Brief
The purpose of this Review is to provide all the parties named below with an assessment of the financial and quality dimensions of the Southern Food Services proposals. The proposals include the introduction of a single provider for food service provision nationally.

It is understood by the reviewer that there is likely to be an alternate offering led by the Service & Food Workers Union for consideration by the SDHB. This review does not address that proposal.

Intended Audience
The Intended Audience of this document and the deliverables produced under this review are:

- Southern DHB (SDHB)
- Health Benefits Limited (HBL)
- Service and Food Workers Union (SFWU)
- Amalgamated Workers Union (AWU)
- Public Service Association (PSA)
- New Zealand Nurses Organisation (NZNO)
- Council for Trade Unions (CTU)

Experience of Reviewer and Conflict Declaration
From 2002-2010 I have held board positions in both ADHB and CMDHB with eight years as Chair. I was the executive Chair of the Auckland DHBs that changed its laboratory services, a change process that began poorly but later succeeded in improving services while reducing costs. I was one of the DHBs representatives that initiated the Health Sector Relationship Agreement (HSRA). I have worked with Trade Unions since 1990 when I became an external advisor to the Cleaners and Caretakers Union and then its successor, the Service and Food Workers Union. I was honoured with an award of lifetime membership with the Service and Food Workers Union in 2012.

In October 2014 I provided a report to the Auckland DHBs that reviewed the proposition in the HBL National Business Case for a single provider for food service provision. They have since committed to such a course of action.

Statement of Independence
At all stages in the project I have had available to me the people who are subject experts in all aspects of this proposal. All confidential material I have asked for has been made available and the report has not been censured in any way. I accept that there may be independent commentary provided on its outcomes by HBL and SDHB.

Summary of my assessment
My approach is to make this report as assessable as possible to the user groups. I have looked at the task from the perspective of all the people affected by this proposed change and I have asked the questions that I would expect the reader interested in this proposition would like to see answered. I have with the permission of SDHB, HBL and unions gone wider than the initial terms of reference to
ask questions of the process because it was clear to me in my investigations that much of the material that might lead to a sensible decision in this matter is inter-related.

The robustness of the Food Services Business Case turns on the SDHB agreeing that it meets its own articulated objectives and delivers the benefits while mitigating the risks. In my assessment this comes down to being satisfied related to six significant judgments.

These are summarised below under the section headings.

**2.0 Benefits Realisation Summary:**
*Are the sector benefits large enough from this single provider for this trade-off to be worth it for DHBs?*

**Assessment**
The potential net benefits in today’s dollars for SDHB are projected to fall within the range of $6.96m to $13.38m and nationally for the sector, $155m to $190m. These benefits are verifiable, material and potentially achievable in my judgment.

*Can a 15 year contract with a single provider be justified given the risk of monopoly provision?*

**Assessment**
There is clear market capability of alternate service provision with adaptive capability if required. This taken together with the contract safeguards that trigger in the event of provider failure lead to my judgment that contracting over a 15 year period is a reasonable position for the DHBs to adopt.

**3.0 Food Quality Summary:**
*Are the Contracted Nutritional Specifications (NNS) the best and safest basis to assess the quantitative and qualitative requirements of this new proposal?*

**Assessment**
As your independent assessor I think the findings of the Nutritional Analysis Report are credible, including those directly related to SDHB. The decision by the consulted DHBs to support the Contracted Nutritional Specifications (CNS) as the basis of measuring comparison of quality outcomes in food service provision nationally is supported by the research.

**4.0 Workforce and Implementation Summary:**
*Is the overall approach to mitigation of job losses credible?*

**Assessment**
This is a central proposition that the DHBs and Unions are testing through consultation in Auckland at present. It has not been smooth and matters are in mediation. Compass appreciate that any jobs lost in SDHB won’t be replaceable within the DHB. As a company they are seeking a larger footprint in the Southern region. This will provide opportunities elsewhere, but not guarantees. The Auckland discussions have put them on notice of the need to be transparent and open in mitigating the impact of reducing job numbers while transferring to these new arrangements. In my judgment this is still an open question that might however achieve some degree of confident resolution from the results of an exemplary mobilization, transition and implementation process.
What degree of confidence is there that this implementation process will succeed?

**Assessment**
The approach to implementation is thorough and credible. Lessons from other roll-outs have been understood and applied. The potential for disruptive change at SDHB is of a lower order of magnitude relative to other DHB roll-outs in the country.

6.0 Governance of National Food Services Summary:
Is this proposed structure capable of providing the necessary governance oversight?

**Assessment**
This is a new governance structure in formation and it is still not settled. The period of the contract is 15 years so finding capable people for ongoing oversight with the continuity of knowledge and experience is very important. If the contract is not working this governance body needs to respond promptly and act decisively with the support of the DHBs. This will require strong and capable leadership able to gain and hold the confidence of the various sector groups. As such it is still to be tested.
1.0 Background Context

a) Why are DHBs having a national focus on the quality and cost of Food Services?

The external financial pressures on DHBs are formidable. The Business Case identifies funding challenges as “a result of increasing clinical costs and rising public demand. To maintain and improve frontline care, DHBs across the sector are looking to identify improvements in efficiency and cost containment. In tandem, Health Benefits Limited (HBL) has been tasked to identify Sector-wide cost reductions in areas of administrative and support services, and new procurement arrangements.”

The Indicative Case for Change (ICC) identified three categories of under-performance in respect to the current provision of service. In summary they were:

- food service procurement is not cost efficient due to multiple food supply arrangements which don’t leverage commercial buying power available to the whole sector;
- capital spend is not optimal in relation to maintenance and upgrade of kitchen facilities and delivers a poor environmental footprint;
- significant variability in food quality national wide feeds an overall perception that hospital food is poor quality.

b) What are DHBs wanting to achieve with the new proposed solution outlined in the Food Services Review?

The new proposed solution in the review of Food Services will, based on the Evaluation Report meet the DHBs criteria for potential Sector-wide approval if the services it proposes to introduce can:

- adopt national nutritional specifications that drive consistent quality and service levels
- enable procurement savings around capital programmes;
- better leverage sector volumes to achieve economies of scale;
- consolidate the number of facilities that support service delivery;
- increase rationalization including with the number of contracts with suppliers, sub-contractors, menus. etc

c) What has changed from the Indicative Case for Change through to the Food Services Business Case?

The key changes have been a:

- move from a centralised production model featuring two production plants (located in Auckland and Christchurch) to a distributed production model using best-of-breed suppliers;
- shift from a Steamplicity Production Method at the majority of DHB sites to a Cook-Chill Production Method (except at Auckland City Hospital and Manukau Surgery Centre);
- decision not to go to an End-to-End Delivery Method at the majority of DHB Sites in favour of retaining the existing Integrated Delivery Method at most DHB Sites.

d) Why were in-house providers not considered in the tender process?

DHBs with in house services could choose to, but were not required to, respond to the Expression of Interest process. However, if they were interested in providing food services, they would automatically be invited to submit a proposal and be considered at the Non-Binding Indicative Offer stage, regardless of whether they submitted an Expression of Interest. During the procurement process, HBL did not receive any indications from DHB-owned organisations that they would like to submit a proposal for the provision of Food Services.

However, since the finish of this process one of the unions representing the Food Services Staff at the SDHB have formally signaled that they wish to put together an alternate proposal, although it is unclear whether this would extend to an offer to run the Food Services at the SDHB. The Board has agreed to receive a submission and their proposal is due 9 April 2015.
e) What had been the market process of selecting which provider DHBs wish to deal with if food service delivery was to change?
The process of narrowing selection to a single provider is best illustrated by the following chart:

f) What are the restrictions on information in the process to date, why have these restrictions been applied and what is now available in the public domain?
During the procurement process, members of the project team were restricted from sharing information on:

- solution proposed by respondent;
- HBL’s projected benefits for the proposed solution.

These restrictions were applied as the information was considered commercially sensitive and, if passed on to respondents could:

- give some respondents an unfair advantage over other respondents who were still involved in the procurement process;
- have a detrimental impact on HBL’s ability to negotiate a contract that was commercially favourable for the Sector.

As illustration of the point, negotiations with the preferred provider generated significant extra savings in the final discussions in early October 2014 that had a material impact on the savings available under the proposition.

HBL is now out of this procurement process and has shared information on the proposed solution with the SDHB. The Request for Binding Offer Document and SDHB’s baseline costs have been shared with the unions to enable them to have base data to build up their proposal.

2.0 Benefits Realisation

a) This is a long-term contract (15 years) that locks both parties into an arrangement that will likely exist long after the original decision-makers have moved on. What is the compelling case for 15 years?

The length of contract has been the most controversial element of this new proposed solution. It allows for three terms of five years each. It will require robust and structured contract management in a systematic fashion to deliver the benefits.

The business case demonstrates that the benefits increase over time. This is achieved as the capital invested by Compass is recovered over a longer time, plus they have the ability to spread overhead costs and establishment costs over a longer timeframe to deliver a lower unit cost.

In terms of safeguards, the draft contract proposed contains the following clauses on Term:

- the Agreement will continue in effect for a term of up to 15 years. Each DHB has the option of terminating the Agreement at the 5 year mark and the 10 year mark (respectively) with no cause;
- the term of the Agreement is also subject to earlier termination (either full termination or partial termination in relation to an individual DHB or particular premises) in accordance with the terms of the Agreement.

The contractual terms of agreement have a detailed and explicit performance management framework with KPIs that measures performance against legislative compliance, delivery of clinical services and quality of care to standards. Failure to meet these requirements triggers explicit and immediate financial penalties.

This is a fixed price, performance based agreement and so is dependent on strong contract management to hold the Service Provider to account and to manage and monitor accordingly. The protections are in contract, with the ability to ultimately terminate in whole or in part where the Service Provider does not perform.
The longer the term, the more critical the on-going contract and relationship management is to ensure that value is delivered over the life of the agreement. There has been a high degree of consciousness around this and the inherently conservative approach of the Sector has ensured that maximum protections and safeguards have been negotiated into the contract.

**b) Is there agreement from the DHBs around the country for formal sign-off that the base line data they have supplied is accurate sufficient for direct comparison with the new proposed solution?**

All DHBs signed the base line validation in 2013. One year later all bar two (Canterbury and West Coast DHBs) have confirmed their final base-line data with formal sign-off. In the case of the two unsigned DHBs all data has been supplied but their interests are in both food and laundry and discussions are ongoing with HBL. There has been further refinement as DHBs come closer to contracting.

**c) This new proposed solution when compared to DHB base-line costs offers national savings in today’s dollars of 13%-15% over the contract lifetime. Are these savings verifiable?**

DHBs typically spend $110 million annually in the provision of food services. Two thirds of this spend is through contracts existing with two main service providers currently. The balance is the cost of provision of in-house services in one third of the DHBs.

The Business Case value proposition commits to savings in the range of 13%-15% in today’s dollars annually over the contract life of the new proposed solution. The difference in the range of 2% is a sensitivity range. Although savings are not equally distributed throughout the DHBs the Business Case argues there is significant financial advantage to the sector in the new service model.

For SDHB savings to be verified there needs to be direct matching of the new contract price against the base line data of current delivery. This baseline has been confirmed. The contract price has been confirmed and as at March 2015 provided a NPV range of $6.96m to $13.38m over the life of the contract conditional on DHB take-up of the offer. The spread in the range is affected by the impact of the variable price based on overall DHB volumes subscribed to the proposition and the assumptions made about future cost growth if the current state were to continue. SDHB has taken a conservative position in this assessment.

Thus it is reasonable to assert that the savings in the range are verifiable.

**d) What happens to these savings if other DHBs don’t subscribe to the national business case proposition?**

There has been significant modeling done to provide for the circumstance where not all DHBs sign up to the national offer. For SDHB the impact is material if it needs to pay a higher price per meal to Compass if this proposition is not adopted nation wide.

In alerting the Board to potential financial risk SDHB Management has projected conservative NPV savings within a range $6.96m to $13.38m over the term of the contract.

**e) Why is there a NPV range of $6.96m to $13.38m?**

The savings to be made derive from a halt to future cost growth and a fixed price reduction. Under the Compass proposal base costs will fall and annual costs will be pegged to an agreed index. This provides certainty in managing the cost growth.
Under the new contract there are two major volume adjustment mechanisms that impact price. The first relates to DHB participation and takes effect on 31 May 2016. In effect the price is altered depending on participation rate of DHBs in the National Food Services Provision.

At present the Auckland DHBs have signed and are in operation. This represents 31% of the DHB market for meal provision. Together with the SDHB this constitutes 37.9% of the market.

The next DHBs in line already have Compass in provision currently:

- Tairawhiti (1%)
- Taranaki (1.5%)
- Bay of Plenty (4.0%)
- Nelson Malborough (2.6%)
- Canterbury (15.4%)

In total this suggests 62% of the market is already committed and/or currently supplied by Compass. All those with Compass currently will be better off by accepting the new arrangements. It is reasonable to conclude the likely participation levels will be a minimum of 62%.

At 62% participation the 4.5% suggested by management as a one-off price adjustment at 31 May 2016 can be factored in to the current NPV projections. This lowers the annual savings by an estimated $220k per annum. Certainly as other non-Compass DHBs join this proposition the impact on SDHB can only be positive. It is expected that all DHBs will have declared their position by 31 May 2016.

The second price factor is a function of overall annual volumes. This will take effect from 1 April 2018. This only kicks in if there is a +/- 2.5% change against baseline unit volumes at a national level.

Baseline unit volumes are calculated as the volumes of Patient Meals and Meals on Wheels in the 12 months prior to the date the Service Provider commenced charging Day 1 Prices for each customer. The baseline volumes are fixed for the term of the contract.

Here there is both risk and benefit.

Simply put, if national volumes of patient meals rise outside the range of an annual increase of baseline volumes of 2.5% the unit price per meal will fall realising an additional benefit to every DHB.

If the volumes fall outside the range of 2.5% the unit price will rise which will be an additional cost. This is measured annually.

In short the incentive to stick with the contract is very high for the DHBs collectively.

What is not in dispute is that the benefits to SDHB are still real and material at NPV of $6.96m and there is significant upside if the volume of meals represented by the DHB sector adopting this proposition increases.

\textbf{f) Where do the financial benefits come from?}

At a generic level the National Business Case identifies financial benefits as outline below.

<table>
<thead>
<tr>
<th>Financial Benefits</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in DHB operating expenditure for Food</td>
<td>This will be achieved through a reduction in: a. The cost of providing Food Services as a result of larger scale</td>
</tr>
<tr>
<td>Financial Benefits</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Services</td>
<td>and more efficient purchasing;</td>
</tr>
<tr>
<td></td>
<td>b. Preparation costs as a result of improved supply chain efficiencies, new technologies, process efficiencies and consolidation of therapeutic diets;</td>
</tr>
<tr>
<td></td>
<td>c. Food wastage as a result of national Nutrition Standards, and new technology and processes that improve patient food ordering accuracy and satisfaction, and reduce the time from food ordering to delivery; and</td>
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<tr>
<td></td>
<td>d. Expenditure on operational and contract management services as a result of a centralised contract management function.</td>
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<tr>
<td>Avoidance of capital investment in Food Services</td>
<td>DHB capital will be freed up for use elsewhere as a result of:</td>
</tr>
<tr>
<td></td>
<td>a. DHB divestment of assets; and</td>
</tr>
<tr>
<td></td>
<td>b. Removal of planned future investment in kitchen facilities and other assets from DHB plans, as a result of the divestment of those assets (except as needed as part of a landlord’s duty of care and requirements under health and safety and employment legislation).</td>
</tr>
<tr>
<td>Reduction in DHB operating expenditure for Food Services procurement management</td>
<td>This will be achieved through a reduction in cost and effort for DHBs in managing Food Services procurement processes, as a result of a single national process and single national contract.</td>
</tr>
<tr>
<td>Increase in revenue to DHBs from retail operations</td>
<td>Increased returns to DHBs from improved cafeteria experiences driven by Service Provider investment in staff and visitor retail space.</td>
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</table>

In SDHB the avoidance of future capex is not the driver it is within other DHBs. The operational costs are the clear focus for reduction. It remains to be seen if new cafeteria revenue or increased profitability can be driven from this change.

**g) What are the impacts on the Profit & Loss and Cash Flow of the DHBs ongoing?**

Potential net benefits in today’s dollars across the country are projected to fall within the range of $155 to $190 million.

**h) Is there full transparency in the national business case sufficient to identify the new capital expenditure that will or will not be required in each DHB and has this cost been assessed in relation to the benefits expected in each DHB?**

In sum the new provider is responsible for all new capital expenditure to be introduced to deliver the new service model. The host DHB is responsible for all the maintenance and upgrading where required of their own fixed infrastructure.

In SDHB there is no new capex required though there will be maintenance required on existing plant.
i) *Can a 15 year contract with a single provider be justified given the risk of monopoly provision?*

If DHBs subscribe to the national contract they will be agreeing to take other providers out of the food services marketplace (including their own in-house services) in favour of one single provider.

While this could reduce direct competitive tension within the health provision, it is also clear there are very substantial food service providers operating elsewhere in industry with adaptive capacity to return to the health market in the event of market failure by the new provider. There is precedent with this in Auckland with the change of Laboratory Services provision from two providers to one. Initially this change went very badly and one of the original providers was returned to the market with a 10% share. The contract enabled this to occur almost immediately provider failure was identified. There is now a settled provider arrangement.

In short, faced with a potential provider failure in part of the service the contract provisions were strong enough to re-introduce a competitor and still capture the significant majority of the intended savings.

Therefore saying ‘yes’ to this proposition involves a direct trade-off over the term of the contract. DHBs are trading off an existing industry-specific competitive tension (where there is currently more then one provider including doing it ‘in house’) in favour of substantial and material improvements in the benefits available through contracting with a single provider.

**Benefits Realisation Summary :**

*Are the sector benefits benefits large enough from this single provider for this trade-off to be worth it for DHBs?*

<table>
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**Can a 15 year contract with a single provider be justified given the risk of monopoly provision?**

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3.0 **Food Quality**  

*a) What is the summary of the major changes in the Food Service Delivery Model?*

The key changes to Food Services delivery for each of SDHB’s sites are set out in the table below.

**Table 2: Proposed Service Delivery Changes by Site**

<table>
<thead>
<tr>
<th>DHB Site</th>
<th>Proposed Changes</th>
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</table>
| **Dunedin Hospital**            | Patient meals will change from a *Cook Fresh* to a *Cook Chill* method: meals will continue to be made up of a mixture of fresh and frozen ingredients (e.g. vegetables), pre-prepared ingredients (e.g. tinned fruit), and prepared meal components (e.g. yoghurt punnets, chilled pasta dishes). The main change will be a greater proportion of reheating of prepared meal components than is currently the case.  
**End-to-end** responsibility for patient meal delivery and collection will shift from the DHB to the Service Provider.  
*Dunedin Cafeteria* will become the responsibility of the Service Provider.  
Meals-on-Wheels will change from being prepared in bulk onsite to the use of individual frozen meals that will be heated in the hospital kitchen for distribution to clients. |
| **Dunedin Hospital**            | Patient meals will change from a *Cook Fresh* to a *Cook Chill* method: meals will continue to be made up of a mixture of fresh and frozen ingredients (e.g. vegetables), pre-prepared ingredients (e.g. tinned fruit), and prepared meal components (e.g. yoghurt punnets, chilled pasta dishes). The main change will be a greater proportion of reheating of prepared meal components than is currently the case.  
Patient meal delivery will be integrated between the DHB and Service Provider: DHB staff will continue to be responsible for some aspects of delivery and collection. |
| **Southland Hospital**          | Patient meals will continue to be prepared using a *Cook Chill* method: more meal components will be purchased prepared from suppliers.  
Patient meal delivery will be integrated between the DHB and Service Provider: DHB staff will continue to be responsible for some aspects of delivery and collection.  
*Southland Cafeteria* will become the responsibility of the Service Provider.  
Meals-on-Wheels will change from being prepared in bulk onsite to the use of individual frozen meals that will be heated in the hospital kitchen for distribution to clients. |
| **Wakari Hospital**             | As the meals will be prepared in Dunedin kitchen, as currently occurs, Patient meals will change from a *Cook Fresh* to a *Cook Chill* method: meals will continue to be made up of a mixture of fresh and frozen ingredients (e.g. vegetables), pre-prepared ingredients (e.g. tinned fruit), and prepared meal components (e.g. yoghurt punnets, chilled pasta dishes). The main change will be a greater proportion of reheating of prepared meal components than is currently the case.  
Patient meal delivery will be integrated between the DHB and Service Provider: DHB staff will continue to be responsible for some aspects of delivery and collection.  
*Wakari Cafeteria* will become the responsibility of the Service Provider. |
| **Lakes District Hospital**      | The provision of Food Services at Lakes District Hospital will continue to be outsourced to a third party service provider. |

*b) What has been the work done by independent experts on the nutritional quality of food proposed?*

The work on the nutritional value of the food has been done by Dr Heather Spence supported by
Mike Drake of Food Management (New Zealand) Limited. This work is presented in their Nutritional Analysis Report. In addition there was specific work done in SDHB and the report published on 22 October 2014.

Dr Spence’s work has been reviewed in draft by six DHB dietitians and a regional DHB hospitality manager from SDHB. The reviewers were all from DHBs with in-house services and the report in final form is inclusive of the acceptance of most of their recommended changes. This is an open process.

c) So how is the improvement in quality visible?

Under the proposed solution, SDHB will move to a Contracted Nutritional Specifications (CNS), standardised patient meal choices, and standard diet codes. The Contracted Nutritional Specifications (CNS) allows the Sector to achieve procurement and operational savings while improving quality, service levels and patient satisfaction.

A representative from SDHB’s food service was part of HBL’s Food and Nutrition Advisory Group (FNAG) who were responsible for developing the proposed Contracted Nutritional Specifications.

Based on survey returns from the Sector, HBL expects the new standards will provide additional choice for patients at meal times.

A comparison of the proposed Contracted Nutritional Specifications for Adult Inpatients against the current menu offering at Dunedin Hospital indicates that there will be increased choice for patients as outlined in Table 3 below.

Table 3: Summary of Comparison between Proposed Contracted Nutritional Specifications and Current Offering at Dunedin Hospital

<table>
<thead>
<tr>
<th>Meal/Service Offering</th>
<th>Proportion of National Standard Items Currently Offered (Per Day)</th>
<th>Additional Items Offered Under Proposed Contracted Nutritional Specifications</th>
</tr>
</thead>
</table>
| Breakfast              | 75% (15 out of 20)                                            | • Fruit juice/drink  
• Congee  
• Calcium enriched low fat milk *(Note: SDHB currently offers trim milk, not calcium enriched)*  
• Protein choice (e.g. yoghurt, cheese slice, ham, bacon)  
• Butter |
| Lunch                  | 61% (11 out of 18)                                            | • White roll/bread  
• Wholemeal or wholegrain roll/bread  
• Butter  
• Margarine  
• Three spreads |
| Dinner                 | 91% (10 out of 11)                                            | • Side salad |
| Dessert                | 75% (3 out of 4)                                              | • Jelly and ice cream  
*Note: Dunedin Hospital offers only one dessert per day – either a high energy dessert or a cold/hot dairy dessert. Under the proposed national Nutrition Standard, both items will be available for patients on the standard menu.* |
| In-Between Meal Snacks | 50% (1 out of 2)                                              | • High energy snack  
*Note: Dunedin Hospital currently does not offer decaffeinated coffee which will be available under the proposed national Nutrition Standard.* |
| Beverage Round         | 83% (5 out of 6)                                              |
**d) What are the current specifications that are measurable?**

There have been no set of food service nutritional specifications that are either measured or compared within the DHB sector at present. The development of the Contracted Nutritional Specifications (CNS) is the first time a set of approved specifications has been agreed for application nationwide. This specification was originally signed off by the Food and Nutrition Advisory Group (FNAG) and will be applied to measure the performance of food service provision nationally. They will be reviewed bi-annually. The FNAG has further evolved to become the Food and Nutrition Subcommittee of the Customer Services Council. A description of its functions is in part 6. **Governance of national Food Services** of this report.

**e) How does the Nutrition Analysis Report describe the difference between quantitative and qualitative analysis when measuring food service standards?**

The Nutritional Analysis Report addresses both quantitative and qualitative aspects of both the current service delivery and the proposed new solution.

Quantitative analysis looks at the level of nutrients. Nutrient content of menus is quantified as kilojoules of energy, grams of protein and fibre, litres of fluid, and milligrams of Vitamin C, calcium, iron and zinc.

Qualitative analysis makes no attempt to quantify "how much of each nutrient?", but asks "does the amount of choice on this menu meet CNS targets?", "do portion sizes meet CNS targets", and "is this menu item concentrated enough in terms of our target nutrients?"

**f) So what does a qualitative analysis tell us?**

Specifically, it compares each DHB menu with:

- daily choice specified in the CNS (eg, three choice of main item at dinner);
- the number of different choices there must be over a two week menu cycle;
- a minimum portion size for some items such as main lunch and dinner dishes, dairy desserts;
- the nutrient density for items such as soup, meat/vegetarian dishes, dairy dessert, juice, breakfast cereal. "Nutrient density" is "the amount of protein and/or energy and (for some items) calcium or Vitamin C or fibre in one portion of the food;"
- a target for the fat content of mince.

**g) Is there justifiable evidence that using the Contracted Nutritional Specifications (CNS) will provide a qualitative uplift for the patient health?**

To paraphrase Dr Spence’s comments as follows:

Some DHBs exceed the Contracted Nutritional Specifications (CNS) agreed by the Food and Nutrition Advisory Group for some number of meal choices at some meals. Therefore the CNS can be reduction in the number of menu choices at some meals and therefore under the definition, a reduction in provision.

Across the DHBs sampled most CNS goals for type, frequency, and nutrient density of food were met. Five of the seven DHBs exceeded the minimum choice goals at one or more meals for adult menus, and three exceeded minimum choice goals at one or more meals for paediatric menus."

At the same time however, the qualitative analysis also showed that some who exceeded on "number of menu choices" did not meet on nutrient density and/or other aspects for some dishes on their menus. For example only two of the 7 DHBs current menus meet the fat/mince target.
This suggests swings and roundabouts in the current provision.

The application of the Contracted Nutritional Specifications (CNS) will for the first time deliver a national measurement process assessing the relative merits of food service delivery among DHBs and will hold the national provider to account to deliver the approved standard.

**h) What about the SDHB? What does the report on SDHB conclude?**

Dr Heather Spence summary comments are as follows:

- Based on results in the above report, the CNS will provide a nutritional improvement in menus, both qualitatively and quantitatively. The CNS will provide a wider choice of food at main meals (for instance bread & spreads, fruit), and snacks, for all patient groups. There will be one or more children’s menus (there is none at present), as specified in the CNS.
- It is important though, that the presentation of Southern DHB menus is very attractive and meal choices on patient menus are appealingly described. Meal appearance is likely to be an important factor in encouraging patients to eat.
- We have further refined the qualitative analysis tool since the October 22, 2014 report. Content assessed is identical, but the decision process has been clarified for many of the standards. The qualitative analysis looks at what’s on the menu, how often, how much, and is the nutrient density standard met for main dishes? Our improved tool is more stringent and a re-analysis of all DHB menus is likely to show a lower compliance with CNS than previously reported. We have started this re-analysis exercise but have not yet done Southern DHB at time of writing.
- On pages 17 and 18 of the Southern DHB Nutritional Analysis Report (October 22, 2014) the qualitative analysis results will probably include a longer list of items not meeting the CNS. This is due to the sharper focus of the analysis tool now used.
- Our work on this project was recently peer reviewed for scientific stringency and validity.

**i) How will there be continuous checking of food quality to validate the improvement in nutritional outcomes?**

Prior to the CNS there has been no audit of food nutritional quality as is proposed here under these specifications. HBL is working with Dr Heather Spence to provide an audit apparatus that will be endorsed by dietitians and the provider and will provide both a baseline of current food quality for all DHBs, and a future measurement system.

**j) What happens if there is an infection break-out? Has this been anticipated? Are there penalties?**

Compass describes their approach to Food Service criticality and infection control risk in their current contracts with 7 DHBs. There will be DHB specific Business Continuity plans agreed in the Mobilisation phase prior to Compass commencement of the new Food Service proposal. Compass will align their Food Safe, Hazard and Critical Control Practices as required, benchmarked on their current internal best practice and DHB requirements and are in the process of adding a Food Quality Manager to their business to meet the requirements of this contract opportunity.

The addition of the national Contract allows continuity of service in the event of a service critical failure to be mitigated through the single provider arrangements across the DHBs. Compass will also be held to a KPI around Safe Food and Beverages where there are financial consequences for breach.

**k) Is there measure for accountability to DHBs proposed in this new proposed solution for the procurement, provision and delivery to the bedside that has been assessed through a quality lens?**

The Compass model is to control the service from kitchen to bedside to ensure quality and service
outcomes. However some DHBs, on a hospital by hospital basis are choosing to retain their current arrangements, which might be an integrated service between the food service/provider and health care assistants and move to an end-to-end service where it makes sense. This is the case with SDHB.

The future menu will have to be designed to provide meals, snacks and beverages that will meet the qualitative and quantitative goals of the CNS, for meal selections that patients expect.

The CNS outlines duty of care requirements that focus on menus. Menus must be appealing and provide food choices that patients will eat and enjoy and the menus must provide variety in colour, texture, appearance, flavour, cooking method. Menu design includes these criteria.

No matter the model adopted in any individual DHB there is detailed, ward by ward requirements for the current state which Compass is committing to adhere to under general terms of the contract including KPIs (times, accuracy, timeliness, etc).

1) Are the Contracted Nutritional Specifications (CNS) the best and safest basis to assess the quantitative and qualitative requirements of this new proposal?

If DHBs support the CNS then in the judgment of the appropriate experts, this proposal meets those requirements.

Food Quality Summary:
Are the Contracted Nutritional Specifications (NNS) the best and safest basis to assess the quantitative and qualitative requirements of this new proposal?

Assessment
As your independent assessor I think the findings of the Nutritional Analysis Report are credible, including those directly related to SDHB. The decision by the consulted DHBs to support the Contracted Nutritional Specifications (CNS) as the basis of measuring comparison of quality outcomes in food service provision nationally is supported by the research.
4.0 Workforce and Implementation

a) What is the time frame of implementation of this new proposed solution nationally?

The roll out model has three stages from Mobilisation through Transition to Operational Service. The implementation of the national Food Services delivery model is expected to take approximately nine months. It is intended that this will commence in July 2015 – subject to the relevant DHB approvals being obtained.

b) Does the new proposed solution require any change to the existing collective agreements covering the existing food service workforce in each of the DHBs?

No.

c) Is there any evidence of further training being required under the new proposed solution that would up-skill the current workforce?

Extensive training will be required for the new procedures to support the new Compass service delivery model.

d) What is the extent of the change in role numbers from the existing provision to the new proposed solution?

The Business Case for Southern projects a potential reduction in total job (FTE) numbers of an estimated 20% as a result of the proposed changes in the service delivery model. This percentage has been arrived at from information about current operations collected by HBL from Southern DHB in May 2013 and estimates provided by Compass Group as part of developing the proposed solution. The actual number will become clear during the Mobilisation process.

There are approximately 120 kitchen staff or 98.3 FTE (2013/14) as shown below.

<table>
<thead>
<tr>
<th>Description as per GL Account code</th>
<th>Food Services-Dunedin (including 1 FTE Manager who sits against another cost centre)</th>
<th>Food Services-Invercargill</th>
<th>Cafeteria-Dunedin</th>
<th>Wakari Café</th>
<th>Invercargill Cafeteria</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotel Service Supervisor</td>
<td>6.84</td>
<td>1.85</td>
<td>0.92</td>
<td>1</td>
<td>10.61</td>
<td></td>
</tr>
<tr>
<td>Cooks</td>
<td>7.67</td>
<td>2.33</td>
<td>1.57</td>
<td>4.65</td>
<td>11.57</td>
<td></td>
</tr>
<tr>
<td>Kitchen Assistants</td>
<td>38.17</td>
<td>4.69</td>
<td>8.96</td>
<td>6.04</td>
<td>60.23</td>
<td></td>
</tr>
<tr>
<td>Other Hotel Service workers</td>
<td>38.17</td>
<td>4.69</td>
<td>8.96</td>
<td>6.04</td>
<td>60.23</td>
<td></td>
</tr>
<tr>
<td>Management &amp; Amin</td>
<td>4.69</td>
<td>2</td>
<td>2.78</td>
<td>0.26</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>57.37</td>
<td>17.04</td>
<td>13.31</td>
<td>3.29</td>
<td>98.31</td>
<td></td>
</tr>
</tbody>
</table>

Compass already has a considerable footprint in Dunedin with contracts with the City Council, the Stadium and with food services in schools and retirement villages in the region.

e) What are Compass aspirations?

This is what Glenn Corbett, Ceo of Compass has said:

“Compass Group recognises the unsettling impact change has on people and is committed to supportive and transparent leadership of change. The exact impact of the proposed changes on individuals will not be known until completion of the Mobilisation stage which would be completed
prior to Compass Group commencing responsibility for the Food Services (if the DHB elects to proceed with change). Once the detail around individual roles is known Compass Group will enter into consultation with staff and their representatives on the impacts of change and the potential options available to them.

There is a shared commitment by Compass Group and Southern DHB to minimise job losses. In the event that any positions become disestablished as a result of this change the main focus will be on identifying potential redeployment opportunities within either Compass Group Food Services, the wider Compass Group business outside of Healthcare and in the wider DHB. Extensive training and support will be provided to support people into changing or new jobs.

Compass Group has employed a dedicated Change Specialist and Redeployment Specialist to provide the best possible support to people during change. The Change Specialist is unconnected to any change or selection decisions and is purely focused on identifying and facilitating appropriate support for individuals.

The Redeployment Specialist will provide centralised management of redeployment, identifying all potential redeployment opportunities within the new Food Services model in the DHB, the wider Compass Group business and the wider DHB. The Redeployment Specialist will co-ordinate all redeployment selection processes ensuring potential opportunities are well communicated to all impacted staff and a fair and transparent process is followed, with a view to placing as many impacted people as possible into suitable employment.”

f) What are the mitigation strategies proposed under the new proposed solution to address redeployment? Are they contractual or non-binding/intentional?
In anticipation of the proposed changes, SDHB have been bringing on new staff under fixed term contract rather than permanent arrangements. This is intended to protect the permanent workforce through the change period.

The proposed redundancy cost sharing arrangement with Compass Group will create an incentive to ensure Compass Group’s redeployment policy is adequate in its intent.

In this respect, the proposed strategies could be characterised as somewhere between contractual and intentional. Key aspects of the redeployment approach include:
- a commitment to redeployment where possible, with redundancies to be the course of action of last resort
- a redeployment working group comprising Compass Group, DHBs and union representatives to identify redeployment opportunities and match surplus staff to those roles

g) Who pays the cost of redundancy should it occur?
Where redundancy occurs, and redundancy payments are to be paid, it will be paid by Compass who will recover the costs from the relevant DHB in a proposed cost sharing arrangement.

h) Is the overall approach to mitigation of reduced job numbers credible?
The change in SDHB affects in gross numbers up to an estimated 20% of the roles in total of the current workforce. The change will take place over an extended period of time, potentially up to nine months. There are incentives for both the new provider and the DHBs to manage their redundancy costs.
In many respects this is where the value of the Health Sector Relationship Agreement (HSRA) should be most potent. It was designed to gather the best result for the workforce and the DHBs cognisant that the health sector faces continual change and changes to process are inevitable.

Clearly the existing workforce needs certainty. The style of engagement with Compass will be a critical determinant in them being confident their interests are being managed respectfully and their options are clear. This was the same challenge faced in Auckland and it has had a rocky start with unions and the DHB employers moving into mediation. The opportunity to get this right in Dunedin will be a signal to other DHB staff around the country about the capacity of Compass to deal effectively with the change programme.

It is my observation that attention to the workforce who have had to deal with much uncertainty has provided the most challenges for all parties to manage in this process to date, and only in part due to the necessary confidentiality that surrounds tender negotiations. This also includes ensuring staff are fully engaged and fully understand the information provided.

There has been considerable communication, including both regular and ad-hoc meetings between DHB and staff and unions. Despite best efforts by the DHB they have not been in a position to provide the information, in a timely manner, that staff would like in order to determine their individual futures. Compass can only provide the certainty once the SDHB has made the decision.

This is potentially a 15 year contract and the behaviour of all parties at its outset will set the tone for the future engagement.

**i) What are the costs proposed in the first year for mobilization and transition?**

**Mobilisation Costs** – This cost covers Mobilisation activities that need to be performed by Compass Group on behalf of the DHB in order to successfully implement the proposed service delivery model.

**Transition Cost** – This cost relates to Compass Group management of the Food Services operation during the Transition Period. During this time, Compass Group assumes operational responsibility and risk for Food Services, with activities undertaken to move from the current service delivery model to the proposed solution.

**Sector Implementation Cost** - This covers any additional DHB costs incurred in supporting Compass Group to implement the proposed solution during the Mobilisation and Transition period (e.g. IT support).

To implement the solution proposed in the Food Services Business Case the following Implementation costs have been included in the Financial Projections;

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount projected as per Business Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Case and pre-mobilisation Reimbursement Fee</td>
<td>$0.23M</td>
</tr>
<tr>
<td>Mobilisation Costs</td>
<td>$0.84M</td>
</tr>
<tr>
<td>Transition Costs</td>
<td>$0.19M</td>
</tr>
<tr>
<td>Sector Implementation Costs</td>
<td>$0.12M</td>
</tr>
<tr>
<td>Total</td>
<td>$1.38M</td>
</tr>
</tbody>
</table>

**Business Case and pre-mobilisation Reimbursement Fee $0.23 M**

This cost relates to Southern DHB’s share of costs incurred by HBL for running the procurement process and preparing the Business case. This cost will be paid if the proposed solution goes ahead
or not. Costs include staff time, travel costs and other incidentals’ related to the procurement process and business case preparation

**Mobilisation Costs $0.84M**
To implement the solution proposed in the Food Services Business Case, Compass Group will need to establish the new service delivery model by providing Mobilisation Services at each DHB. The Mobilisation Cost can be broken down into 3 Parts; Shared Mobilisation Costs, Customer Specific Mobilisation costs and potential Redundancy Costs.

The Shared Mobilisation costs have been allocated to each DHB based on their proportion of Population Based Funding (PBF).

**Customer Specific Mobilisation Costs**
The Customer Specific Mobilisation Costs are specific to each DHB and related to the new costs incurred with change of systems and the management of processes at SDHB which are specific to the Compass mode of operation. In the case of Customer Specific Mobilisation Costs, SDHB will be charged on actual resource required at the DHB to implement the proposed solution. For the purposes of the business case the Population Based Funding (PBF) allocation has also been used to model these costs in advance of the contract actually passing to Compass.

**Redundancy Costs**
A provision has been included for any redundancy cost. This redundancy provision is based on a national estimate of projected numbers, a portion of which has then been allocated to Southern DHB on the basis of population size. It has been included as a planning assumption to ensure the Business Case Projections are robust and provides a conservative estimate of potential benefits. It should not be taken as indicative of numbers of staff who may receive redundancy compensation

**Transition Costs $0.19M**
Effectively once mobilisation occurs, the next phase is implementation at which stage Compass Group assumes operational responsibility and risk from the sector. The transition cost relates to those DHBs that are currently In-House Sites. The total cost assumption for the in-house sites equates to $1.1M, this cost has been allocated against individual DHBs using meal numbers expected to be produced during the transition period. Effectively this reflects the cost and return expected by Compass Group to manage an outsourced DHB site.

**Sector Implementation Costs $0.12M**
In order for Compass Group to successfully implement the proposed solution, each DHB will be expected to support Compass Group by undertaking a series of activities. The financial projections in the Food Services Business Case include a provision for additional costs that may be incurred by DHBs to fulfil their obligations during the implementation period, e.g. the cost of employing a fixed term Project Manager to manage DHB Obligations. The total provision is projected to be $1.77M and individual DHB allocation has been based on Population Based Funding (PBF) proportions.
Workforce and Implementation Summary:
Is the overall approach to mitigation of job losses credible?

Assessment
This is a central proposition that the DHBs and Unions are testing through consultation in Auckland at present. It has not been smooth and matters are in mediation. Compass appreciate that any jobs lost in SDHB won't be replaceable within the DHB. As a company they are seeking a larger footprint in the Southern region. This will provide opportunities elsewhere, but not guarantees. The Auckland discussions have put them on notice of the need to be transparent and open in mitigating the impact of reducing job numbers while transferring to these new arrangements. In my judgment this is still an open question that might however achieve some degree of confident resolution from the results of an exemplary mobilization, transition and implementation process.

What degree of confidence is there that this implementation process will succeed?

Assessment
The approach to implementation is thorough and credible. Lessons from other roll-outs have been understood and applied. The potential for disruptive change at SDHB is of a lower order of magnitude relative to other DHB roll-outs in the country.

6.0 Governance of national Food Services
The Food Services Agreement entered into between Compass Group, HBL and DHBs provides for the provision of food services to DHBs that elect to join the arrangement. The Contract Management function, performed by HBL at this time, is the Sector’s vehicle by which it enforces and makes decisions with respect to the Agreement.

The Food Services governance framework is designed to govern the DHBs’ and HBL’s interests as they relate to the Food Services Agreement.

In this regard, the key features of the governance framework are:

• A distinction between the governance requirements of pre-contract, implementation and steady state contract management activities;

• Flexibility to incorporate further DHBs as they become party to the Food Services Agreement;

• Its construction with the Interim Shared Service Council at its apex;

• Flexibility to incorporate regional governance requirements (such as the Northern Region Implementation Sub-Group) as required; and

• Provision for review of the governance framework in May 2016.

The interaction between the different parts can be illustrated by the chart below:
Decision Making Authorities

It is important to note that the delivery of Food Services is governed by the Food Services Agreement. The decision making rights with respect to the Agreement are defined by the Decision Matrix, which forms part of the Limited Agency Agreement agreed between HBL and DHBs.

In principle:

- The Interim Shared Service Council will set the terms of reference for the Food and Nutrition Subcommittee.
• The Food and Nutrition Subcommittee will govern matters of national significance. Its formal decision making powers come when it sits as the Approvals Committee. On some matters (full termination of the Agreement change in the range of services offered under the Agreement or extension of the Agreement) it will be required to consult the Interim Shared Service Council prior to making a decision.

• The Contract Manager together with the applicable DHB(s) will make decisions on matters under the Food Services Agreement that only apply to that DHB or DHBs.

• The Contract Manager acting independently will make decisions on mechanistic matters, such as instigation of a process or requests for information.

• DHBs acting independently will make decisions on day-to-day operational matters, and retain ultimate sovereignty with respect to their involvement or otherwise in the Agreement (although noting the penalties that would apply in the event a DHB opted to terminate their involvement).

**Governance of National Food Services Summary:**

*Is this proposed structure capable of providing the necessary governance oversight?*

<table>
<thead>
<tr>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a new governance structure in formation and it is still not settled. The period of the contract is 15 years so finding capable people for ongoing oversight with the continuity of knowledge and experience is very important. If the contract is not working this governance body needs to respond promptly and act decisively with the support of the DHBs. This will require strong and capable leadership able to gain and hold the confidence of the various sector groups. As such it is still to be tested</td>
</tr>
</tbody>
</table>

ENDS