

# Hira April and May 2023 workshops

# Feedback summary and theming

## Background

In April and May 2023, several workshops for digital health suppliers were held by Te Whatu Ora Hira Programme, in partnership with the Digital Health Association:

# 20 April (full day, face-to-face), **Te Papa Hauora – Health Precinct, Manawa Building**, Christchurch: attended by over 70 people.

* 15 May (full day, face-to-face), Ko Awatea, Middlemore Hospital, Auckland: attended by 110 people.
* 23 May (half day, online), attended by over 50 people (included a separate one-hour online workshop on Equity by Design on 26 May).

The workshops began with a welcome from DHA chief executive Ryl Jensen. Ryl was followed by Hira Programme Director Ray Delany and Hira team members Kathryn Jarden-Brown, Gerard Keenan, Hayden Smith, Jen Rutene-Smith and Sarndrah Horsfall, who gave an overview of different parts of the Hira tranche one roadmap.

Attendees then joined breakout sessions for different topics: Interoperability; Data and channels; Services for healthcare consumers, community and whānau; Equity by design (not offered in the Christchurch workshop as the facilitator could not attend because of flight issues); Services for healthcare providers. Note that because of time restraints for the online workshop, people choose two of four potential breakout groups to attend, and were offered a separate online Equity by design session later the same week, which many attended.

This document captures and themes the feedback from the workshop. Thanks to everyone who attended for your participation and strong engagement. All feedback will be carefully considered as work on the Hira Programme continues.

## Feedback from the breakout sessions

# Interoperability themes

* **Better understanding of Hira/change management**
  + Attendees found having production roadmaps and delivery timeframes available very useful as it allowed them to embed timings with their own product planning.
  + Understanding when test environments will be available and when things will move into production is very valuable.
  + Vendors are keen to get the next level of the roadmap, to better understand what has already been done and what’s coming.
* Share the research behind the roadmap.
* How do we prioritise what we do first, based on impact and what is most meaningful?
* How are we going to let providers know of the approach to getting data out of the different sources?
* Hira is a massive change and adoption programme – how do we provide and get the right level of support? It can take the sector a long time to change.
* How long do we allow the system to transition from taking in data from local sources to using dynamic data?
* **Standards/conformance/certification/auditing**
* We need to spend more time thinking and talking about the importance of standards. None of the underlying tech will reach its full potential unless we are all aligned on the standards. We have to work together on this, which is challenging in a large, complex sector.
  + Vendors want to know a lot more about the mandatory standards/guardrails, how to conform and where the material is.
  + How do New Zealand Information Security Manual (NZISM) standards fit in?
  + Certification process needs to be visible to the industry.
  + Standards for interoperability will be mandatory – onboarding certification process, security conformance, data quality from different customers.
* How do we describe data – if we don’t have the same classifications and language, how do we use that data? Standards help us understand data and make it simple.
  + There needs to be a certification programme that includes the need to adhere to standards, with kudos for those who achieve certification.
  + If you don’t adhere to the standards, you can’t participate in the ecosystem.
  + Need a strategy for the adoption of standards. Support for their adoption could include training courses, ‘phone a friend’ service, sample code.
  + APIs go a long way in providing standardisation for the sector, but may need more direction.
* Our procurement processes need to support interoperability.
* SNOMED CT is good but still not good enough for high-quality data, and we also need clinical system buy-in.
* Te Whatu Ora could should start including SNOMED CT as a standard in future procurements.
* AI can support free text into SNOMED CT, but having information in a more understandable form is even better.
* How do we take the standards and give them life and meaning? How can we work together to define the standards to the right level of detail and then take that info and thread it into RFPs and contracts etc?
* **Supporting innovation**
  + How can Hira enable and support innovators to come up with ways of solving problems? Need to share standards and then create an environment in which people can build and innovate.
  + Could we facilitate and promote developers to solve problems – like a Guild?
  + Build on some of the things learned in COVID – like leaving the cancer test kit at the door.
  + Can we start building against prototype APIs?
  + System developers will need time to adjust, and the system has to be robust enough to work all the time, across the entire ecosystem.
* Vendors could focus efforts on innovations, while Hira does the data leverage and linkage.
  + **Digital identity**
* Digital identity spans across several sectors, they all need to be involved.
* What is the definition of digital identity?
  + Identity is critical – there are five areas of concern: consumer, workforce, organisation, things/devices (IOT), consent and delegation guardianship (need to understand who accesses information).
* **Marketplace/sandbox**
  + Sandboxing needs to be built into Marketplace.
  + Marketplace can help share/clarify challenges and opportunities.
  + Run a sandbox ‘hackathon’ and share where to get help across the ecosystem - eg: FHIR expertise.
  + Create a community marketplace.
  + Need developer environments via the marketplace or a developer portal.
  + **Datasets and sources**
* PHOs already have comprehensive data warehouses, how do we bring connectivity to that data?
* PMS systems were set up to be flexible for practices – data sources will have to go up a level to support interoperability.
  + Having one EHR would save GPs a lot of time, as they would not need to log into different datasets.
  + What happens to the old data – is it migrated, discarded etc?
* **Other comments**
  + Māori data sovereignty:What works for Māori and equity will work for everyone.
  + People aren't happy with the term ‘consumer’.
  + There are learnings from the FinTech Market and open banking, such as providing a pre-RFP environment, sandboxes and clear protocols.
  + Speed up the delivery of personas mapped to the architecture.
  + Share the research behind the roadmap.
  + FHIR is complex and Hira needs to support that better with others and existing understanding from the industry.
  + What is the situation with FHIR vs Open EHR?
  + What if people don’t have a device? How can we be sure data is secure?
  + The person must be in control of their data – as is the case in NHS.
* There was discussion about the events notification service (ENS) which will see updates going to everyone who needs them – information will go to multiple places. There could be several million transactions a day.

# Data and channels themes

* **What excites you about Hira?**
* Surfacing of the data/health information, including:
  + A legitimate, national patient summary health record and the possibility of what it looks like.
  + Integrating legacy systems into APIs.
  + The potential for a national unified view.
  + Consumers being able to access their information from all their healthcare providers.
* Creating an eco-system for sharing health information, becoming less siloed, enabling business integration and sharing of useful information.
* Having identity and access management in tranche one, so it can be unpacked in future tranches.
* Tools making it easier for whānau to have control over who can access their information. More whānau centred.
* Rules embedded on how information is shared.
* Having SNOMED CT and other terminology and translations available.
* The Hira connector plane.
* National event notifications has exciting potential.
* Record locator enabling finding of records.
* Agile way of working – changing the way we deliver so that engagements with whānau/ hapōri/communities/vendors are fed directly through to the Data and Channels team.
* Moving the focus from clinician to patient and whānau. This will take time, and it will take all of us to make that change.
* Changing and adapting language and reflecting it in our APIs as a result of feedback from our whānau/hapōri/communities. Eg, Immunisations can be a triggering word for some whānau; whereas the slight change to ‘imms’ alters people’s perception of the healthcare sector.
* **Tranche one and beyond**
  + Need more clarity on data source delivery/timings of the services so there can be early engagement with vendors.
* Recommend smaller incremental releases.
  + Why is primary care GP data listed, but not secondary care collections?
  + Is the patient health record read-only in tranche one, ie, updates not able to be made?
  + Who is delivering a free to view personal health record and will this complete with patient portals?
  + Beyond tranche one, are referrals planned for Hira, and will hospital encounter information be available?
  + Will people be able to opt-out of central government collection of their health data?
* **Be open and transparent**
  + Some people are still unclear of the purpose of Hira.
  + There is a perception that Hira is building everything from scratch.
  + Need cross-programme alignment, ie, with screening, imms, HSAAP.
  + Co-design with all touchpoints, not just users & consumers.
  + Don’t let perfection stand in the way of ‘pretty good’.
* **Early engagement with digital health suppliers and others is critical**
* Need to know about services as early as possible to plan, get funding and build on our end then we could adopt them shortly after they are made public.
  + Engage with the vendor community early, get roadmaps out early, be transparent about what we are doing, keep talking.
* Publish backlogs and roadmaps to give insight into delivery.
* Early view of the interface and parameters we require to use them.
* Need continued engagement – one-on-one working relationships. Does Hira have multiple vendor-relationship managers ready to go?
* This engagement will help understand difficulties and barriers encountered by Hira to help identify delays and understand challenges.
* Important to partner and share the problems to solve together with the vendor communities.
* **Data**
  + Priority needs to be on getting the tranche one data sources surfaced.
* How do researchers for academic medical centres access patient data? There is no research angle shown in the roadmap.
* Is there a plan in tranche one for electronic data sharing between public and private health providers? In terms of private health data.
  + Don’t lose sight of the pillars of security and accuracy.
  + Hira needs to be clear on what is required by vendors and the sector to ensure completeness of data.
  + Hira needs to be clear that some datasets may not be complete.
  + Configure systems to improve data quality; encourage improvement of data quality by surfacing where improvements are needed.
  + Many PHOs already have a lot of the primary care data, cleaned, transformed and standardised.
  + PHOs have good understanding of variation of clinical practice and normalising for that behaviour across practices.
  + Is there any standardisation on the front-end API for data access? There was mention of FHIR previously.
  + Why is only primary care data included in tranche one? Why not secondary care and community care data?
  + Providers such as dentists don’t have a PMS but are capturing data. How can this data be provided? Including private providers.
  + Why aren’t care plans included tranche one? When will this be included? Need to also include patient self-generated data to inform care plan.
  + Additional data sources can be added to the programme backlog to inform tranche two data sources, examples could include primary mental health data, InterRAI data (aged care/ home care), HPI extension, maternity, location mapping. The Hira Digital Enablement and Engagement team can capture these as in opportunity canvases.
  + How do we capture non-clinical data, such as data about the health workforce and assets?
  + Will Hira be sharing data from other government departments, eg, social services, ACC etc?
  + Will the surfacing of Hira data sources be a system of record or source of truth? Who is curating the source of data?
  + How do we deal with data that is hidden at the consumer’s request? Should GPs be made aware that some data is hidden?
  + Need to consider how we build trust in the sharing of data.
* **Supporting innovation**
* How can we enable the digital health services community to help solve problems? Eg, have a purpose driven innovation process – create an environment to solve problems by innovators.
* Have a list of problems and create an environment where these can be tested/solved.
* We should consider creating a centre of excellence and enterprise scholarship for university students. Linking in with universities, for prototyping health tech innovation.
* **Standards/conformance/certification/auditing**
* The certification process needs to be more visible, including how people connect into it.
* Need to set clear requirements for API performance to ensure all types of providers can meet expectations.
* Will there be a charge for certification, what is the support for small organisations?
* **Sharing learnings and research**
* Research undertaken by Hira should be shared – for example, on Marketplace.
* There will be lessons learned from the implementation of the APIs – let’s learn them together.
* Publish the personas work and data analysis or specifications on national data.
* **Māori data sovereignty standard** should be applied to all. Publish guidance as part of guardrails (Te Aka Whai Ora lead).
* **Equity must be built in:** Publish equity guidelines on Marketplace and share expectations with vendor community.
* **Role clarity between Hira and vendors**
  + Need to be clear on what only Hira can do, and what vendors are expected to deliver/contribute. What does Hira expect of vendors in terms of delivery?
  + Vendors/partners are keen to contribute to delivery of capability, especially if already existing that could be leveraged.
  + For example, if Hira focuses on a consumer app, do vendors also continue to work on this or put their focus elsewhere? Consider providing opportunity to vendor community to build Te Whatu Ora consumer-facing app.
  + Another example, confirmation required on how Hira intends to deliver the data sources with Digital Rights Management (DRM) applied. Noted DRM was not visible in architecture. Is this a gap? Recognised as a capability vendors could provide.
  + Codesign with vendors – take them on the journey.
  + What will be mandated, and when? Vendors need to prepare, understand impact and align their own businesses.
* **Thriving ecosystem**
  + What can Te Whatu Ora and DHA do to ensure all vendors participate in the ecosystem, especially for smaller players, to ensure a thriving digital health ecosystem?
  + Will Hira consider incentivising vendors to participate? Recommended Hira look at the Singapore model.
* **Other comments**
  + Are there vendor personas? Will be useful to inform commercial framework.
  + Clinicians could be digital champions.
  + Data and channel delivery is very individual focused with no real picture of whānau.
  + Is physical access (not just digital access) to data considered?

# Equity by design themes

**Building equity into our work**

*In summary, great interest and engagement. All workshop audiences were quick to call for equity standards and or consistent features that vendors can work to achieving.*

* Equity is of increasing importance and there is a lot of focus on operationalising equity in our work. People who are unsure how to do this need support.
* Equity needs to be relevant to people in all roles – finance, support etc.
* There is a paradigm shift to pae ora – moving to a people, whānau, localities approach and away from a medical, DHB-centred model.
* We have to act in a Treaty partnership mode.
* We need to have more of these equity sessions.
* What are we doing to support principles to use in relation to Te Tiriti Waitangi? How is data consumption going to be more than just ‘text on screen’?
* We can add/embed Māori language into our products as we did in China, which means interfaces (UI) in Māori language.
* Validation is necessary to protect and promote te reo Māori.

**Māori data sovereignty/data**

*In summary, Māori data sovereignty is confusing for vendors and others in the sector. This is compounded by contractual clauses in renewed contracts already asking providers to show evidence of implementation of Māori data sovereignty.*

* Te Whatu Ora needs to be really clear on what vendors need to do in relation to Māori data sovereignty; not leave them with an undefined set of obligations.
* We need more knowledge to protect and embed principles of Māori data sovereignty.
* Will there be a Māori data sovereignty workshop, so we can discuss further?
* We need analytics to measure when a user views sovereignty data.
* We need to understand what the explicit data sovereignty issues are and implement solutions.
* How strictly will Māori data sovereignty be enforced (it should be absolutely enforced)?
* How are we thinking about ‘reference’ data such as whakapapa?
* Māori data is captured at input, but how do we access Māori data repositories so we can provide to patients?
* What are the approaches for data privacy and security in Hira and marketplace apps, with regard to equitable design and access?
* Who is able to view/access data?

**Whānau-centred approach**

***I****n summary, a whānau-centred /whānau ora approach needs to be articulated more clearly.*

* We currently have whānau accounts. We need to incorporate new foundational whānau-centred features/engagements.
* What about changing individual NHI to a whānau approach? Whānau member NHI(1); whānau member NHI(2).
* The systems were designed 30 years ago and don’t map to a whānau ora approach. We need a whānau ora approach when designing programmes and services.
* Should one person own the patient record, or multiple people, eg, parent/child?
* We are user-centric but not whānau-centric.
* To protect whānau-centric we need a cultural care indicator and ethnicity data reporting.
* Vendor engagement is a method of ensuring the technology is open, but the approach to users, consumers, whānau requires focus on adoption by people.

**Procurement/contracting approach**

*In summary, the RFP approach is inequitable.*

* How equitable is the RFP approach taken by Te Whatu Ora? Not all iwi or Māori providers are in a position to respond to RFPs.
* Good that we are moving to a commissioning approach – this supports innovation.
* Current approach results in us missing out on the providers we really want.

**Innovation**

* Who do we engage to collaborate with on transformation?
* Co-design is important, but also early proof of concept or pilots.

**Other comments**

* Vendors need customers. Both parties are on deficit with regards to capacity and capability (people, funding, skills).
* What are you doing to promote data literacy and technology literacy among Māori?
* Partnership will be part of co-design.

# Services for healthcare consumers, community and whānau themes

* **Better understanding of Hira:** The workshops were a great insight into the work the Hira team has been doing to capture people’s digital health needs.
* **Use the right language**
  + Discussion about the term ‘consumer’: We need to humanise people so they are not just the consumers of a service, but the people we serve.
  + Need to ensure there isn’t a deficit lens on underprivileged communities; don’t use deficit language.
* **Use cases and personas**
  + Hone and Lily’s use casesbrought up considerations such as the security of overseas apps, challenges of language and culture, the need for health navigators.
  + Make the personas more usable – what is the assessment of the information provided, and how do we use it?
  + In future, focus on general needs, and do a representative case rather than giving specific details.
  + Map the future state journey to understand how the stories evolve, what Hira and vendors do. Ie, who is responsible for managing the next step?
  + There were a number of specific suggestions on how the personas could be enhanced.
  + There are some blind spots in the personas – more research would be useful. Eg, what about people who don’t use technology?
  + How do we put a digital and data map over those personas; to enable the future state to actually happen?
  + Where is this work going to go? How do we extract the value and understand where this could be done now?
  + Great that already talking with libraries and schools.
  + Flesh out the locations in the user stories to show why they are important.
  + We need more personas that represent more types of people.
  + Important to ensure personas are representative of the need of all people and whānau and that they feed into deliverables for an omni-channel approach.
  + It would be useful to have the personas information on Marketplace – for example, could create an animation.
  + Care needs to be person-centred, not process and system-centred.
  + In Australia, ADHA has an amazing usability centre, and can simulate consumers coming in for health services.
* **Privacy issues around data**
  + Clinician standards – nurses are not allowed to use text messages – need to consider the clinical standards, expectations and rules.
  + Consumer preferences and choice – I want a text, please give me a call, or an email.
  + Consumers may not understand the implications of using certain platforms.
  + Need policy conversations around consent and delegation.
  + Security is imperative – information needs to be secure all the time.
* **Capturing full range of data**
* What about getting data from other channels and agencies? Eg, Te Whatu Ora, primary and community care and vendors.
* Need to capture data on non-pharmacy medicines.
* How can you be confident you are seeing all the data?
* Where is the bridge between agencies, eg, Ministry of Education administration of medicines in pre-school and school.
* What is the source of truth for data? There are different datasets of different quality in different systems. Need to be clear about standards.
* What is the base level of information required for managing care?
* **Share learnings and research**
* Important to make the personas and supporting research materials available as they will support innovation and discussion across the sector.
* Many vendors would also welcome the opportunity to share their materials – how can they do this?
* There are a lot of impressive health apps available; Hira can help tell stories about these apps.
* Consider having a community marketplace where people can share health information and collaborate.
* Providers of services shouldn’t have to spend money doing work that has already been done. Communities shouldn’t be asked the same questions over again. It is Te Whatu Ora’s role to enable better coordination and sharing.
* Consumer research should be shared with industry, which doesn’t often have the funding to undertake their own research.
* **Engage Pacific communities** in the conversations; find the right partners for a tech build.
* **Need Hira navigators**
  + Navigators could help support people who have inequitable access to digital services.
  + These services need to be established by and within communities, not provided externally.
* **Digital rights management/control over your own data**
  + People need to be able to say what data they want shared with who.
  + Not everyone wants to see their full electronic health record, they want practical information, like what and when their next appointment is. And the information they want may change with time.
  + Need to have the right digital health services for the right people, with a strong focus on accessibility.
  + Need to make sure people can update their ethnicity, other demographic information, and their contact details.
* Consent and delegation is vital, especially for whānau, to be able to choose to share part of their health record, ultimately with other relevant agencies (eg, medical insurance agencies).
* People need to have trust in how their health information will be used, shared and stored.
* **General**
  + How does Hira identify ‘good enough’ and then test and learn in a way that meets the needs of people and whanau?
  + How does Hira avoid key risks, but ensure we don’t get bogged down by trying to make it 100 percent right for everyone, first time?
  + Could have a ‘connect-a-thon’ with the vendor community to crowd-source solving a specific problem.
  + Could DHA put on a session for Hira to talk about the standards-based approach to My Health Account integration, possibly using the Manage My Health use-case as an example?
  + Having people and whānau involved is critical in driving support and adoption of the solution.
  + Taking an omni-channel approach will be important as people often have a preferred channel.
  + How does Manage My Health fit in? It is intended to be only one of many consumer apps able to support authentication through My Health Account.
  + Smaller vendors may not be able to participate because of cost or capacity – this needs to be considered.
  + Connectivity is a big issue, particularly for rural people. It requires an all-of-government collaborative approach (Health, MSD, Justice, MBIE etc).
  + Important to leverage services that already exist in remote areas, eg, library services.

# Services for healthcare providers themes

* **HealthOne:** HealthOne works well in the South Island, but needs tailoring for elsewhere. How do we get a ‘HealthOne’ for the North Island?
* **Priorities**
  + There was support for the delivery prioritisation of demographics, medicines, diagnostics, primary care data (problems, allergies, adverse reactions), immunisation, entitlements.
  + The most important elements digital health suppliers would like to see in future tranches included referrals and progress, care plan, patient feedback, orders, appointments, next of kin, religion, consents, enrolment and utilisation, communication between providers, current services accessed, allied health treatment, security, patient reminders, provider identity, data sovereignty, IPS elements.
* **Capturing full range of data**
  + Are we looking at primary health data only, and is secondary data coming in subsequent tranches?
  + What about data from social and other agencies? Eg, ACC, MSD.
  + What is the minimum viable product for the international patient summary?
  + Include radiology reports (currently in tranche two).
  + There are too many apps clinicians are expected to use to access different datasets. Interoperability is key for simplicity.
* **Digital rights management/control over your own data**
  + We need strong digital rights management, allowing consumers to shape and change who sees what data.
  + Patients won’t necessarily want to see their whole IPS. They may just want to see appointment and meds information.
  + Responsible use agreement (eg, privacy, consent, delegation) will be met when the data leaves its primary source. Eg, will my hospital data be seen by the community allied health workers?
  + In other countries, the patient chooses what information is shared and with whom.
  + Identity, privacy, delegation and consent frameworks all need to be in place before Hira proceeds.
  + There was discussion about patient controlled confidentially flags, and models from Australia.
* **Challenges accessing/providing information**
  + How can we ensure that primary care/community care/allied health can all access this information?
  + Kaupapa Māori providers and outreach workers struggle to provide services as they have limited infrastructure. We need to provide them with a minimum viable products so they can get the support they need. They can’t afford to build or buy their own systems.
* We need to have access to enough data to make good clinical decisions.
* Non-registered practitioners need to be able to contribute social and clinical data for completeness.
* Need to be able to see who your care team is; when you have interacted with them; your care plans (aged care and longitudinal care).
* **Existing datasets**
  + We are all now ‘on the train’ for delivering, what does that mean for the existing datasets and datasets that are still being designed and developed?
  + Existing datasets are good value; but there are other datasets that people need to be able to view and edit.
  + We already have the technology to provide patient summaries, giving us the opportunity to leverage and extend that rather than reinvent the wheel.
* **Data quality**
* How will Hira manage conflicts in data such as demographics and meds reconciliation? Will it be the one source of truth?
* **Digital clinical safety** 
  + 67% (Auckland workshop) and 75% (online workshop) agreed or strongly agreed their organisation had clinical subject matter experts involved in the development of digital products.
  + Auckland workshop: 46% agreed or strongly agreed and 41% strongly disagreed or disagreed that their organisation kept a clinical risk register. Online workshop: 50% agreed or strongly agreed and 13% strongly disagreed or disagreed that their organisation kept a clinical risk register.
  + 57% (Auckland workshop) and 38% (online workshop) agreed or strongly agreed their organisation was mature in considering digital clinical safety in the development of digital products.
  + **Vendor conformance with clinical safety**
* There was discussion on vendor conformance with digital clinical safety. It was felt that most vendors were doing this at some level, informally. Need to make sure what is happening is clearly mapped out.
  + - Auckland workshop: Conformance is critically important; is at an early stage in Aotearoa; retrospective fitting is difficult; digital suppliers need clear, consistent and achievable prerequisites and to be supported; need a back-up process in case of failure; need to make conformance easy; think about all circumstances.
    - Online workshop: Conformance needs to be clearly mapped; a high priority as there is a lot of sensitive information out there; protects the consumer and impacts how digital tools are implemented; we are dealing with personal health data so safety is key; we need to mirror international standards; how will ongoing management of risk after initial conformance be ensured? Software as a medical device to avoid double up.
* **Use cases and personas**
  + Was very valuable to see the personas.
  + There was strong interest in the creation of vendor personas, and in having access to the clinical personas.
  + Expand the use cases for health providers – where they sit for a vendor community; how vendors can use them.
  + It would be great to see the merging of personas – from patient to health service provider.
  + Personas need to reflect challenges of those in regional, rural and remote communities.
  + Need to have personas for less conventional consumers and clinicians; and a vendor persona.
  + Publish work done around personas so vendors can use the learnings.
  + Personas need more detail, consider doing short videos on them, or infographics rather than having to read about them.
  + Send personas out before the workshop so people can become familiar with them.
  + Share the research behind personas.
  + Consider the consumer in the design of the product.
  + Need to recognise the limitations of personas.
* **Equity**
  + We need additional social data to provide more fullness around equity, and the involvement of social providers.
  + Health literacy is important for equity.
  + The whole country need to have the same level of equity.
  + Digital literacy and access, physical devices and connectivity are all important for equity.
  + Clinicians need to understand a person’s disability needs and the support they require.
  + Holistic care is important for hapū and iwi – wellness must be incorporated. Should be: access to the wider whānau, hauora data (other government data), social information.
  + How will vendors build equity into what they are developing? It must be equity by design – giving consumers the choice of who they share their health information with.
* **Share learnings and research**
  + Be transparent about the research being carried out. Vendors need to know where to focus their efforts.
  + **Delivery of Hira**
* More work needs to be done on procurement.
* Incentives and the commercial model need to involve the whole workforce and their data.
* Need an incentive to meet the FHIR standard, to bring vendors on board.
* The privacy framework around HIRA is so important that there should be an update given about it at every meeting.