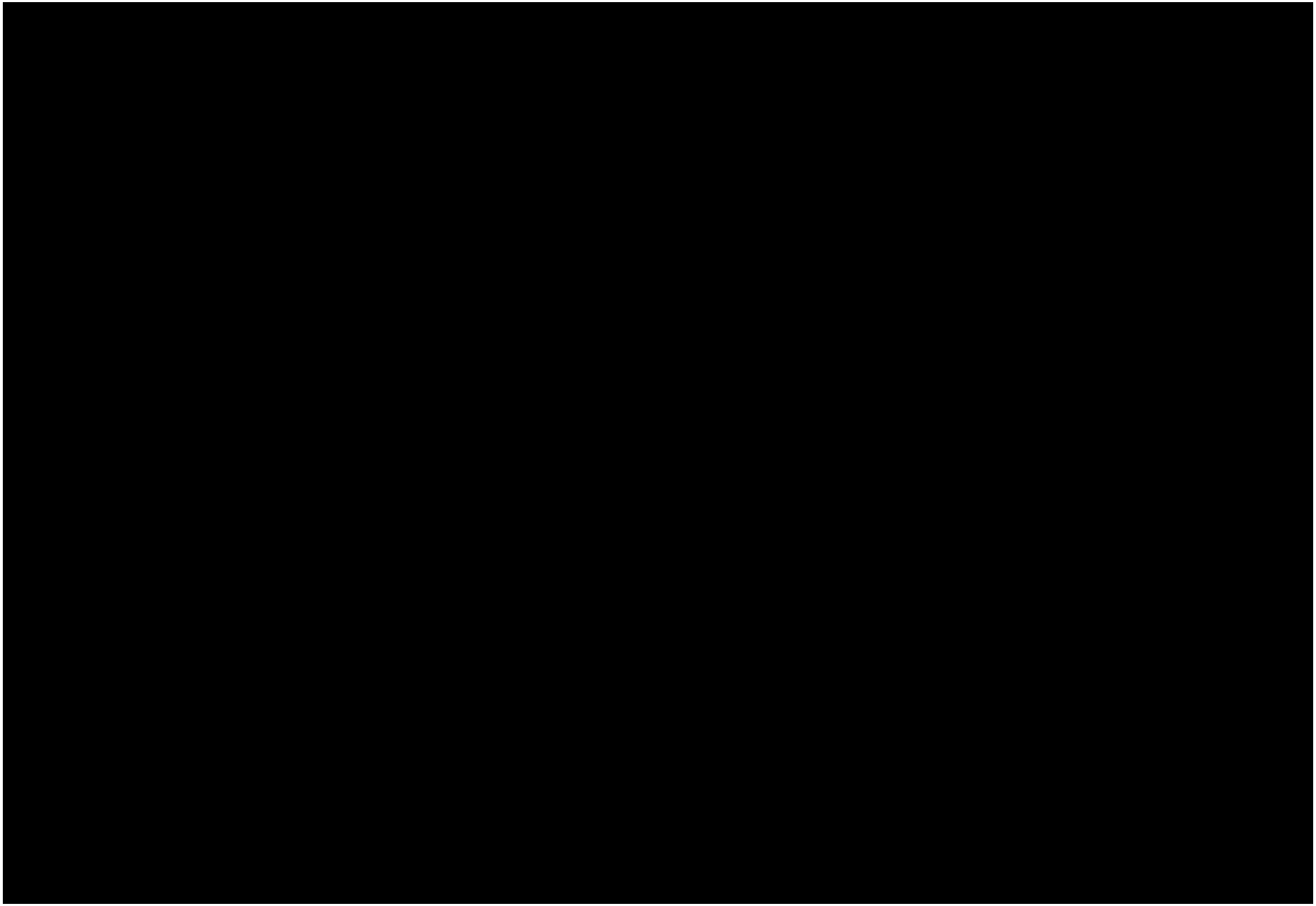
- This taskforce has a robust and tested methodology for identifying saving opportunities and an iterative process to continually learn and extrapolate the impact of such initiatives. This methodology should be extended to the other taskforces.
- The savings achieved can be more easily reconciled against the originally planned initiatives identified, compared to the other taskforces.

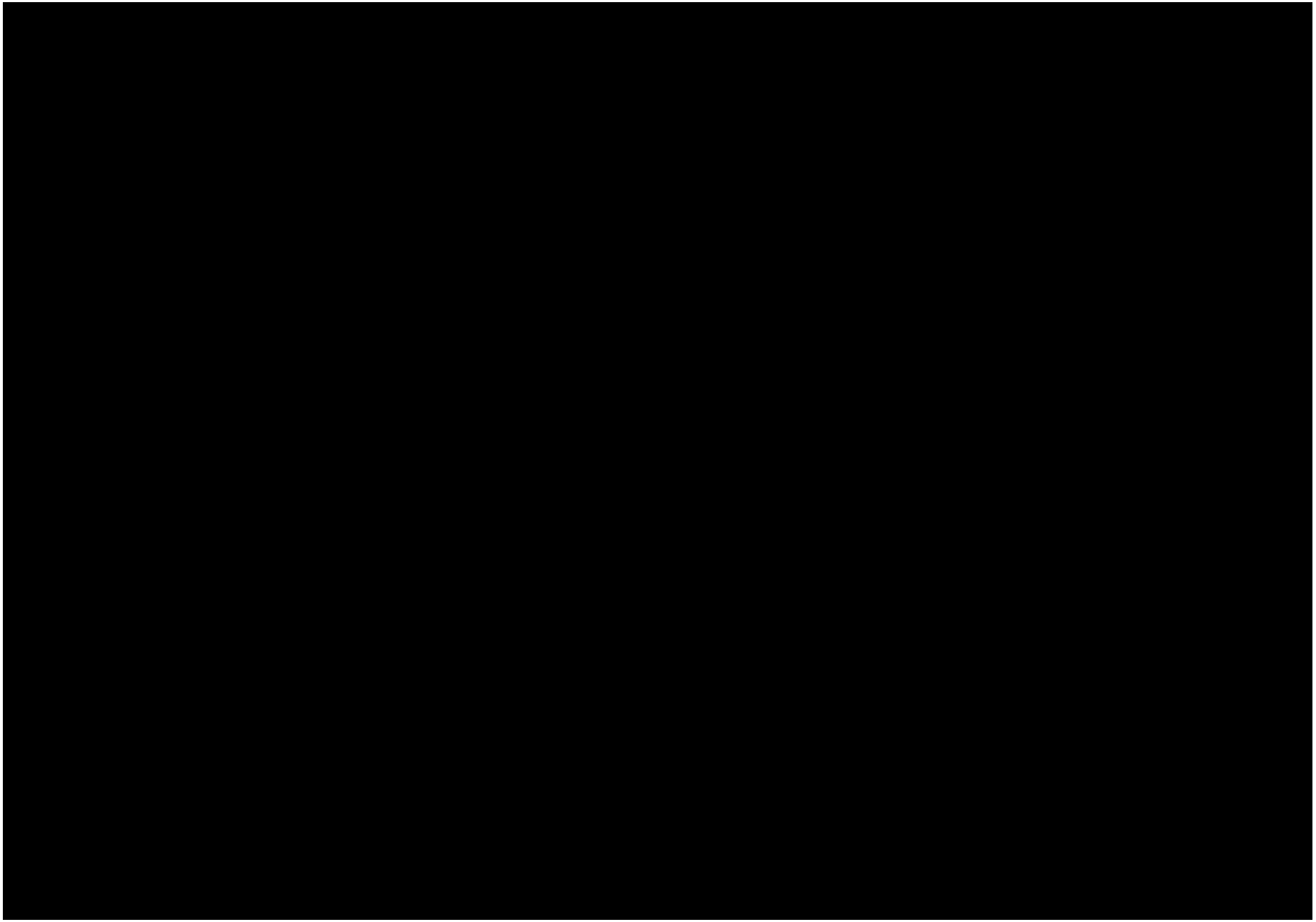
[1]KeyedIn - CDHB Taskforce Savings and Impact data, 15 June 2020.

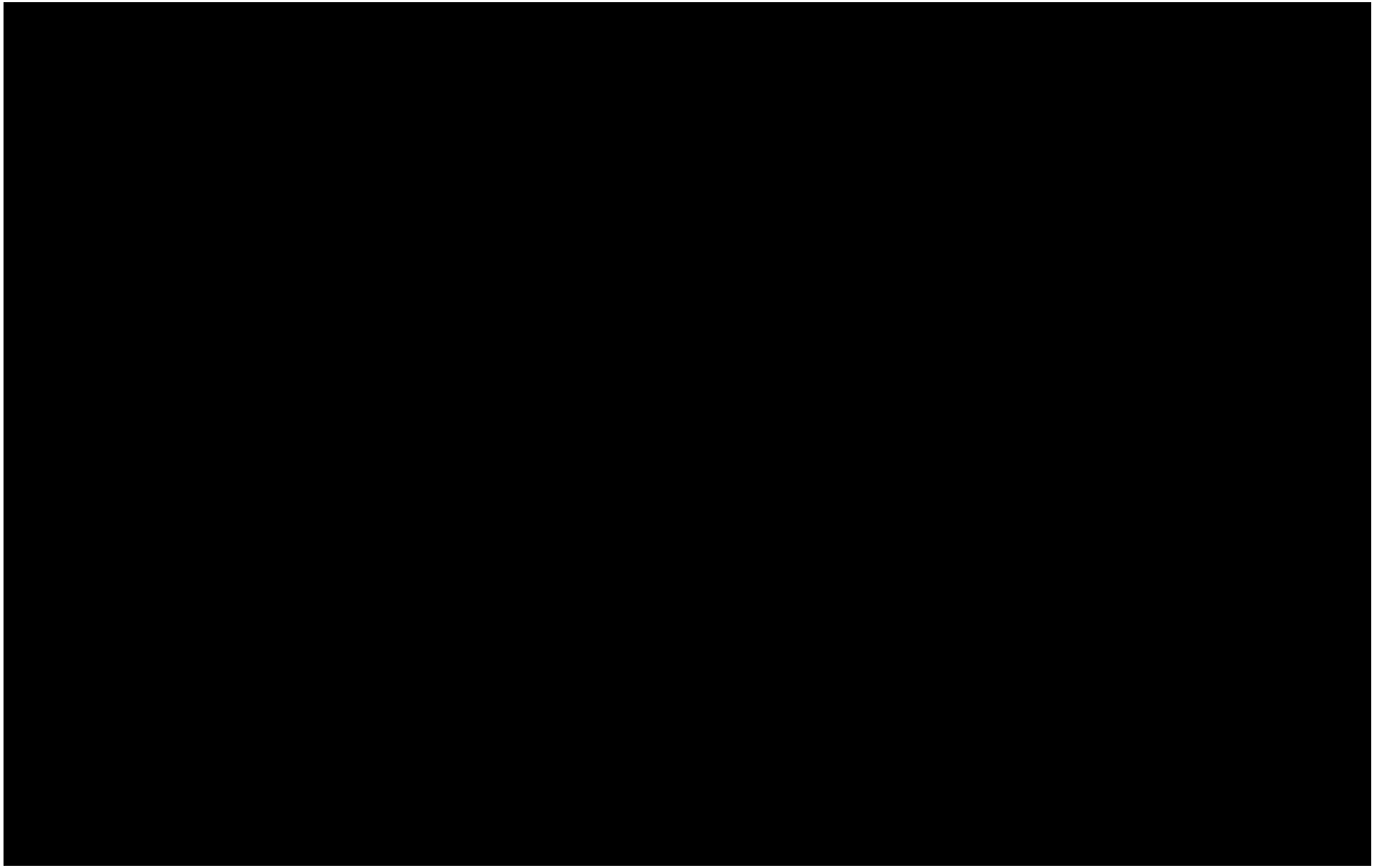
Application of the diagnostic framework

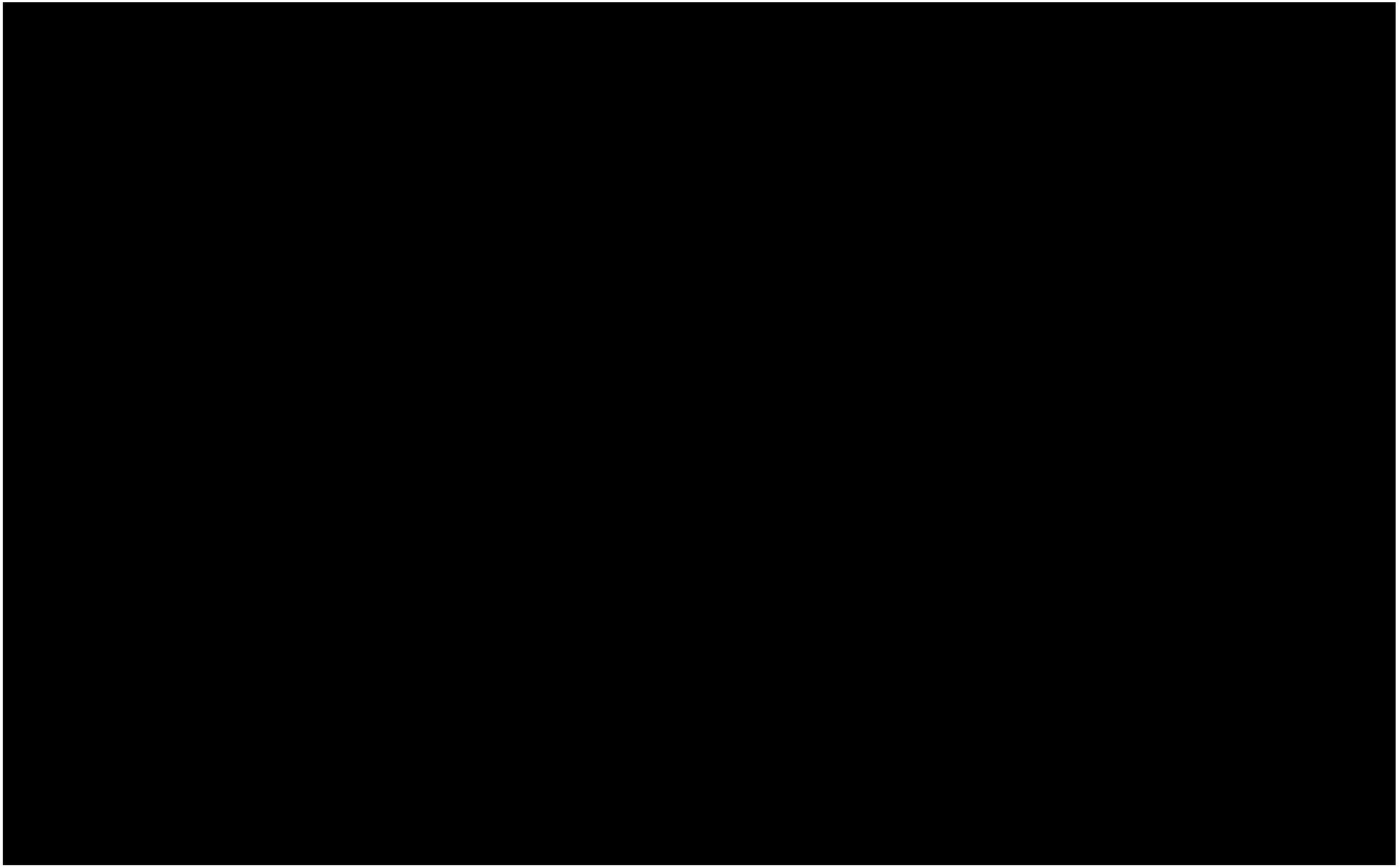
The diagnostic framework has been applied based on interviews and workshops with CDHB stakeholders between 10 June 2020 and 9 July 2020 as well as information and documentation received up until 30 July 2020.

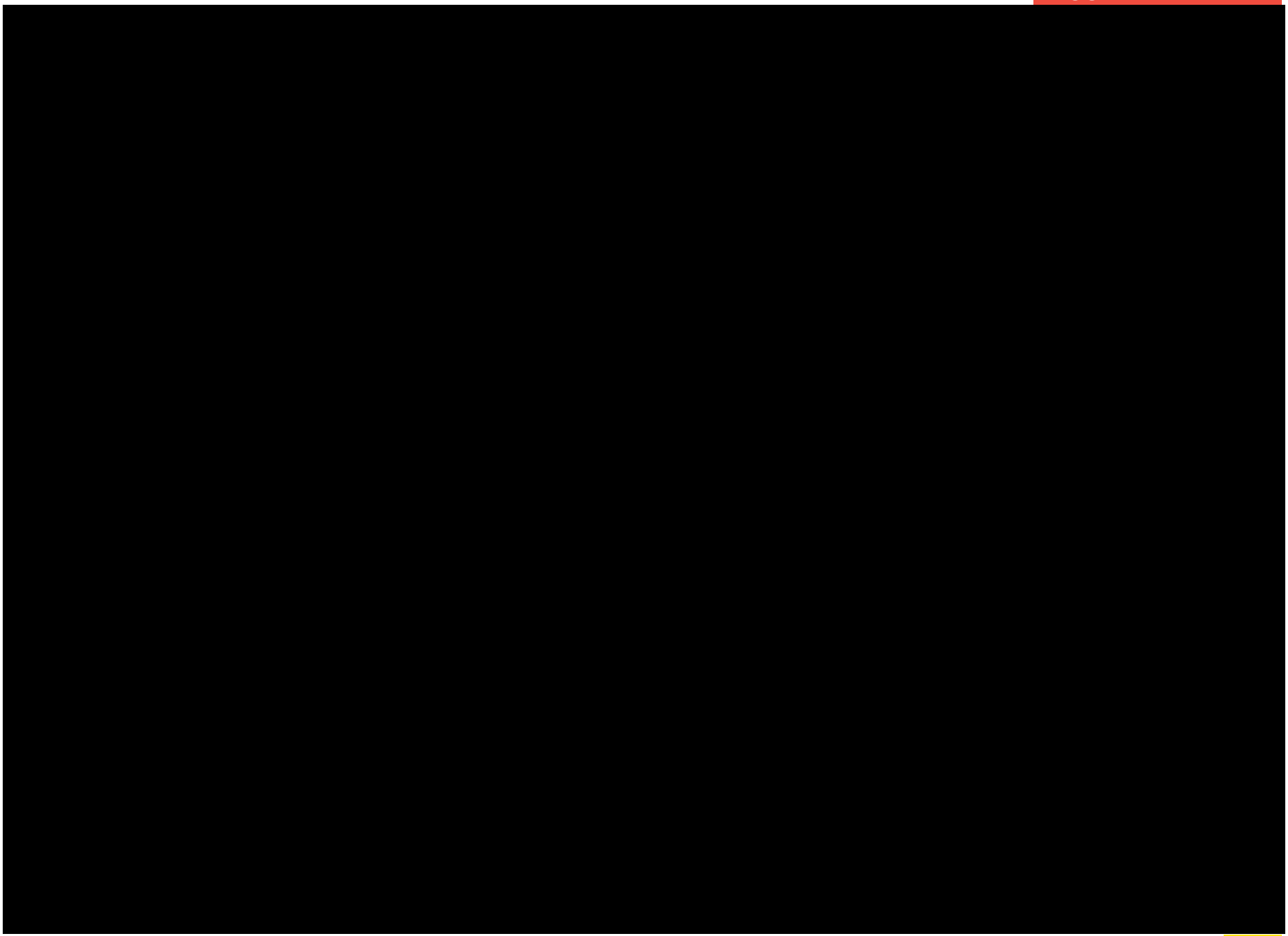
Ratings largely apply to each of the five taskforces, however in a few specific instances the ratings differ between taskforces – these are explained in the notes.

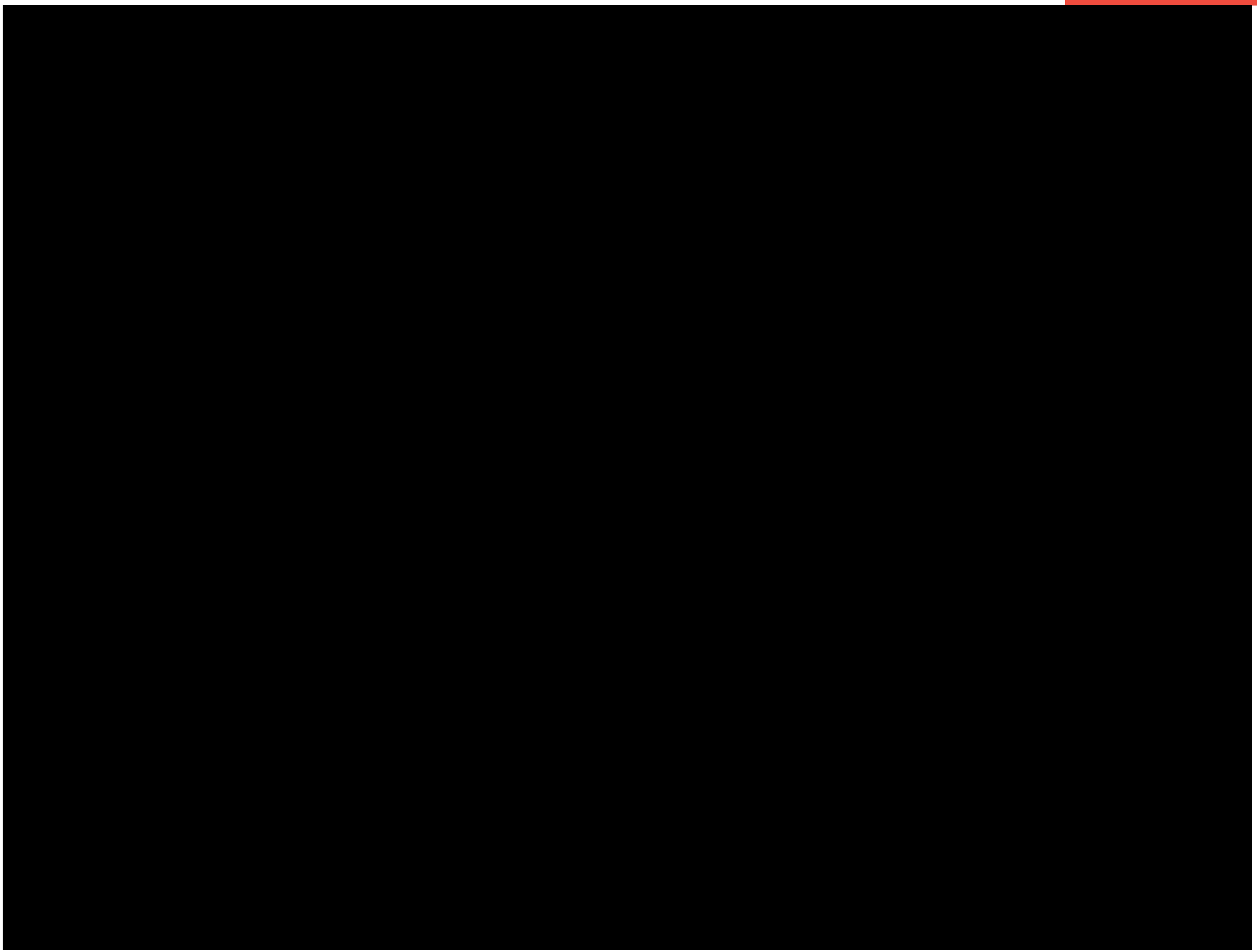


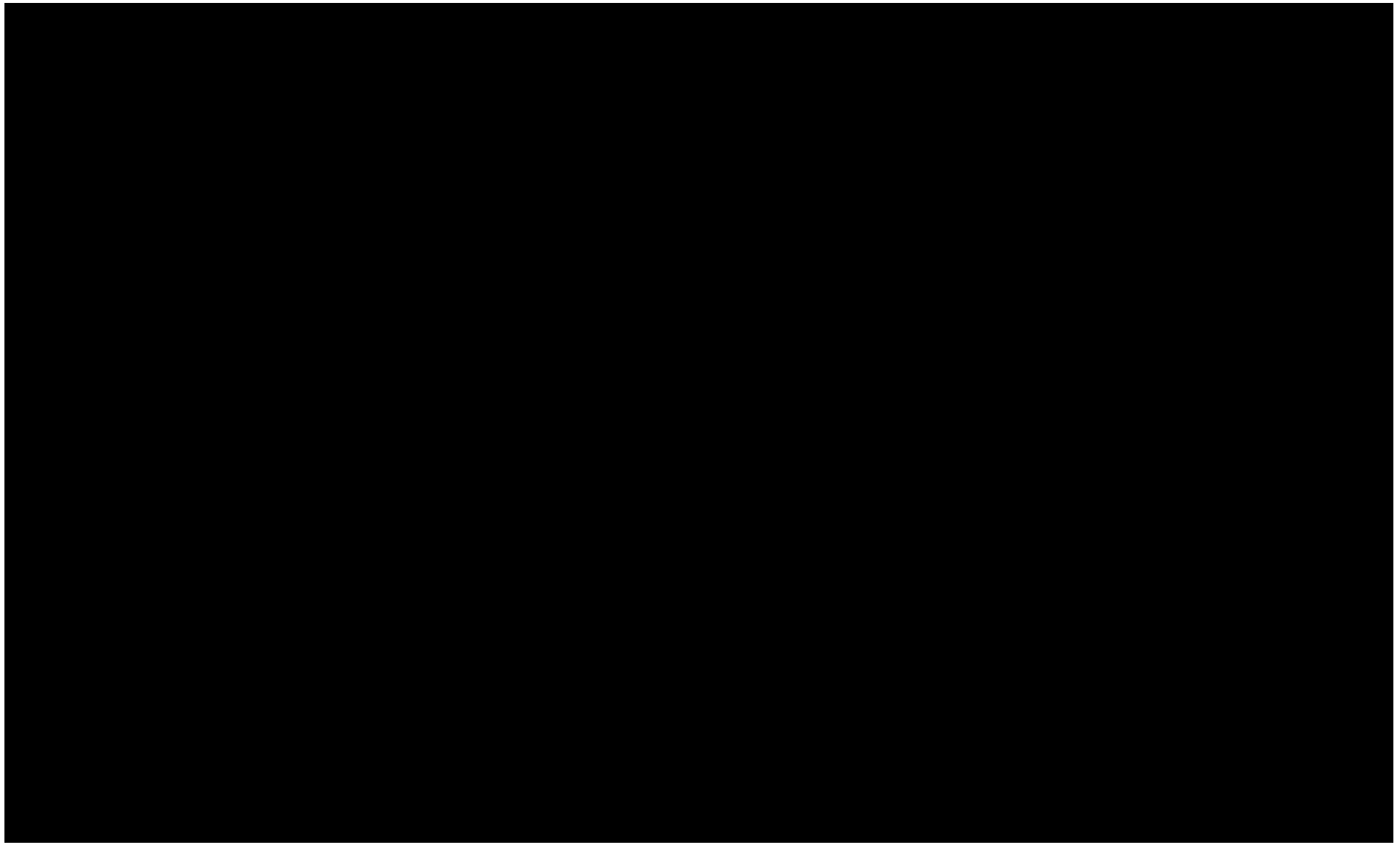


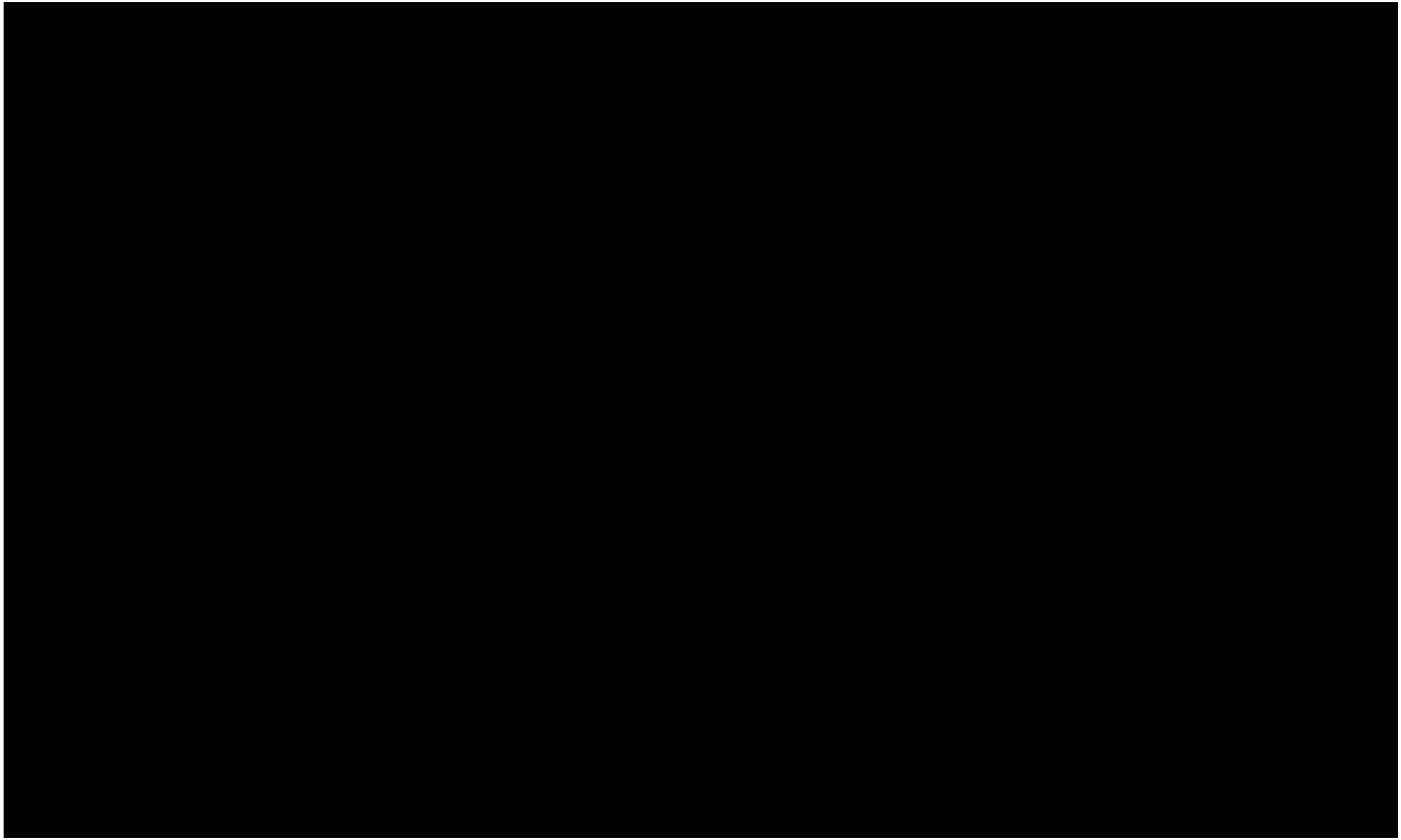


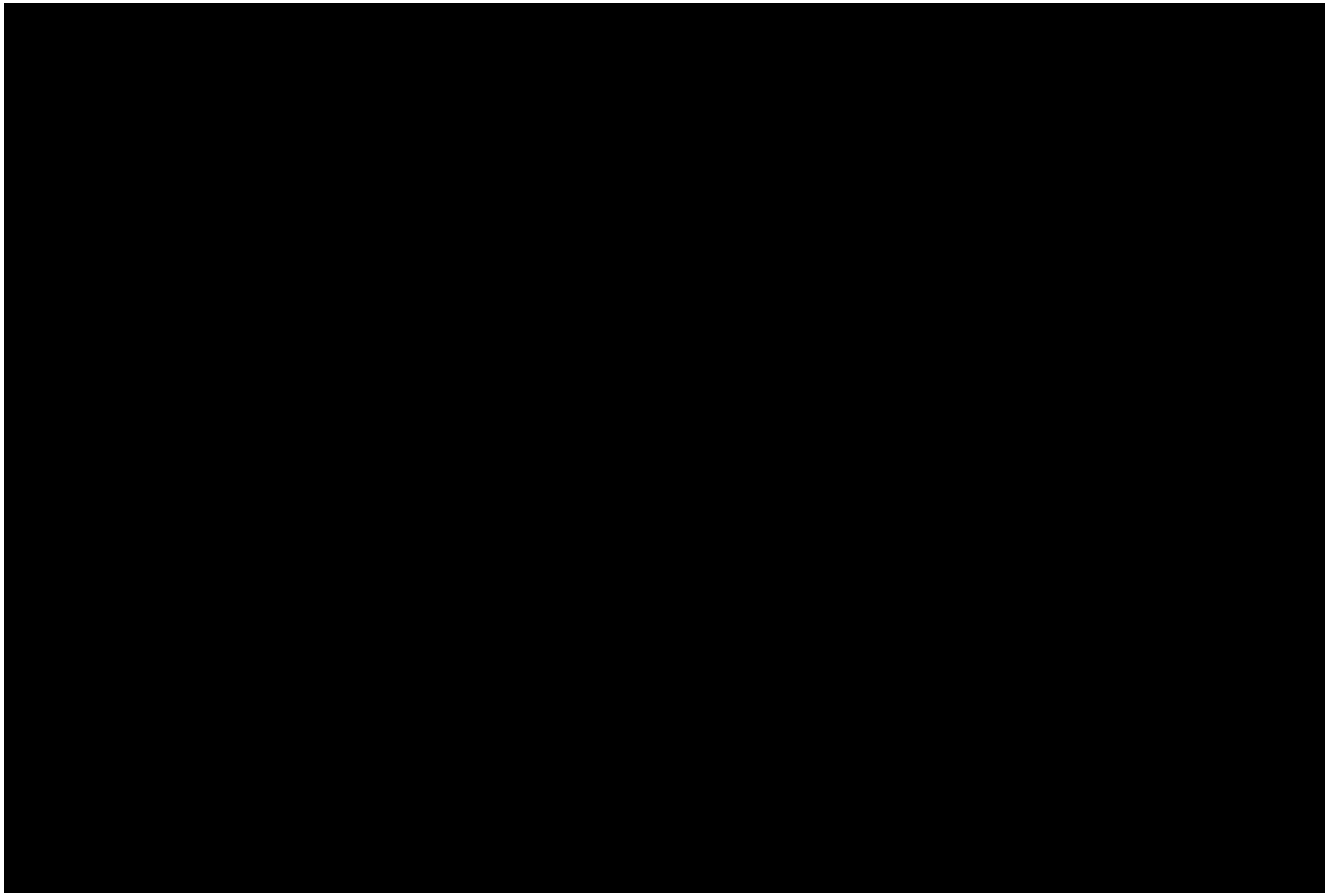












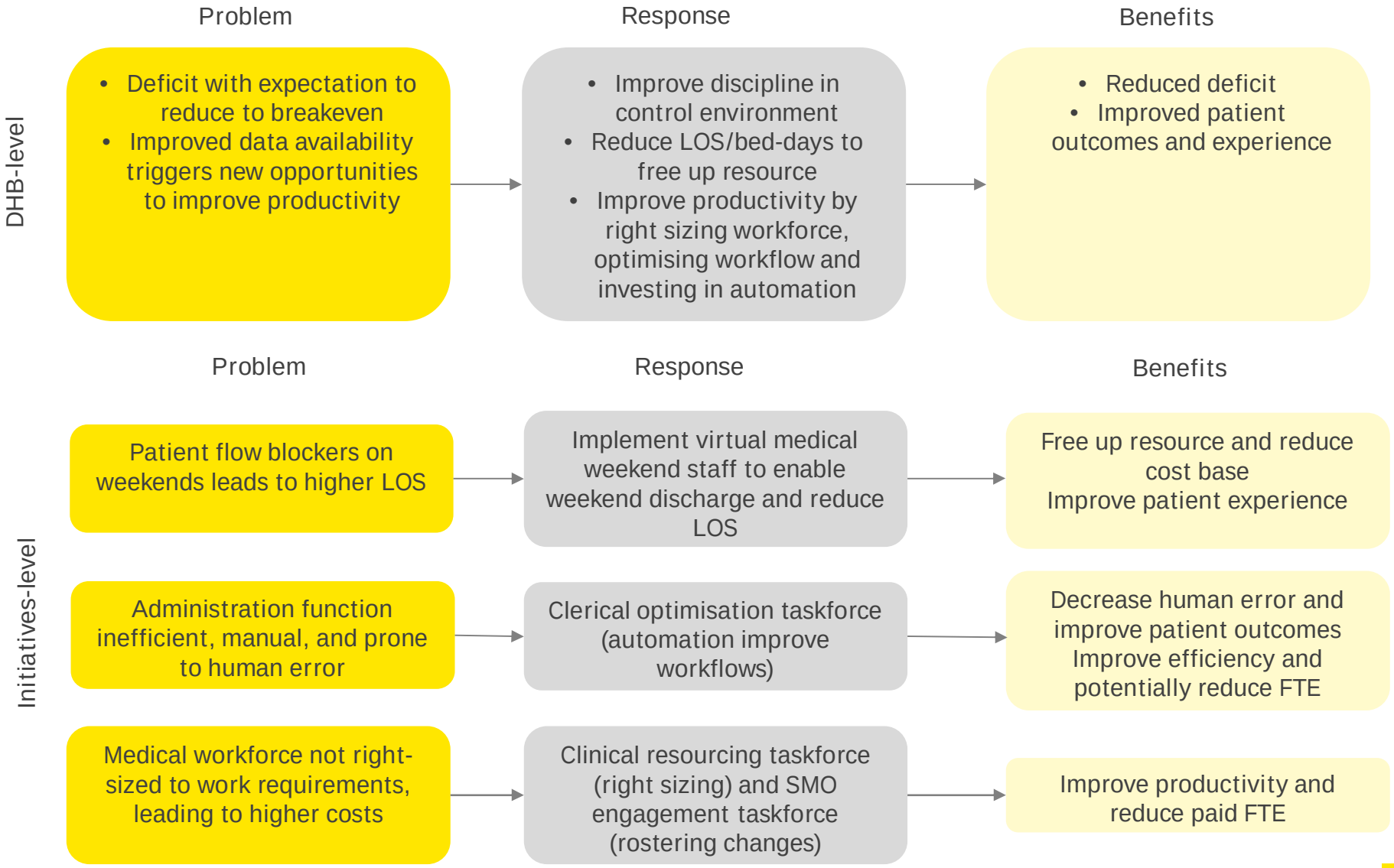
Communicating the taskforces' intervention logic

Communicating the level of detail required to QFARC and the Board has been noted as an area the CDHB taskforces would like to improve on.

Clearly linking the actions of taskforces to the expected benefits will help with the communication of the taskforce's intended actions and benefits. To support this, we have put together the diagram overleaf as an example. This diagram is at a high level, however, it can also be applied for each initiative.

Example key intervention logic

Figure 15: Example key intervention logic



Appendix C – Service change requirements

Service change

The Ministry of Health sets out guidance in relation to service change[1]. Key steps required in that process include:

?	Discussion with DHB's Regional Relationship Manager at an early stage (prior to Board approval) to clarify if the Minister is to be notified / facilitate approval or approval in principle
✓	Identification of agreed service changes within the Annual Plan

It is perhaps most likely that CDHB service changes to achieve the taskforce programme would be triggered through considering the change to be a significant service change, as per question B of the Ministry's guidance in Table 11. The criteria for significant service change applies where there is a significant impact, such as:

1. Service eligibility criteria.
2. Access to services.
3. Meaningful shifts or additions in workforce / FTE including individual service changes [Introduced in the 2019/20 Operational Policy Framework].
4. The financial position of the DHB.

In addition, a significant service change process has to be initiated when:

1. The Minister directs the DHB to make such a change.
2. The Minister considers changes are being made to service eligibility, access or the way services are provided.

Table 11: Decision tool for triggering service change protocols[2]

A. Does this proposal meet the current SCS and/or the mandatory components of the Operational Policy Framework?	• If YES proceed to B. • If NO, the DHB(s) discuss with the Relationship Manager(s) before proceeding to secure ministerial approval for SCS exceptions or approval for OPF mandatory component exceptions.
↓	
B. Does this proposal trigger any of the existing protocols that require ministerial approval (ie, significant service change, the capital approval process, the public/private service protocols)?	• If YES the DHB(s) discuss with the Relationship Manager(s). The Ministry will use agreed criteria as to whether the Minister needs to be consulted using the service change protocols. • If NO, proceed to C.
↓	
C. Does one or both of these situations apply to this proposal? a. The proposal requires public consultation under the NZPHD (Planning) Regulations (section 92(1) of the NZPHD Act, as amended by the NZPHD Amendment Act 2010). b. The proposal is likely to result in substantial public comment.	• If YES, the DHB(s) discuss with the Relationship Manager(s) to facilitate the proposal as to whether the Minister needs to be consulted on the substance of the proposal. • If NO, the DHBs can proceed with the change proposed, provided the change is clinically appropriate, that a robust process is followed (as per the Minister's expectations of DHBs) and public confidence is managed by the DHB.

More detail is required on the initiatives that are deemed to require service change. Initiative descriptions appear to be aimed at improved productive efficiency through either technological solutions or improved allocation of resources, which may not be subject to Ministry approval.

[1]Source: (See NZPHD (Planning) Regulations (section 92(1) of the NZPHD Act and SOC Min (10) 15/2.
[2]Source: Operational Policy Framework 2020/21, Ministry of Health, 4 May 2020.

Service change (cont'd)

MECA also assign guidance and principles that need to be considered in the context of service change. The ASMS DHB MECA 2017 – 2020 outlines several processes required as part of proposed service changes:

?	The employer shall invite the employees concerned to participate in the review at the earliest practical opportunity.
?	Before the employer undertakes any review which might impact on the delivery or quality of clinical services, it shall consult and seek the endorsement of the Association as to the purpose, extent, process and terms of reference of such review and will give due regard to the Association's advice.
?	The employer will advise the Association and affected employees of the recommendations of any concluded review in order to ascertain whether there are any serious professional or clinical concerns. In the event of such concerns the employer will either endeavour to satisfactorily resolve them with the Association and affected employees or reach agreement over a process for resolution.

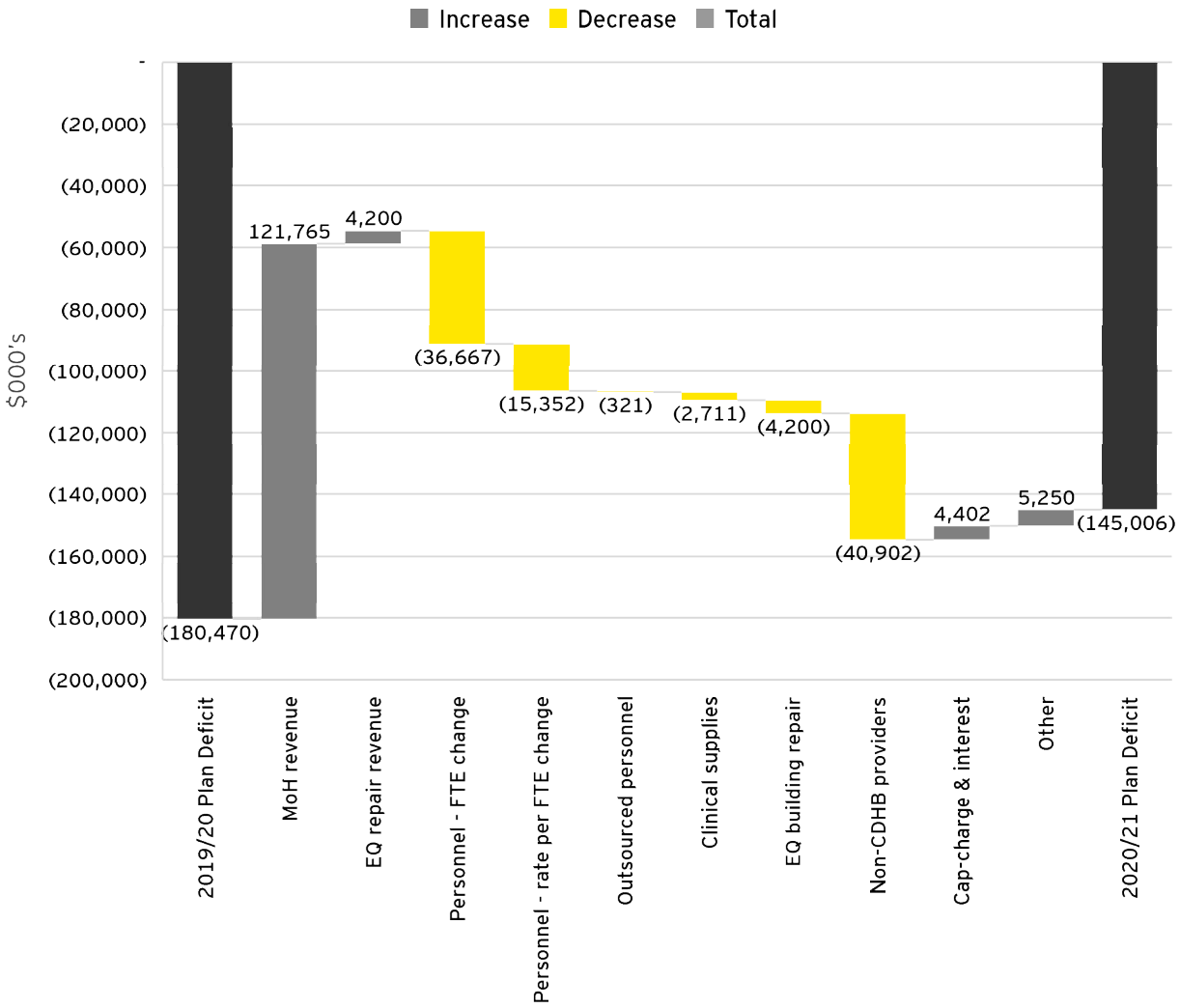
Should the proposed service change affect resident medical doctors, the NZRDA sets out requirements regarding consultation. Once the proposal is submitted to all affected RMOs, the process is expected to take >4 weeks, culminating a vote upon which two thirds of those RMOs affected must agree for the change to be implemented.

Those initiatives within the taskforce work programme that may have such an impact would be expected to have such a process within their delivery plan, and should be appropriate risk weighted according to the likelihood of the proposed change being accepted by those accepted individuals.

Appendix D – 2019/20 Plan to 2020/21 Plan uplift

2019/20 Plan vs 2020/21 Plan

Figure 16: 2019/20 Plan against 2020/21 Plan



- The planned deficit for 2020/21 is $35m less than planned in 2019/20. A significant uplift in revenue is a major driver of the improved position.
- Operating costs associated with personnel and non-CDHB providers are planned to increase further – by $93m compared to the 2019/20 Plan. This incorporates above Plan FTE growth in 2019/20.
- Accrued FTE is expected to increase by 358 FTE ($36.7m) and rate per FTE by $1.7k (total $15.4m) from the 2019/20 Plan, and outsourced personnel increased by $0.3m between the 2019/20 Plan and 2020/21 Plan. Only a subset of this this FTE has either corresponding tagged revenue or realisable cost savings from insourcing.

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