



Sector Indicative Case for Change

Facilities Management and Support Services: Food Services

Submission to Health Benefits
Limited *Te Ara Maia*

3 May 2013



For a better working life

New Zealand Public Service Association

Te Pūkenga Here Tikanga Mahi

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Introduction

This submission is based on the views of ...

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 58,000 members. We are a democratic organisation representing members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

We have over 17,700 members in the district health boards, mostly employed in clerical, administration, nursing, allied health and support staff roles. We have a number of members employed in kitchens and nutritional services in the DHBs, mainly as food supervisors or managers, and as dietitians. In developing this submission we relied heavily on the information provided by Health Benefits Ltd and also discussed the issues in the indicative case for change (as summarised in the Powerpoint presentation) with groups of members likely to be directly affected. We also sought feedback from other members who had an interest in the proposal.

However, we are frustrated in our ability to provide a truly comprehensive submission responding to the proposal set out in the indicative case for change (ICC) because of our lack of access to crucial information on the costings used to generate the alleged savings from the preferred option.

The PSA is an affiliate of the New Zealand Council of Trade Unions Te Kauae Kaimahi (the CTU) and endorses the submission of the CTU.

PSA submission

Overview

The PSA is concerned that the ICC is focused almost purely on the economic, commercial, financial and management case for change. There is little or no emphasis on the quality of food or the needs of patients. To our members the goal of delivering nutritious quality food that is planned and prepared to sustain patient recovery is paramount. We expected to see a greater emphasis on this in the ICC.

The ICC is also a high level document. As already mentioned important financial

information has been withheld making it difficult to present a meaningful submission. The information that is available is generalised and high level, again making it difficult to respond in a meaningful way to the proposal. It is not clear to us that the preferred option does generate significant savings and there are risks that any savings deriving from this option would be made at some cost to safety and quality.

We are also concerned about the context for this project. The ICC refers to the Minister's Letter of Expectations to DHB chairs for 2012/13, which refers to the need for further improvement and cost containment. It also talks about the need for transformational change to achieve the 'required' savings. We take this to be a significant contribution towards achieving HBL's target of \$700 million over five years. There is a risk that HBL will be pushed towards transformational change to achieve these targets when what may really be required is better co-ordination and sharing of best practice in food services between DHBs.

The Auditor-General has also identified other risks associated with HBL's activities, which have implications for this project. At paragraph 2.27 of the recent report on the health sector the Auditor-General states:

Our auditors reported that some DHBs were delaying making changes to systems and processes, pending the outcomes of sector and regional initiatives. We acknowledge that there is activity within the sector on collaborative procurement processes, and this might have contributed to some delays in taking remedial action. DHBs still need to consider the risks associated with delaying when they will make improvements¹.

Our members advise that there have been initiatives aimed at sharing lessons and best practice in the food service area and we are concerned that improvements from this source may be lost or delayed, increasing the likelihood that the pressure will build for a change of the type proposed in the ICC.

The Auditor-General's report also notes that the gross HBL savings target of \$700 million does not take into account any associated costs in achieving the savings, such as the \$87.9 million investment by DHBs to implement the Finance, Procurement and Supply Chain project. We did not see any associated costs arising from achieving the project savings in the food services ICC.²

We also note the comments by the Auditor-General about the need for HBL to improve the transparency around the measurement and reporting of savings, and suggest that this will be particularly important in the case of such a large project as envisaged in the food services ICC³.

¹ Controller and Auditor-General, *Health Sector: Results of the 2011/12 Audits*, April 2013
<http://oag.govt.nz/2013/health-audits/docs/2011-12-audits.pdf> p. 18

² Ibid p. 40

³ Ibid p. 41

This submission is organised around the headings in the ICC, rather than the headings in the feedback template. We found this template almost impossible to apply.

*Existing
arrangements and
business needs p. 16*

The strategic case for change

The ICC argues that the sector, as configured is unable to leverage scale volumes for food procurement and that the approach to food provision to date has resulted in:

- a variety of food service models and variable service quality and service levels
- inconsistent processes and procedures that affect service delivery outcomes
- a lack of national standards that would enable a consistent approach to service delivery
- inconsistency in the way data is captured and services are measured
- a focus on reactive maintenance rather than driving a whole-of-life approach to the management of kitchen assets
- not fully leveraging Sector wide volume (e.g. equipment and food procurement)
- incremental and traditional solutions
- multiple suppliers providing similar services
- duplication of facilities and people in geographically compact areas
- differing cost profiles across each DHB, e.g. there is little consistency in the cost of food production across the Sector
- inconsistent and reliable management information to allow meaningful comparisons between DHBs; or more importantly for the Sector to proactively manage costs down or to understand the extent of under or over spending within the Sector
- inconsistent policy or standards for food and beverage services, menus and therapeutic diets

However, there is already considerable leverage in the system and scope for more without resorting to the level of change proposed. For example, Waikato, ADHB and Northland DHB already have a combined milk and dairy contract; Waikato and ADHB combine all other food contracts (and we understand that there are clauses in the contracts that would allow other DHBs to use the contract as well); and we understand that both spotless and Compass have national contracts in place enabling them to leverage their volumes.

There will still be a variety of service quality and service levels if you move to a single contractor delivering 35% of meals as it will depend upon the service level required by each DHB.

This information is necessarily generalised. For example, many DHBs are well ahead on their maintenance of equipment and plan ahead.

The reference to incremental change suggests that this is not enough, presumably to meet the savings required of HBL. The point about the need for 'transformational change' arising out of this requirement has been made in the Overview above. Incremental change could well be an appropriate way to promote efficiencies, national consistency and leverage off volumes, without the risks that arise from a transformational change such as that proposed in the preferred option. HBL could provide a facilitative role in promoting those changes instead of resorting to the nuclear option.

Key statistics p. 16

Under 'Key statistics' the ICC reports that 8.7million patient meals are served per annum in New Zealand hospitals. ADHB does 1.1 million or 12.5% of the total nationwide volume and we estimate that together with Waikato (another large in-house provider) their share of the total volume would be approaching 20%. That is an indication an already existing large scale operation with significant leverage in volumes. We understand that both offer some of the lowest cost meals in New Zealand hospitals so it is difficult to see how there could be savings made for those 2 in house services.

Again this raises the problem of the reliance on generalised figures in this ICC. When you already have a number of efficient services, there is a significant risk that these efficiencies could be lost by moving to a centralised, contracted out system.

Potential opportunities p. 17

The potential opportunities in Food services are listed on p. 17 of the ICC. We repeat them below, together with our comments in italics:

- rationalising and standardising items such as diet codes, number of contracts with suppliers etc. (for which there is already a measure of agreement). *PSA comment: standardisation is already underway but we have strong reservations about 'rationalising' the codes. There is a need for a wide range of diet codes to ensure that patients get the food they need for their particular circumstances and illness. To do otherwise is to generate risk*
- taking a whole of country approach to supply chain challenges, e.g. food delivery *PSA comment: this could be explored without a centralised approach as proposed*
- consolidating the number of facilities that support service delivery *PSA comment: this is an issue best tackled either within DHBs or between DHBs in a region*
- leveraging scale to reduce procurement and input costs leveraging national contracts to reduce management layers, rationalise number of contracts, and provide more competitive pricing *PSA comment: as mentioned above there is already considerable leveraging on volume within parts of the system and it is not clear that there are savings to be made for them*
- adopting national processes and standards that drive consistency, quality and improved service levels *PSA comment: this does not require the centralised production model of the preferred option*

- investing in new technology such as food production to improve productivity
PSA comment: there may be advantages in some parts of the country but costs to those who already have high productivity
- reducing waste both from a production perspective and patient food quality
PSA comment: it is not clear what is meant by reducing waste from 'patient food quality' perspective. Later we discuss the likelihood of increased waste from the steamplivity model proposed in the ICC

Potential business scope and key service requirements p. 17

When outlining the business scope the ICC refers to managing food supplies, and includes managing nutritional supplements. If a contractor is going to manage the nutritional supplements that will have implications for the dietitians. Who is going to hold or manage the budget for the supplements or are they part of the calculated meal price? If it is part of the calculated meal price it will restrict the dietitian prescribing the best possible nutritional supplement needed to have a maximum outcome for the patient.

Main benefits p. 19

The main monetary benefits, with PSA comments in italics are:

- Reduction in future Sector capital expenditure – *PSA comment: 65% of the meals will still be produced within DHBs and they will therefore need equipment. While not having to pay capital upfront the DHBs will still be paying by way of a capital recovery charge per unit. If the provider is having to borrow to fund the capital expenditure on the private market it is likely that the cost of borrowing will be higher than if the DHB was borrowing for this purpose. The capital recovery charge per unit may result in higher costs for capital for the DHBs over time.*
- Reduction in food wastage – *PSA comment: In theory it is correct that steam meal will reduce the time from food ordering to delivery but (a) this will not be the case for the 65% still being produced within DHBs and (b) the one-size meals being proposed are likely to lead to increased food wastage by those (particularly the elderly) who cannot cope with meals they find too large. See the comments under Appendix Ten*
- Operational efficiencies for staff - *PSA comment: in many wards and DHBs there is already end-to-end provision of food services. Those where there is no end-to-end provision may have developed a model that is appropriate to them – it should not always be assumed that end-to-end is automatically better.*

The main non-monetary benefits, with PSA comments in italics are:

- Improved service levels including quality standards to support effective clinical outcomes – *PSA comment: the ICC argues that the quality of food will improve through agreeing standards and subsequent improved management of the providers. Standard setting is already underway, without the impetus from this project. These standards can be used to improve service provision (without relying on contractual mechanisms in the case of in-house services). We are not sure about how effective contractual mechanisms for delivering improved*

performance will be as a single provider will have considerable leverage over the DHBs.

- Improved number of patient meal choices – *PSA comment steam meals will offer patients the same 21 choices day after day. If a patient is on a restricted diet for medical reasons, if they don't like to eat some foods, or if they have cultural reasons for not eating some foods, the choices will then be heavily reduced. There would still be the same menu day after day which could lead to people not eating and increased wastage.*
- Improved transparency of Food Services costs – *PSA comment: some DHBs, such as ADHB, already have accurate systems for capturing the full costs of providing Food Services. There is scope to improve transparency by sharing best practice, instead of rolling out a centralised system.*
- Consistent, national service delivery and quality standards – *PSA comment: these are being developed already, without the centralised model.*
- Improved environmental sustainability through reduced utility consumption – *PSA comment: the issues around environmental sustainability are complex. The proposal is likely to lead to increased transport and CO² emissions, while the use of disposable plates also raises serious questions.*
- Release of floor space for alternative use – *PSA comment: new production methods **may** reduce floor space but hospital kitchens will still be cooking 65% of meals. They will also need to store steam meals and frozen meals for meals on wheels.*

Risks p. 22

The main risks that could either improve or undermine the achievement of the investment objectives are set out in appendix 7. There are some additional risks that might affect implementation, and beyond implementation to operation. These may be at a lower level than those identified in the register but include:

- The risk from natural disaster, such as the Christchurch earthquake
- The risk from weather patterns such as floods or snow. Members in the West Coast advise that the alpine passes can be cut off for a week or more during winter
- Traffic congestion in the larger cities
- Risks arising from the challenge of integrating food services produced locally (the 65%) with the new centralised and privatised system (the 35%)
- Risks to patient health because the system may not be able to cope with the specific dietary needs of particular patients

Dependencies

Key dependencies are set out in table 6 and include: the need for proactivity and programme champions required within DHBs; sufficient endorsement from the Sector; upfront funding; reliance on DHB staff; respondents have sufficient capability. These all have huge implications. If one these dependencies doesn't happen it could cause major problems with the project. What contingencies does HBL have in mind to deal with this possibility?

Options pp. 26-30

The Economic Case – Exploring the Preferred Way Forward

There is no genuine appraisal of the options set out in this section of the ICC and no evidence offered in support of the statements made for and against those listed. The PSA is not convinced that all the possible options are captured by this discussion of the options and their advantages and disadvantages. We think that portraying the status quo in the way the ICC does minimises the possibilities for this option. It is

acknowledged that work is underway in leveraging best practice but suggests that only small cost savings can be made. If a more active role was taken by HBL in co-ordinating or facilitating this process then greater savings could probably be achieved. As it is the activities of HBL are probably slowing or freezing the process of DHBs finding efficiencies, according to the Auditor-General.

We note that, for example, Southern DHB has already purchased the C-Bord Diet Office programme being run by ADHB. This programme has allowed ADHB to operate a personalised menu system that is specific to the patient's own diet restriction and which ensures that non-compliant items are not offered. Being able to offer a wide range of diet restrictions also helps to cater for the large range of ethnic/religious groups who must abstain from particular foods. C-Bord also provides an auditing tool that enables the kitchen to check that the menu entry for each patient is correct, unlike in other paper based systems. Reports can be obtained showing how many items were actually served at a particular meal aiding in future forecasting of portion numbers. HBL could work with DHBs to get agreement to a standardised system such as C-Bord and drive consistency, quality and efficiencies that way.

It may also be that solutions may cut across these options. For example, it may be that an enhanced status quo option as described could be improved by providing for some regional solutions as has already occurred in the case of Auckland, Northland and Waikato DHBs. It needn't be all regional, all national or all status quo.

The main problem here is that we do not have the information to make a detailed submission on the options. From what we know it is likely that more can be achieved via an enhanced status quo but we cannot argue the case in detail because DHB specific information is missing.

Outlining the Commercial Case

Outlining the procurement strategy pp. 31-33

The PSA is concerned about the model that sees single respondent identified at such an early stage of the process. We are also concerned about the entire Food Service system for New Zealand hospitals being dependent on a single provider. We know that measures were taken to retain a "competitive tension" but the reality is that 10 or 15 years down the track this provider will have effectively monopoly control. It will be very difficult for the DHBs to go elsewhere.

We also have some questions about the process that led to Compass being selected. For the EOI neither locations of the kitchens nor method of production were specified so it is unclear how Compass (and the other interested parties) could supply an indicative cost if they don't know all of this. We know much work is still to be done and that a contract has not been signed, but we are concerned that the single Respondent may have made widely inaccurate indicative costs but their unique role in the process will still give them the advantage when contracts are finally signed.

The proposal from the single Respondent is for a national service serviced by two production plants – one in Auckland and one in Christchurch. It refers to the possibility of a third plant in the North Island to address risk concerns. We are fairly confident that such a plant will be needed but these costs do not appear to be part of the current indicative meal cost.

We also referred elsewhere to the risks from disaster. It is not clear that the Respondent has done the specifications necessary to mitigate the risks if disaster were to strike and factored that into their costings.

KPIs p.35

All the KPIs identified would be necessary but there are gaps.

- Internal audits; it is easy to be ready for an external audit of the Food Safety Plan and associated practices but to comply throughout the year is more difficult.
- Verification of a successful Food Safety Plan by Swab testing/ environment testing. This needs to be done by an independent person. We understand that currently where Food Services are contracted out swab testing is done by the manager who is likely to only do swabs in spots they know are going to be clear.
- Tray accuracy. The trays with steam meals are done at ward level not over the trayline and there is a real risk of mistakes.

Other KPIs need to be clarified, for example:

- Patient satisfaction. There is a question about what rate patient satisfaction is going to be acceptable and whether that will be an improvement on current satisfaction rates in the hospitals.
- Clinical satisfaction. This will also need to be expanded to make clear which clinicians are being referred to

Potential impacts pp. 35-36

The ICC is right to identify that success in delivering the recommended end state operating model and fully realising the potential benefits available is heavily dependent on effectively managing the change impacts. We are clearly worried about the impact on our members but the whole project is vulnerable to a poorly managed transition because there will be a point at which there will be no going back because the hospitals will not have the capacity to pick up on provider failure. We have had several examples in the public sector of similar problems, ranging from the Novapay fiasco in education to Labs Plus at Auckland DHB.

Outlining the Financial Case

Financial benefits pp. 37-39

The lack of data available to the unions makes it difficult to comment meaningfully on the financial case, for example we note that Table 10 has been removed for “commercial reasons”.

However it appears that at this point in the process the level of financial information

available to HBL is also less than optimal when it comes to establishing the financial benefits. The data in table 13 is generalised across the DHBs and doesn't include the costs of transition. We are not sure why, given the likely upfront costs of transition, we have estimates of between \$47 million and \$60 million being saved in the first year, particularly when best case scenario sees implementation only beginning in December.

We also know that the Respondent has not seen the ward kitchens they will be dealing with and the variations across DHBs are not reflected in table 13, so at best these are large assumptions. The picture could be further complicated if HBL makes good the suggestion on p. 29 that some DHBs who have submitted a bid to continue to provide their own services may be able to do so.

*Assumptions
impacting the
benefit calculations
pp. 39-41*

It is also not clear on what basis HBL has estimated CAPEX requirements over the next 15 years to be \$95 million – nearly \$30 million more than the DHB figure. You have stated the reasons for your concern about the DHB figure but it represents the only hard data you have. Where does the \$95 million come from? At page 41 the ICC explains that \$66 million CAPEX figure is predominantly made up of the projected CAPEX for a Northern Region Food Services solution but we understand that the figures DHBs in the Northern Region submitted to HBL might not align with the Northern Region Food Services solution. We would suggest relying on the data in the returns to HBL.

As identified earlier in the ICC the costs of capital will be recouped through a capital charge per unit so that the DHBs will end up pay for CAPEX one way or another. It is also not clear how this charge has been reflected in the assumptions about savings per meal. On p. 38 there are statements about the average cost of meals over the next 15 years reducing, but because we lack the figures we do not know what the impact of the CAPEX charge will be on this cost.

Outlining the Management Case

Milestones p. 45

We have little to say about the Management Case, except that the project milestones from here through until December 2013 seem very optimistic and it is striking that the milestones in Table 11 have a binding offer in June, before a business case is finalised and approved. It is difficult to see how, once this project proceeds past consideration of the indicative case for change, there can be any changing of direction or moving to another Respondent. The timeline is tight and the risks of costs accruing from any delays will mean that, if nothing else, momentum is likely to deliver HBL's preferred option with Compass as the single respondent.

Appendix Ten: Summary of the Proposed Service Delivery Model

Appendix Ten sets out the proposed service delivery model which contains some of aspects that the PSA is most concerned about.

Impact on kitchens

With 65% of production still happening in hospital kitchens under the proposed service delivery model it is not correct to talk about a receiving kitchen. It will be a production kitchen, especially for the larger hospitals. Integrating the production and receiving processes will be a big challenge with two systems working side by side. For those hospitals that run effective in-house kitchens (or those staffed by the staff of a different contractor) it may also be complicated by staff employed by two different employers working alongside each other on potentially different pay and conditions.

It is also not clear what facilities will need to be retained in each kitchen in order to continue to produce meals. For example, in a large kitchen with two traylines will there be just one trayline or will two need to be maintained?

Steamplicity

The use of Steamplicity cooking in the wards raises many questions. Firstly the steamplicity process is a standardised process, with meals coming in one size. Overseas research has shown a higher plate waste as a result as patients cannot choose the vegetables or starch or a smaller size meal⁴. Research underway in Wales by Susannah McWilliams illustrates that having fixed portion sizes for all may have two consequences: that there will be a large amount of plate waste and that those with large appetites may not get enough⁵. Our members report that in their experience elderly patients in particular can be overwhelmed by larger portions.

Overseas research has also shown patients consuming fewer calories with steam meals as they cannot choose all components and are more likely to leave things on the plate. A group of patients not at nutritional risk had their food intake over one lunchtime assessed and compared with their energy requirements. The study found that patient intakes did not meet their estimated requirements leading the researchers to conclude that patients with a poor appetite would be even less likely to meet their nutritional requirements⁶. These authors identified other disadvantages with steamplicity as being “less variety for long stay patients,... no variability in portion size and meal components, second helpings are more difficult to provide, it does not provide for cultural, religious or special dietary requirements, and some popular dishes like fried fish and chips or pastry-based dishes do not work well with this system”⁷.

One menu with **the same** options each day, even with the superficially attractive number of 21 options might be satisfactory for short stay patients but it is not suitable for long term patients such as those in mental health, health services for the elderly, and rehabilitation units. Overseas research has shown less customer

⁴ Roberto Sonnino, Susannah McWilliams ‘Food waste, catering practices and public procurement: A case study of hospital food systems in Wales’, *Food Policy* 36 (2011) 823-829

⁵ E-mail from Susannah McWilliams 1 May 2013

⁶ M. Hickson, L. Fearnley, J. Thomas, S. Evans, ‘Does a new steam meal catering system meet patient requirements in hospital?’ *Journal of Human Nutrition and Dietetics* 20(5) 476-85 October 2007

⁷ *Ibid* p. 477

satisfaction as there is menu fatigue⁸. As previously observed this will create problems for those who require culturally appropriate meals (particularly in Auckland and Wellington), for those with specialised diets e.g. pureed, gluten free etc. or for those who just don't like to eat certain things.

Steam meals need to be micro waved and the whole tray needs to be assembled at ward level. This requires sufficient space at ward level in the corridors or in the ward pantries to do so and many ward kitchens are not appropriate for this either because of lack of space, they are shared between two wards or because they are also used by visitors (particularly in children's wards). Our members estimate that extra staff will be required to manage the serving of this food on the wards – one heating and one serving – and that there will be more double handling.

The system relies on manual handling of paper menus and decision making by staff on suitability of meals relating to diets. This compromises patient safety. At ADHB they have moved to the C-Bord computer system that prevents the wrong meal given to a patient, which could have disastrous consequences. Our members also consider that reheating meals in the ward environment increases the risk of bacteria getting into the food and this risk would increase if there was only one staff member doing the task as food is more likely to sit around unrefrigerated for longer periods.

Meals on Wheels

The proposal for meals on wheels is also disturbing. Using frozen meals but heating them up before delivery, would have major food safety implications. Meals can only be reheated once and they then have to be consumed within an hour to be safe. Meals on wheels recipients would not have the choice anymore to leave the meal until later. If they do so, they would risk food poisoning.

The daily delivery of frozen meals to the hospital kitchen just in time for reheating is also risky as it can push timelines out very easily at the hospital kitchen end. If they do deliver in advance extra storage space will be needed in the hospital kitchen, which will take up quite a bit of refrigerated space. It is proposed that the rethermalisation will also take place in the kitchen, which will require extra oven space and clash with the 65% of meals still being cooked there.

Conclusion

The PSA is of the view that HBL's preferred option for Food Services should be abandoned and instead more effect should be put into enhancing the improvements that are already underway under the status quo. These could be promoted and co-ordinated by HBL instead of reaching for a 'transformational' solution that is driven by targets for savings instead of patient need.

⁸ Orrevall, Y., and A. Ödlund Olin. "P253 Comparison of a traditional warm food plated catering system and a steam cooked plated catering system at a University hospital." *Clinical Nutrition Supplements* 4.2 (2009): 131.

There are real risks in the proposal, particularly around the reliance on steamplicity and the integration of a parallel system into hospital kitchens and wards that will already be busy. The consequences of getting this wrong are huge for patients and staff.

The PSA has real concerns about the process. It appears that this stage of considering the indicative case for change is the only point at which the project can be diverted, yet we do not have the figures on which to base a challenge to the financial assumptions. The process looks likely to lock in place a single contractor before all the information is available. The reliance on a single contractor raises real risks of monopoly behaviour. For those hospitals that currently provide Food Services in-house the reliance on a contract with an external provider will also mean that they can expect delays in remedying problems that they manage relatively quickly at the moment.

We would urge HBL to abandon this proposal.

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