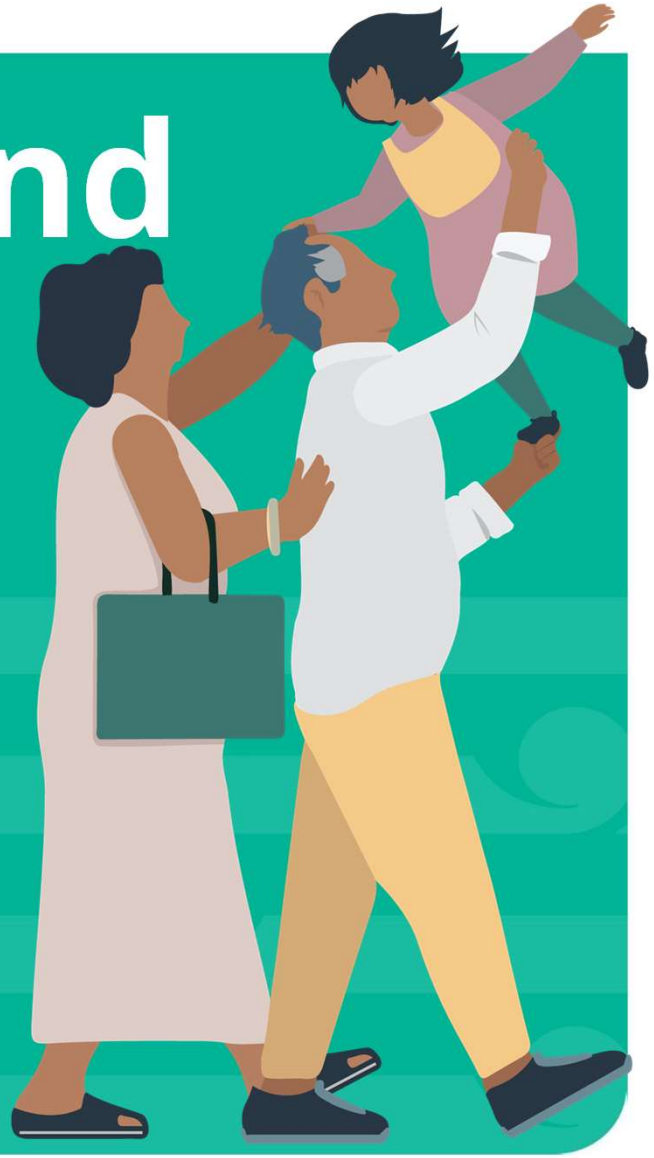
Interim
HEALTH NEW ZEALAND
HAUORA AOTEAROA
He hinonga taupua

Interim
MĀORI HEALTH AUTHORITY
TE MANA HAUORA MĀORI
He hinonga taupua

Health New Zealand Māori Health Authority

Update on the National Operating Model and High-Level Structure



April 2022

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Foreword from the CEs

Fepulea'i Margie Apa
Chief Executive
interim Health New Zealand

Riana Manuel
Chief Executive
interim Māori Health Authority

A message from the Chief Executives

This paper sets out the new national leadership team for Health New Zealand (HNZ), the Māori Health Authority (MHA) and the functions that will fall within each business unit at a high level. This paper also sets out how we see regional and local delivery working. Importantly, this paper describes our approach to how HNZ and MHA will partner to improve Māori health outcomes and eliminate health inequities. Equity has to be designed into the system – we can't rely on the goodwill of individual teams or people.

As we write this document, we are 10 weeks into our roles with less than 10 weeks to likely legislation enactment. While national leadership roles are determined, there is room for co-design and engagement on how we organise ourselves at regional and local levels. Sector-wide working groups on some functions will be established with leaders (and some external experts to challenge us) to input into the development of operating models that align with our overall transition objectives – to simplify the way we work, unify our teams, make visible consumer voices and embed enablers of equity and sustainability.

Our healthcare networks are facing into one of the most difficult winter periods we are likely to experience, with a possible resurgence of COVID-19 and other viral illnesses that may peak over the same period. We are aiming to begin the first few steps of transition in the remaining months of this calendar year at a time when many parts of our workforce have had limited respite over the last two years of multiple COVID-19 waves.

In implementing Cabinet's health reforms to realise the five system shifts, we aim for minimal disruption to frontline care for people, their whānau and communities. This will be achieved by ensuring the leadership and expertise of DHB CEs is secured until the end of September 2022, or longer by agreement, to support and implement the new operating model. Reporting lines for DHB CEs will revert to the HNZ CE from 1 July 2022. Between now and 30 September 2022, we aim to complete 12 weeks of 'sprints' of operating model development with existing leaders, to ensure we capture the best of opportunities while managing the risks of discontinuity. These sprints will further refine our operating model as a single national entity.

Within this document we have made a number of suggestions and ideas around current thinking of the direction of travel and potential reporting lines of existing roles and function across the system into this new national leadership team. We would like these ideas to be considered as part of the co-design process and acknowledge that any changes to an individual role will be considered at the point when a formal change management process is initiated.

Your health and wellbeing matters – we will pace change in a way that aims to make best use of the talent and skills we have. We thank you in anticipation for your participation.

Fepulea'i Margie Apa and Riana Manuel

What is the purpose of this document?

Describing the establishment and transition of the new entities

This document describes the first phase of establishment and transition for the 2nd tier national leadership team and regional leadership roles within HNZ and the MHA.

We aim to establish and appoint to these roles before 1 July, or have acting arrangements in place. This will enable the transfer of functions and reporting lines across the Ministry of Health, Te Hiringa Hauora, District Health Boards and Shared Services Agencies (SSAs) into new leadership structures within HNZ and MHA during July – September 2022. Some functions may take longer to shift into the new leadership arrangements, and others will have interim leadership arrangements, while specific parts of the operating model continue to be developed post 1 July. Working groups are already in place for National Procurement/Supply and Data & Digital functions.

This document has been developed for those whose employer will change from 1 July. This includes:

- All staff employed by the Ministry of Health in functions that have transferred, or are about to transfer, to HNZ or MHA;
- All staff employed by District Health Boards and their SSAs; and
- All staff employed by Te Hiringa Hauora (Health Promotion Agency).

This document signals further consultation and engagement with staff and/or their representatives that are likely to be affected by these changes in future phases of transition. We will work consistently with expectations agreed in MECA and other existing change documents.

This document contains six sections:

Section 1	Overview of how we will change to deliver on our purpose
Section 2	From transition to transformation – an overview of our approach to building our operating model
Section 3	Information on HNZ functions • Section 3.1 Delivery Team Leadership • Section 3.2 Clinical Team Leadership • Section 3.3 Enabling Team Leadership • Section 3.4 Office of the Chief Executive
Section 4	Information on MHA functions
Section 5	Putting it together – system shifts and regional working
Section 6	Next Steps – working groups on operating model and selection and appointment process

This document does not:

- Repeat the context for reform – however, links to these papers can be found here.
- Outline a blueprint for how HNZ and MHA will work with the wider sector. There is more work to do on this approach.
- Detail how we will fulfil our obligations to being effective partners in Te Tiriti – this work is to be done in partnership with Iwi-Māori Partnership Boards and regional functions that are currently being established.
- Detail how we will achieve equity, but it describes the roles and functions of teams and the expectations of their work to enable gains in equity.

The above points are either currently being or will be progressed with the appropriate partners and stakeholders

1. Overview

The Government's vision is to build a healthcare system that achieves pae ora / healthy futures for all New Zealanders. An Aotearoa where people live longer in good health and have improved quality of life, and where there is equity in outcomes for Māori and communities with inequities.

The outcomes we are trying to achieve

We want to build a healthcare system that works collectively and cohesively around a shared set of values and a culture that enables everyone to bring their best to work and feel proud when they go home to their whānau, friends and community. In doing so, the totality of the reforms are expected to achieve five system shifts.

These are:

1. The health system will reinforce te Tiriti o Waitangi principles and obligations.
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well.
3. When people need emergency or specialist healthcare this will be accessible and high quality for all.
4. Digital services will mean that many more people will get the care they need in their homes and local communities.
5. Health and care workers will be supported, valued and well trained for the future health system.

The improvements in outcomes we aim to prioritise that will operationalise the way system shifts are achieved include:

- **Equity:** tackling the gap in access and health outcomes between different populations and areas of New Zealand, with a particular focus on outcomes for Māori, Pacific peoples and disabled people.
- **Sustainability:** embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care.
- **People and whānau-centred care:** empowering all people to manage their own health and wellbeing and have meaningful control over the services they receive, and treating people, their carers, and whānau as experts in care.
- **Partnership:** ensuring partnership with Māori in leading the design and delivery of services at all levels of the system, and empowering all consumers of care to design services that work for them.
- **Excellence:** ensuring consistent, high quality care in all areas, and harnessing clinical leadership, innovation, and digital and new technologies to continuously improve services.

What agencies will be established and what is their role?

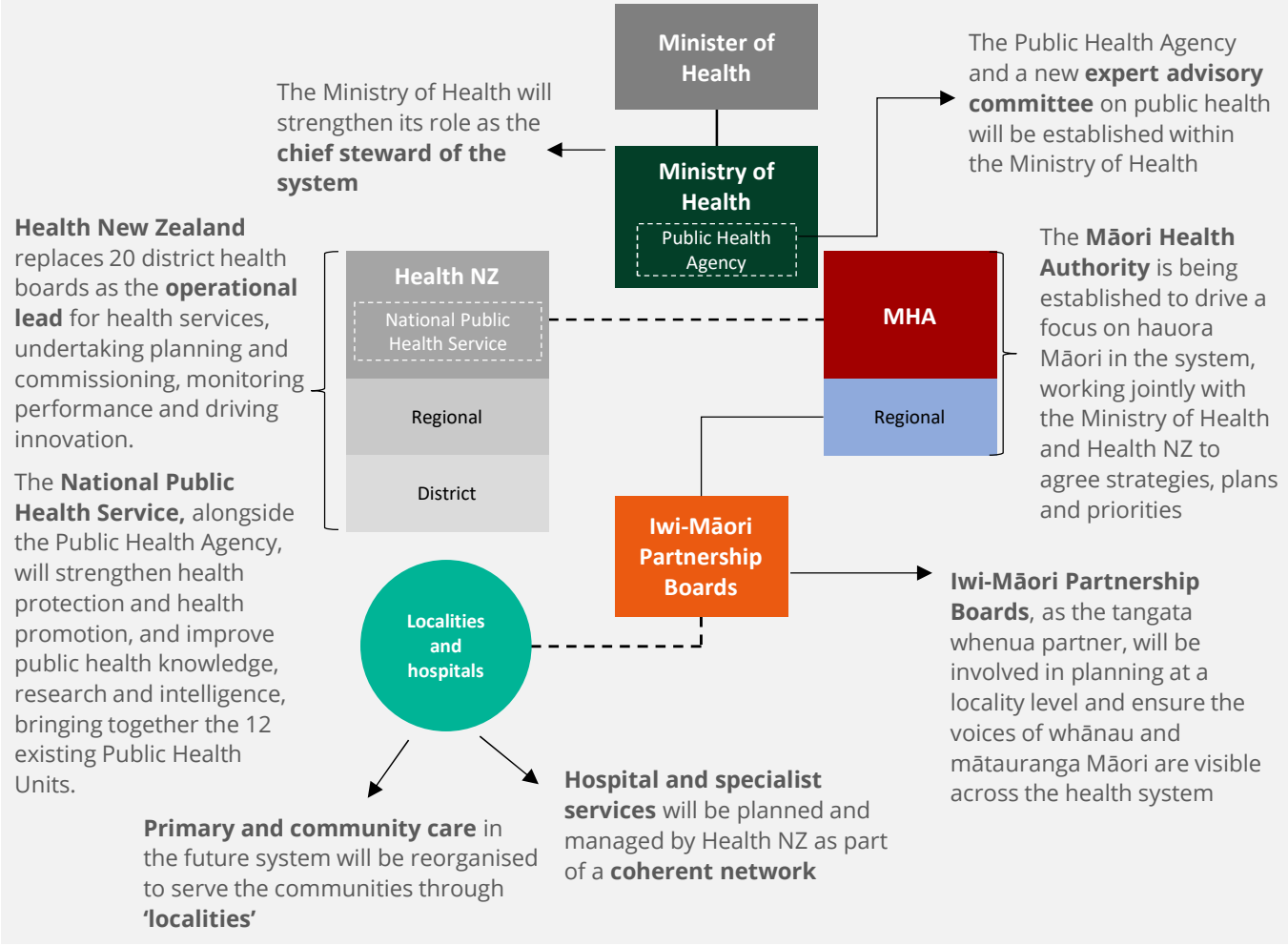
The establishment of entities is dependent on the Pae Ora Bill being passed

- As it stands, the Bill is set to come into effect from 1 July 2022, or at another date specified in the final statute. The legislation will set the context for the functions of the entities displayed in the diagram to the right.
- Cabinet has agreed to a number of functions and responsibilities at a national, regional and local level for HNZ. HNZ will work alongside the MHA at a regional level through four regional divisions. District funders, localities and Iwi-Māori Partnership Boards will ensure communities have access to primary and community care based on their aspirations and needs.

The role of the Ministry of Health

- The Ministry of Health (the Ministry) will remain the chief steward of the health system and lead advisor to the Government on matters relating to health. This includes a renewed focus on stewardship, strategy, policy, regulation and establishing a new regime for system and outcome monitoring. With regard to Hauora Māori, the Ministry will co-develop policy advice with the MHA.
- The commissioning of frontline services now sits in the operational parts of the system. However, the Ministry may commission some national interventions in line with its strategic role, in agreement with HNZ and the MHA (e.g. national campaigns).

Key components of the reformed health system



What will be in place from Day 1?

Day 1 for the reformed system is intended to be 1 July 2022

- Day 1 for the reformed system is intended to be 1 July 2022. This is when new legislation will replace the New Zealand Public Health and Disability Act 2000 and formally establishes HNZ and the MHA. On this day, the District Health Boards (DHBs) and Te Hiringa Hauora / Health Promotion Agency will be legally disestablished and their staff, contracts, assets and liabilities, including in relation to SSAs and organisations owned by individual DHBs, will transfer to HNZ. Shared services and other DHB-owned organisations will transfer to HNZ ownership as whole organisations.

- In the new system, DHB Chief Executives will continue to provide leadership and expertise, offering transitional leadership as part of HNZ from 1 July to 30 September 2022. During this time, we will continue to confirm and shift reporting lines to HNZ and MHA for functions to either a national, regional, or local leadership role. Ministry of Health commissioning and operational functions will transfer to HNZ and MHA. This will evolve as we go through the co-design process and on the basis that a formal change process has been initiated.

Accountability mechanisms

- The Government Policy Statement and the New Zealand Health Plan will set the multi-year strategic direction for the system and form a key part of the new accountability settings. The design of functions within HNZ and MHA will aim to deliver the objectives laid out in these accountability documents. These documents will replace the DHB Annual Plans. The Ministry will monitor system performance, and will support the Minister of Health to use ministerial intervention powers when required. The MHA also has a role in monitoring Māori outcomes across the system in partnership with the Ministry.

To date, HNZ and MHA have been focused on transitioning and setting up platforms for transformation. However, transformation won't occur straight away. Listed below are some of the key responsibilities HNZ and the MHA assume on Day 1 that signal the beginning of this transformation journey.

Health New Zealand Some key Day 1 Responsibilities

- Planning, delivery and commissioning of publicly-funded health services
- Day-to-day operational planning and management of hospital and specialist services
- Commissioning primary and community services through the four regional divisions
- Driving improvements in service delivery at all levels
- Defining expectations for high-quality commissioning of services throughout the system, working in partnership with the MHA
- Providing system-wide supporting Infrastructure and back-office functions

Māori Health Authority Day 1 Responsibilities

- Hauora Māori strategy and policy in partnership with the Ministry of Health
- Monitoring and realisation of equitable health outcomes for Māori
- Development of the Māori health workforce and sector leadership strategies and work programmes, partnering with and supporting the Ministry and HNZ
- Actively hosting and supporting Iwi-Māori Partnership Boards to influence priorities and services in regions and localities
- Direct commissioning of mātauranga Māori services, and co-commissioning health services with HNZ
- Leading a partnered inter-sectorial commissioning approach to deliver whānau ora through Māori health services
- Supporting the Ministry and the Budget process across the health system for Māori health outcomes
- Leading the performance and accountability monitoring for the health system for hauora Māori outcomes

How will Health New Zealand and the Māori Health Authority work together?

Two organisations, one vision – Pae Ora

- The Waka Hourua is a developing metaphor for the relationship based on partnership between Health NZ and the Māori Health Authority working towards a common Pae Tawhiti (Vision).
- This update sets out how core functions – Ngā Rā (the sails) – will be established.
- Te Mauri o Rongo (Charter) and alignment of values will guide how we engage with each other and our consumers, whānau and communities.
- The Waka Hourua as presented here is in its early stages of development and will evolve as a framework for engagement.

2. From transition to transformation: our approach to building our operating model

Nationally planned, regionally delivered and locally tailored

Our approach to organisation change and considerations of function shifts are based on the following principles:

1. **Enable equity gains:** Achieving equity for Māori and populations or groups of people who experience poor health outcomes happens by intentionally designing equity into the way we do things, in alignment with Te Tiriti. This requires national planning to determine areas that need national consistency, coordination and possibly centralisation to realise equity gains. Regional delivery will meet national expectations while tailoring solutions to address local needs and aspirations. We will remove unwarranted variation in priority areas of inequity and where we desire national consistency, while enabling diversity of delivery models tailored to each community's local circumstances. This includes tailoring for Māori in partnership with the MHA, Pacific peoples, people living with disabilities (in collaboration with the soon to be formed Ministry for Disabled People), mental health and rural communities where geographic access is challenging.

2. **Simplify** the way we organise ourselves to set us up for transformation. We will bring together functions that, through consistency and standardisation, enable system efficiencies and the release of resources to frontline care. We will plan services nationally to ensure consistency of specification. We will enable regions to oversee and lead delivery and support the sharing of resources (people, funding, time) to ensure that equity of access and outcomes is improved for populations at a regional level. Local tailoring of delivery models, however, will ensure we are responsive to the diverse needs of local communities within districts. Functions will have clear accountabilities with a span of control that allows focus, clear purpose and accountability for their part of the system. Reporting lines for the purposes of support, direction, feedback and information flow will be simplified.

3. **Unify** our teams across geographic and professional boundaries, so that our people can work together for the benefit of patients, whānau and communities. By simplifying funding models and support networks where information and resources can be shared across districts, regions and nationally, we can focus on what is best for people. We recognise that the sum of people's experiences of healthcare is delivered by 'teams of teams' or a range of professionals that work together to contribute to those experiences. Therefore, we are taking a whole of system approach to how we work and build a culture that leverages the reform opportunity to work collaboratively. When this happens, each team will have a clear focus on their role and can support their members to do their best. More importantly, however, teams can see where they fit in the overall network of care and are able to build connections with other parts, reaching out to strengthen their relationships.

4. **Engage** the people who know best when redesigning parts of the operating model so those functions are positioned well for the future. We will not have all the specific details on current ways of working, work programmes, opportunities and risks of change across the system. So we will establish working groups to engage the experts in the system in both design and implementation of change. The detail on collective ways of working, work programmes, opportunities and risks of change will be outputs of this work. We will, however, invite external expertise to work with us so that we open ourselves up to ways of doing things that have been effective in other health systems or adjacent sectors.

(continued on the next page)

Our approach to change and operating model development

Our approach to organisation change and considerations of function shifts are based on the following principles *(continued)*

5. **Structural change alone is not enough.** The way we work together needs to change. We will need mindset changes to make the shift from the DHB environment to a collaborative national, regional, district and local networked way of working. The New Zealand Health Charter (the Charter) will set the expectations of the culture shift required from the new system. The way we work together to get the best out of our clinical and managerial leaders to share accountability for their teams and span geographical and professional boundaries will be vital to the new operating model. Where existing organisations or team values and ways of working align with the Charter, then we want to support that being retained. We also need to work across the system to support networks that span hospital, specialist, primary and community care to work together.

6. We recognise substantial engagement has been done to date on the Charter, with themes informing its drafting. Further work through co-design with unions and stakeholders will take place. In the meantime, the detail on how we will achieve the alignment of values across organisations will be progressed. We will work with leaders and staff at all levels of the system to determine and support the shifts needed in how we work together.

Phases of change

We are approaching change at a high level in the three key phases shown below. These phases are iterative in nature – various transformation activity is occurring in the transition phase.

1 Transition (to end of June 2022)

- Prepare for implementation of new legislation.
- Creation of a unified management structure, merging almost 30 entities including 20 DHBs, Ministry functions, 7 Shared Service Agencies and Te Hiringa Hauora.
- Establish new leadership roles and set direction.
- National and regional teams established in priority areas to receive transferring functions.
- Working groups established to 'sprint' development of operating models e.g. Data & Digital being established, Procurement & Supplies in progress.

2 FY22/23 Transformation through capability building and quick wins

- New leadership roles inherit operating model implementation and transformation programmes including 3rd tier and regional leadership roles, district/locality functions.
- Build function capability and processes to work across the system.
- Identify opportunities for streamlining processes, for example: forming regional hospital and specialist networks, clinical networks, and nationalising 'enabling' services such as Finance, People & Culture, Pacific and Māori Health.

3 FY 23/24 Transformation and Delivery

- Established and stable leadership structures.
- Government's health system priorities implemented or implementation has been enabled.

Our current focus is on transition

The key focus of this document is Phase 1 | Transition

A number of key activities are happening in this phase, including:

- Implementation activities relating to the merging of entities.
- Simplifying the way we make decisions.
- Unifying our people to work as a team of teams to improve experience and outcomes of care.
- Embedding how we partner with Māori at all levels to improve equity and outcomes through the Māori Health Authority.
- Establishing Health New Zealand to focus on achieving equity for Māori as Tangata Whenua, and for groups who experience poorer health outcomes.
- Building on existing relationships and pathways to amplify the voice of consumers and local communities in how their health is delivered.

Reducing risks to business continuity and disruption to the experience of care for consumers, their whānau and communities while we are changing is a key priority.

A key mitigation is that, for the vast majority of our teams, direct clinical and managerial leaders - particularly in hospitals and specialist networks, reporting lines and functions - won't change from 1 July.

For the vast majority of providers currently funded by the Ministry of Health and District Health Boards, their direct relationship manager will not change from 1 July 2022. Providers will receive correspondence in due course notifying them of the change in funder from Ministry of Health/DHBs to HNZ or the MHA. No other terms and conditions will change unless mutually agreed.

By 30 June 2022, Health New Zealand and the Māori Health Authority aim to:

- Agree the accountability settings for both entities, including Ministerial agreement to the Government Policy Statement, New Zealand Health Plan and other monitoring expectations that will clarify the FY22/23 deliverables for HNZ and MHA.
- Have either appointed or have acting arrangements in place for 2nd tier leadership and key 3rd tier regional leadership roles to enable transfer of roles and functions. Where acting roles are in place, we aim to have recruitment of permanent roles well progressed.
- Establish sector working groups to develop the operating model and complete plans for implementation.
- Complete the roadmap for the proposed shifting of current functions and reporting lines to the new leadership structures, and engagement with partners and the impacted parts of the sector.
- Establish the main accountability and authority delegations appropriate to the next phase.

3. Information on Health New Zealand Leadership Functions

The purpose of this section is to:

- outline the functions that will form the national leadership team of HNZ, and some 3rd tier leadership functions
- describe at a high level the roadmap to determine more detailed functions that engage our current leaders
- outline the existing roles and functions that will shift under those leadership roles
- outline thinking around the existing roles and functions that could shift under those leadership roles

There will be a single tier ELT made up of three sub-teams

We will establish three teams that will make up the 2nd tier national executive leadership of Health NZ:

The three teams comprise:

1. **Clinical leadership** who ensure executive decisions are informed by technical and professional expertise. This team will work with the MHA clinical leadership. It includes but is not limited to:
    - Medical
    - Nursing and Midwifery
    - Allied Health, Scientific and Technical Professions
    - Primary and Community Care

2. **Delivery leadership** who ensure all frontline care, whether commissioned or provided by HNZ, meets expectations of service coverage, quality and improved experience. Some roles will have a partner or co-lead in the MHA and some functions will agree a joint work programme with the MHA to ensure opportunities for Māori health gain are embedded. This team includes but is not limited to:
    - Commissioning
    - Hospital and specialist services (including Procurement and Supplies)
    - National Public Health Service
    - Pacific Health
    - Service Innovation and improvement

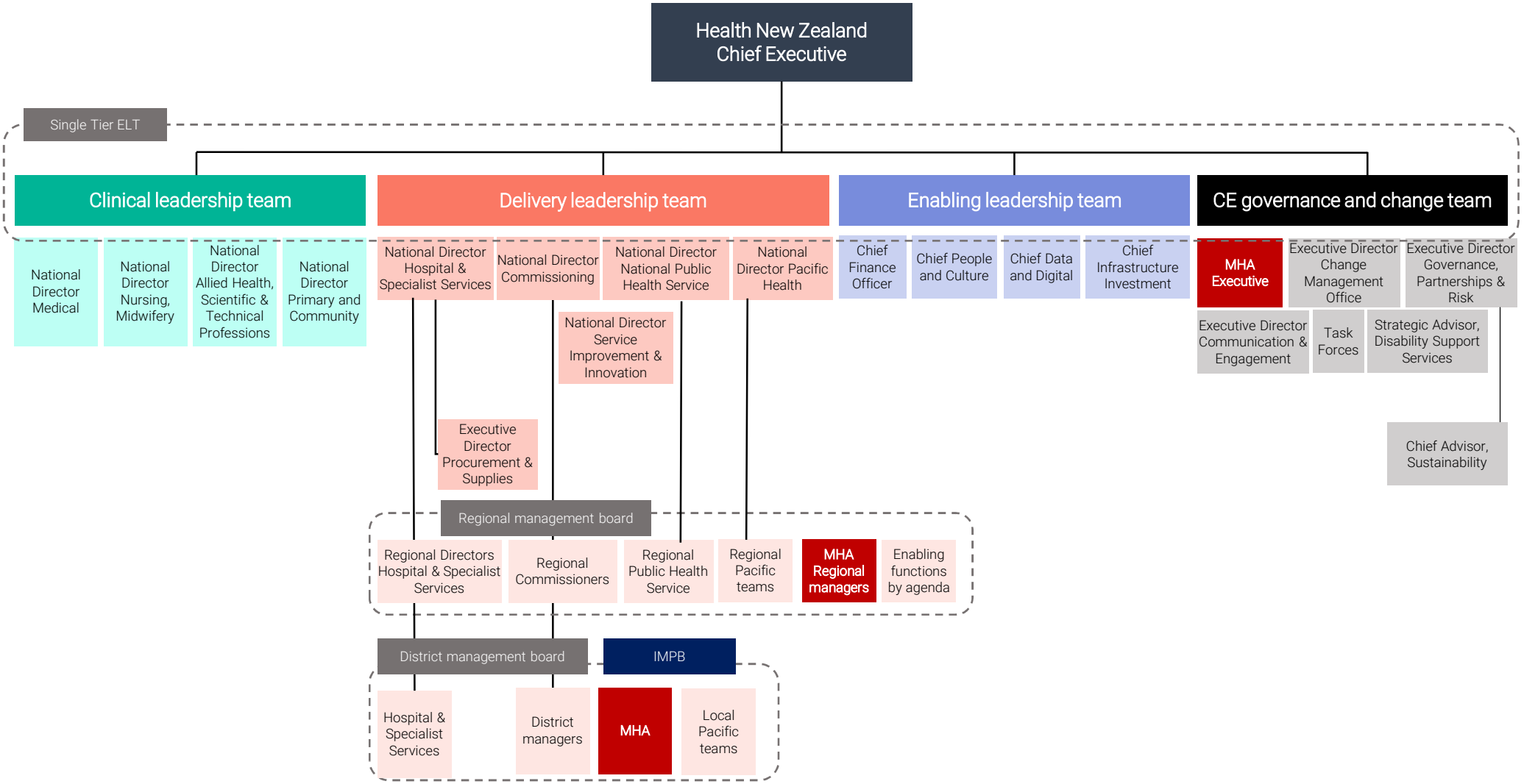
3. **Enabling leadership** who will collaborate as required with MHA executives (in some cases establish a shared service level agreement). This team includes but is not limited to:
    - Finance
    - People & Culture
    - Data & Digital
    - Health Infrastructure

A series of functions will be established as part of **the Office of the Chief Executive.** Some of these functions will be fixed term, as we implement the new organisational structure and associated work programmes. Functions that will sit within the Office include:

- An executive from the MHA who will be nominated by the MHA Chief Executive
- Change Management Office as a temporary function to support Day 1 readiness and support the transition process
- Ministerial and Government support
- Key compliance, accountability and sustainability responsibilities
- Communications and Engagement
- Strategic advisor for Disability Support Services
- Taskforces where the CE requires a priority focus and needs to draw on resources across the system. At the time of writing, taskforces are being established to oversee planned care, tactical workforce development and immunisations

Further detail on the single tier ELT can be found on the following pages.

A single tier ELT with three sub-teams



3.1 Clinical leadership team

Clinical leadership* is critical to assure ourselves that we are supporting the provision of quality and safe care and that professions are enabled to do their best. It also ensures the voice of professions inform our executive decisions from a quality and safety perspective.

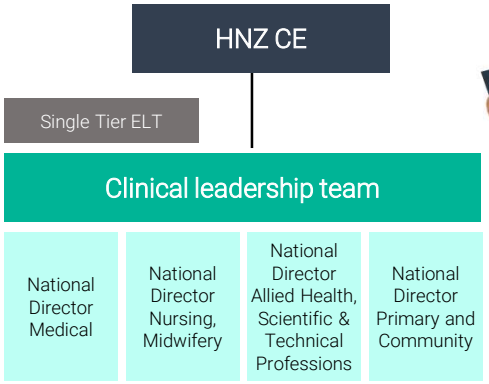
Matters for consultation

We will seek advice from this group on how we embed clinical leadership into our system that is fit for the New Zealand context, drawing on published learnings and experience in other jurisdictions. The concept of a 'Dyad' or dual accountability approach between lead clinicians and managers across the hospital network is of interest. From 1 July, working with the Chairs of existing forums, we will develop a white paper on what a dyadic clinical and management leadership model could look like and how it could be embedded at all levels across our services.

**Clinicians, in this context can mean any regulated professional.*

Decisions that have been made

Clinical leaders will chair their respective national forums. This team will comprise National Directors who lead but will not have direct line management of their regional counterparts.



It is intended that clinical leaders will report through to their local Hospital & Specialist leadership when they are established. The National Director Primary and Community will work with the primary and community sector to establish an appropriate clinical governance and workforce leadership team in partnership with providers.

This team will work across HNZ and the MHA to ensure alignment of national, regional and local workforce development activity for their respective professions and ensure the growth of a diverse workforce with particular focus on Māori, Pacific and people with disabilities.

The role of clinical leaders in the HNZ context is to chair and lead their respective national operational clinical leadership groups (e.g. National CMO Group, National Director of Nursing Group); drive workforce innovations and professional engagement in model of care changes; provide assurance of systems to enable clinical and professional competency in practice; and advise and intervene on clinical risks at a service level.

This team will be tasked with forming a professionally-led, collective approach to the national implementation of workforce and model of care changes, while modelling multi-disciplinary working. This team will work with the Chief People & Culture to align with wider workforce development.

This group has the following priorities:

- Initiate work on what quality and safety activities, reporting and intervention frameworks should be in place nationally. For example, a national serious and sentinel event and clinical risk reporting system that provides visibility on quality and safety incidents at all levels, as well as follow up actions across the networks. This work will joint venture with the MHA Clinical leads to ensure this activity can identify outcomes trends for Māori.

- Work with the National Director Hospital & Specialist Services and National Commissioner to establish strategic clinical networks on national health priorities. Networks will support clinical input into implementation of national priorities, service planning and delivery in hospitals & specialist networks with input from consumer engagement. Networks will also be established to reflect the priorities of clinical leaders in the sector.

- Work with the Data and Digital leads to prioritise systems that need to be established/developed early to enable quality and safety to be visible nationally, regionally and locally.

To minimise disruption to clinical leadership, we will work with existing Chairs of those national groups in their current form to determine the functions and subsequent leadership roles to be appointed from July. This will ensure minimum disruption to national coordination and collaboration activity focused on building the resilience of the system during winter 2022.

3.2 Delivery leadership team

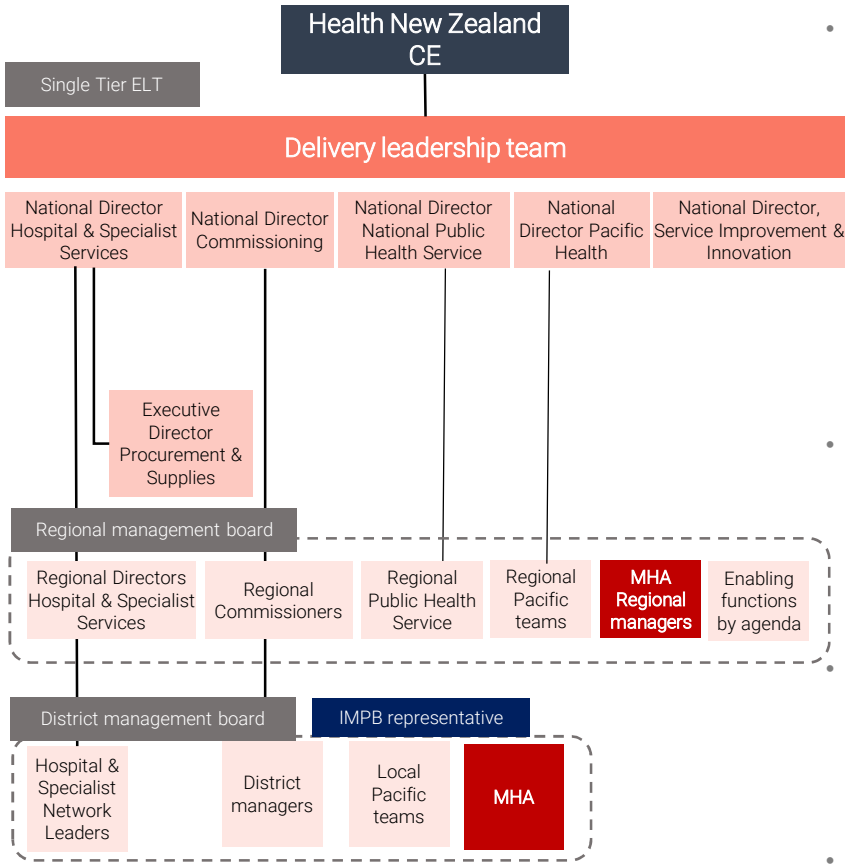
In our delivery system, we want to:

- Enable the spread and diffusion of improvements, innovations and transformations across the system
- Reduce unwarranted variation in care and focus on equity improvement
- Support the diversity of delivery models in regions and tailored to local communities

The structure of these functions implements Cabinet's decisions for regional and local leadership.

Decisions that have been made

This group of leaders are responsible for operational delivery in the system. Delivery of care is either provided by HNZ through Hospital and Specialist networks or commissioned/funded and provided by other community-based services and 3rd party providers.



For the purposes of this function, Hospital & Specialist networks **include the community health services provided by staff employed by DHBs (e.g. district nursing, community mental health).**

New national and regional functions will be established. Existing local teams will be shifted to report to these structures.

The functions and current reporting lines that will shift when leadership teams are established are:

National Director - Commissioning

- National Commissioner will be responsible for the New Zealand Health Plan, national service planning and development, funding and standards which enable the contracting, procuring and monitoring of services in alignment with our health and equity priorities. The National Commissioner will establish four Regional Commissioners who ensure the regional delivery of services aligned to national expectations while tailoring for local delivery. The National Commissioner will ensure regions are responsive to consumer voices and community engagement and enable regional clinical networks to support hospital & specialist care.
- The National Commissioner will establish national functions to enable improved commissioning and support of localities at the regional and district levels e.g. population health needs analysis, health intelligence and analytics, expertise on provider sectors and negotiation of national contracts.
- It is intended that the Ministry of Health commissioning teams and SSAs that have service planning, funding and support commissioning (e.g. Northern Regional Alliance and Technical Advisory Services) will be directed by this role.
- The National Commissioner will establish district managers and locality leaders to support tailoring of implementation to local communities. Initial thinking is that the current DHB Planning & Funding teams and related functions will report to District Managers from 1 July or on appointment of a National Commissioner.

Key roles within the Delivery leadership team *continued*

Continued role and scope for the commissioning function

- A working group, led by the National Commissioner, will be established to determine detail regarding national/regional/local functions, the operating model for funding and how we will transition existing roles and functions into the business unit. It is envisaged that this will be established by 30 September 2022.

- Within the national commissioning office, national leadership teams will be established in the following service areas to implement the Government's objectives and national policy, and working in joint venture or co-commissioning with the MHA, including but not limited to:

    - *Primary and community-based care* to include general practice teams, pharmacy, community-based referred services including diagnostics and NGOs.

    - *Mental health & addictions*, in partnership with the Māori Health Authority to commission across the continuum of care – including from preventative services to acute community-based services.

    - *Māmā, Pēpi, Tamariki* (Child, youth and maternity) to cover all services that impact on the First 2000 days of life of children and health and wellbeing of māmā.

    - *Health of older people services* provided for and impacting on older people to support ageing well in communities.

    - *Acute Care* whole-of-system approach to ensuring capacity and coordination of acute care across hospital and community settings. This includes NASO and national networks such as the Trauma Network.

    - *Adolescent and Young Adults health* whole-of-system view of the care that young people receive and experience throughout the system. HNZ will establish a focused team that involves the participation of young people in the design and delivery of their healthcare.

    - *Ambulatory and Planned Care* whole-of-system approach to supporting the growth and expansion of care provided in ambulatory or community settings (including specialist and diagnostic care) that can reduce acute demand growth. It will also look to expand care that can be provided from acute to primary and community settings.

    - *Long Term Conditions* whole-of-system approach to the integration of care provided to people who live with long term conditions – including cancer care – that aims to slow disease progression and improve wellbeing of people living with long term conditions in communities.

Regional working

We will retain the same four regions – known as Northern, Te Manawa Taki, Central and Southern – as organising networks for the health system, but patient flows that make sense to those communities will be enabled.

We note that the Māori Health Authority and iwi may see regional boundaries differently and the HNZ networks will work to support iwi-determined regions. We will support flow of care for Māori where their regional boundaries may differ to meet the needs of iwi.

Regional Commissioners will be established in geographic areas to ensure translation of national settings and the performance management/oversight of provision. Regional commissioners will ensure enabling functions are providing appropriate business partnering to support regional and local service delivery. They will also ensure tailoring to regional and local communities and support relationships and engagement with local networks and localities. Regional commissioners will work with their regional MHA counterparts and Iwi-Māori Partnership Boards to ensure responsiveness to Māori.

Districts in the reformed system

In this transition period, *"Districts"* refer to the 20 geographic coverage areas of the current DHB system. Within a district, there may be a number of localities. Some districts may see themselves more as a localities. Over time, localities will take precedent and by July 2024, every New Zealander will belong to a locality. Localities will not be constrained by current district geographic boundaries and will make sense to the communities within them.

District Managers will be determined as part of ongoing operating model development. District managers will work within their regional contexts to ensure national settings are applied consistently and, where appropriate, tailored for local populations. District managers will partner with their MHA counterparts to agree areas for co-commissioning, coordinate and support Māori providers while aligning to Iwi-Māori Partnership Board settings and priorities. Local teams will continue to be based in districts to work with Iwi-Māori Partnership Boards, implement and support locality development, ensure integration with local hospital and specialist networks, and support relationships and commissioning with local providers.

Key roles within the Delivery leadership team *continued*

Scope and roles within the Hospital and Specialist Services function

National Director - Hospital and Specialist Services

- Will be responsible for operational delivery and people leadership, and accountable for performance of care provided by public health hospital networks across the country. All hospital & specialist services provided in publicly-funded hospitals or what is known as 'Provider Arms' should report to this role nationally. This function includes the provision of community-based care provided by employed staff e.g. District nursing and community mental health.

- **Regional Directors, Hospital & Specialist Services:** The National Director will establish four Regional Directors to support this wide span of control. We will work with the regional configuration in place today. These regional boundaries, however, will not constrain consumers moving to other regions where it makes sense for them. Regional Directors will be supported to establish health intelligence and analytics, regional clinical networks and other capability to support coordination of activity across hospital and specialist networks. Regional Directors will be supported by business partnering functions from the Enabling leadership team to support operational management.

- The reporting lines for all Provider Arms and their staff should report to this role through their local hospital leadership team and regional directors. The National Director will work with the Clinical leadership team to establish a national clinical governance function to ensure quality and safety. The National/Regional Directors will establish leadership teams, which may be interim, for local hospital and specialist services networks.

- Regional Directors will work within their regions to establish regional clinical networks, work with the National Director to support hospital & specialist service development, monitor regional access and equity of outcomes, and work with their Regional Commissioner counterparts to ensure integration across primary and secondary care is enabled. Regional functions will be established to support information sharing, service planning and sharing of workforce resources, and enable workforce development by coordinating training within each region.

- **Inter District Flows will not be a feature of our system from 1 July** because funding will be allocated based on activity, capacity, and strategic or new initiatives. An alternative process for making costs transparent and visible to all leaders in the network will be established. Regional Directors will establish teams to support the oversight of production planning and capacity management. The enabling functions to support Regional Directors will be confirmed as part of transition.

- While regions are organising constructs, they should not constrain options for local hospitals and networks who may wish to access care elsewhere where there is capacity and better for consumer access (e.g. Taranaki receives care from both Waikato and Midcentral hospitals; similarly, Nelson-Marlborough works closely with the Southern region and Capital & Coast District). This role will enable MHA engagement regionally and Iwi-Māori Partnership Board influence.

  Each district will establish a hospital leadership team. Each hospital and specialist network will retain their local clinical leaders – Chief Medical Officer, Director of Nursing and/or Director of Midwifery, and Director of Allied Health Technical and Scientific Professions.

- We will establish transition workshops in each region to invite clinical, consumer, iwi partners and management leadership to work with us to refine the functions that will be concentrated at a regional level and how to best support local hospital/specialist networks. These workshops will be scheduled for June/July 2022.

- **Executive Director - Procurement and Supplies** will report to the National Director, Hospital & Specialist Services to ensure that the national systems for procurement and supply have the appropriate clinical engagement and monitor performance against expectations for hospital and specialist networks who are the client of this function. A lead DHB Chief Executive will oversee this in the interim. This role will advance the implementation of Health Finance Procurement and Information Management (FPIM) to cover all districts. The Chief Finance Officer will also have a role in the oversight of this national shared service to ensure that the benefit of standardisation and improved coordination of effort is achieved in the hospital & specialist services networks.

Key roles within the Delivery leadership team *continued*

Public Health, Pacific Health and Service Improvement and Innovation

National Director - National Public Health Service

- This role will be appointed to implement the operating model currently being developed by the national public health network. A Joint Officials group is establishing an operating model that integrates 12 Public Health Units currently in DHBs and Te Hiringa Hauora, along with screening and population health functions and COVID-19 functions from the Ministry of Health. This service will have joint management oversight with the MHA. The work undertaken in this process is well advanced and will confirm a structure based on workshops and development with the public health leadership community across the country. Further detail will be made public in May.

- This structure assumes an MHA counterpart who will work with the National Director - National Public Health Service. This business unit will also establish 4 regional directors and 3rd tier roles that incorporate public health protection, promotion, screening and immunisation and prevention services.

National Director - Pacific Health

- This role will be established and appointed to be responsible for Pacific commissioning, workforce development and provider development, and ensure localities are effective for Pacific populations. It is the intention that all Pacific functions within DHBs (both provider arm and commissioning teams) will report to the National Director Pacific Health **but remain locally based**.

- The National Director may establish regional functions where there is critical mass of Pacific populations. The establishment of this business unit ensures that funding flows directly to Pacific providers and communities and delivery is responsive.

National Director - Service Improvement and Innovation

- The purpose of this role is to lead service and model of care changes in our system. The role will achieve this by identifying, in partnership with the MHA, areas of unwarranted variation that should be targeted through national programmes of action to reduce poor outcomes and improve equity and quality of care. It will also establish a platform and processes to enable diffusion and spread of improvement, joint ventures to diffuse proven innovations and support research and evaluation in our operational context.

- The role may also include **health analytics functions** that support a data-driven approach to performance management and internal monitoring. The group will advance shared analytics and business intelligence tools that enable all hospitals and specialist networks, regions and localities to share their performance data and catalyse opportunities for improvement. A national working group will be established to determine the operating model for health intelligence and analytics.

- The National Director for Service Improvement and Innovation will strengthen national **Consumer Networks** to ensure that improvement is led by the voice of consumers. This role and their teams will establish national collaboratives, projects and initiatives across both hospital/specialist and primary/community networks of care.

- This business unit will be the catalyst for improving equity of access by identifying unwarranted variations in care, and establishing programmes to improve and leverage performance intervention levers at both hospital and locality level where progress is slow. The scope of what can be achieved through joining up networks or shifting reporting lines is due to be scoped.

3.3 Enabling leadership team

The role of the 'Enabling' leadership teams is to ensure that frontline delivery services (hospital and specialist services and primary and community care) have the necessary resources to do their job well (e.g. information, funding, capital infrastructure and workforce).
There are four key enabling functions that will support HNZ to deliver on the ambition of the health reforms and provide health services nationally, regionally and locally. These functions ensure we are meeting our budgetary responsibilities, growing our workforce, and building the infrastructure (both physical and digital assets) for the health system.

Enabling functions offer the greatest opportunity for standardisation, consistency and visibility in cost; momentum to build capacity and enable innovation through national coordination; centralisation where it helps maintain pace; and support for rapid delivery and deployment of resources.

Decisions that have been made

The agreed roles for this leadership team will have an agreed Service Level Agreement in place with the Māori Health Authority for support and sharing of functions. The roles include:

Chief Finance Officer

- The Chief Finance Officer will be appointed to oversee the structure and systems for national, regional and district financial management functions. This role works closely with the CFO of the MHA to ensure alignment of financial reporting. The initial view is that all current DHB finance functions and teams will report nationally to the CFO. When appointed, the CFO will lead a national working group with finance teams to confirm the operating model that will ensure responsive business partnership relationships and services are established for regions and localities.

- The CFO will also have an oversight role over Procurement and Supplies. While this function will report to the National Director - Hospital and Specialist Services, to ensure responsiveness to providers the CFO will aim to ensure that national procurement and logistics realise the value from nationalisation, and that standardisation in the right places simplifies the way we work.

Chief People and Culture

- The Chief People and Culture will be appointed to be responsible for ensuring HR business partnerships are well embedded to support regional and local delivery. It is envisaged that the current Human Resource and People and Culture teams will report to this role. A working group with the General Managers, Human Resources in all the entities being merged will be established to develop the operating model. This will include what functions should be established nationally, and the business partnering model to support regional and local delivery.

- Full implementation of current national programmes e.g. Holidays Act remediation, and work with employee organisations to refresh our approach to bargaining (that includes a wider engagement agenda for workforce development, innovation, health, wellbeing and safety) will continue to be supported. Payroll, Employment Relations, Recruitment & Onboarding, Occupational Health, Safety & Wellbeing and Learning & Development will fall under this function. Some of these functions may be regionalised with business partnering in place for local or district based services.

Chief Data and Digital

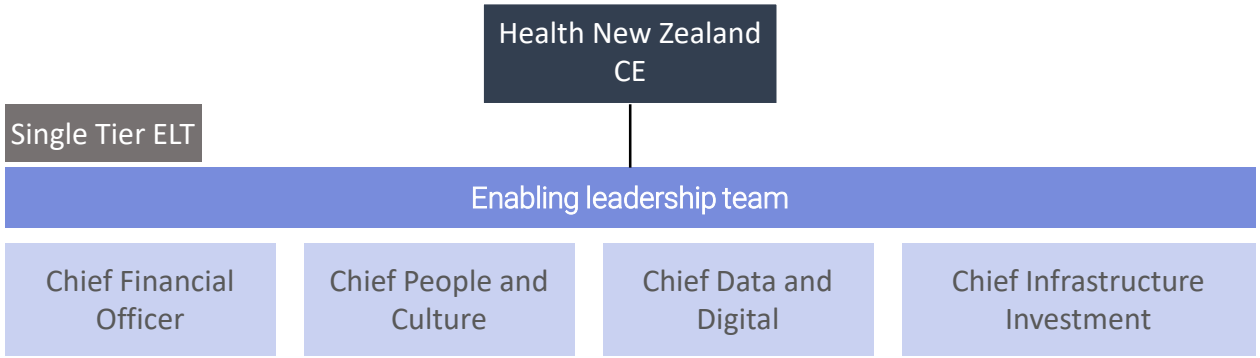
- The focus of national work to date has been to ensure Day 1 implementation of data and digital corporate infrastructure is in place. The Data and Digital directorate from the Ministry of Health, including Sector Operations, has transferred to the HNZ business unit. A working group has been established with an independent Chair to engage all data and digital/IS and IT teams in the entities being merged to develop the operating model for this function. This includes determining what should be led nationally and business partnering models that will enable regional and local delivery. This group will include all Chief Information Officers across DHBs and SSAs. It will provide options on how best to organise large and complex data and digital services to get the best out of our talent, make visible the range of projects underway to identify opportunities for shared learning, and ensure the national priorities for system improvements are achieved. It is important to get the balance right on what should shift to a national level, be regionalised and/or kept local in a way that does not disrupt services and maintains momentum on major capital investments in flight. This function is likely to include digital strategy and investment, corporate ICT, emerging health technologies and innovation functions, plus functions and teams from SSAs.

Key roles within the Enabling leadership team *continued*

Infrastructure Investment

Chief Health Infrastructure

- The Government is seeking a more proactive approach to planning capital, more rapid delivery of projects that are approved, and more transparent visibility of the benefits that can be realised from those investments.
- The Chief Health Infrastructure will manage the infrastructure investment capital pipeline and ensure the execution and delivery of agreed capital projects. The current Health Infrastructure Unit functions have been transferred from the Ministry to HNZ.
- These functions will be strengthened and expanded, and may be integrated with national and regional capacity overseeing capital planning and project execution. This function will be expanded and strengthened as part of the implementation of changes once health capital settings are agreed by Ministers. Its functions include health infrastructure planning, capital investment advice and programme/project delivery. The business unit will also report benefits realisation from investments.
- A working group is to be established with an independent Chair to engage all capital development, design and execution teams to assess how national, regional and local project delivery functions may best be organised. While clinical engineering assets are critical parts of local delivery, the scope of this working group will consider what the opportunities for regional coordination or collaboration may be that do not disrupt local business support for clinical delivery.



3.4 Office of the Chief Executive: Governance and Change team

A series of functions will be established as part of the Office of the Chief Executive. Some of these functions will be fixed term, as we implement the new organisational structure and associated work programmes.

Functions that will sit within the Office include Ministerial and Government support, key compliance and accountability responsibilities such as the corporate secretariat, legal, risk management and privacy.

Decisions that have been made

Key roles within this team include:

Māori Health Authority Executive

- This role will be a nominee from the MHA Chief Executive. They will embed Māori strategic leadership and strong partnership across both organisations. They will work alongside the other mechanisms present to strengthen Māori presence and decision making at all levels of the system.

Executive Director - Change Management Office

- This will be a temporary function to meet our assurance requirements for Day 1 readiness and support the transition process. A Change Management Director will be appointed until 30 June 2023 to manage the transition of all functions. This includes the merger of SSAs.

Executive Director - Governance, Partnerships and Risk

- This role will be appointed to ensure HNZ is able to meet its Parliamentary and Cabinet responsibilities and accountabilities, including transparency requirements such as proactive release policies and OIAs, to support Ministers and Ministers' offices with briefings, parliamentary questions and Select Committees. This team will include Board Secretariat, Chief Legal Counsel, cross-government stakeholder management, and an advice function to support work with relevant policy and regulatory agencies on the operationalisation of policies and regulations that impact HNZ, including briefing the Board and Minister as appropriate.

- This team will be responsible for risk management, internal audit, and supporting HNZ to meet Treasury, Ministry of Health and Board monitoring requirements. This will include tracking HNZ progress against the New Zealand Health Plan from a whole of system perspective.

- **A Chief Advisor, Sustainability** will be appointed as part of this team to advise on how HNZ will achieve the Government's sustainability goals in the health system.

Executive Director - Communication and Engagement

- This role will be appointed and agree an action plan for change communication and engagement. Further work will be done on how to organise national and regional teams for media, communication and engagement with the national group of DHB Communications GMs. We envisage an organisation-wide function that champions trust and confidence in both HNZ and MHA – and the health system more generally. This role will establish the channels that promote transparency across the network.

- **Community voice:** To support this, the Communication and Engagement function will also look to design a communication system that ensures communities and stakeholders are heard, that those communities influence the work and priorities of MHA and HNZ, that effective communication channels are in place to 'close the loop' to ensure health consumer needs are met, and the public is informed about the work ('tell the story') of the two organisations. Where local districts have community forums or councils, those groups will be able to feed directly into the CEO through this role.

- **Community Trusts:** The Communication and Engagement function may also be the point of contact for the more than 50 community and philanthropic trusts that support their local communities' wellbeing. It is the intention of HNZ to continue to support the local responsiveness of those trusts and support their direct relationship with local hospitals and providers.

Strategic Advisor - Disability Support Services

Additionally, an advisor on Disability Support Services will be established to advise the Chief Executive on how the organisation and its services can be more responsive to people with disabilities. This may include supporting the successful implementation of the new Ministry for Disabled People.

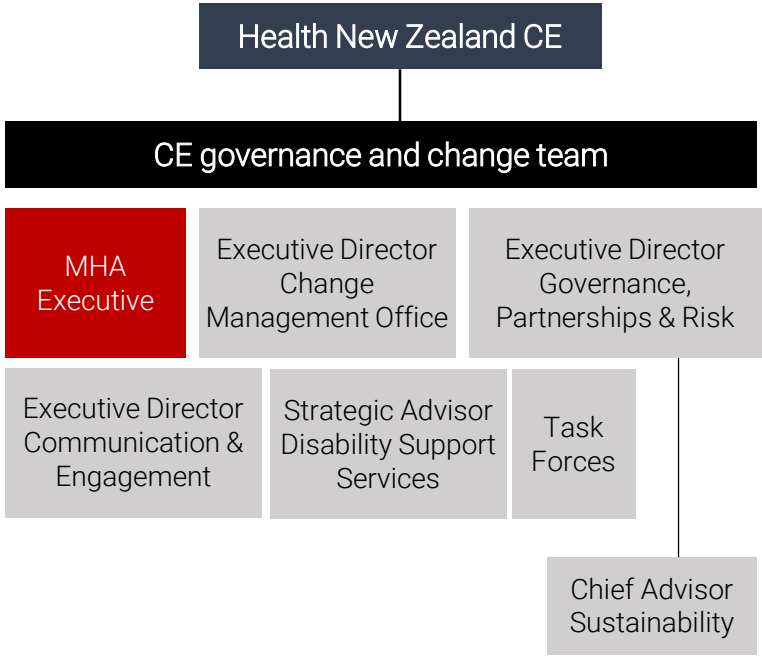
Roles within the Office of the Chief Executive *continued*

Taskforces

Where there are urgent pressures that cannot wait for leadership functions to be established, the CE and the Board will appoint taskforces to make rapid progress on issues. The taskforces may act with the mandate and authority of the CE and the Board to direct and task activity. There are three fixed-term task forces that are in the process of being established in the short term, while the 2nd tier leadership roles are being appointed.

These taskforces are:

1. **The Planned Care taskforce** will centrally coordinate commissioning and engage with clinicians on prioritisation of activity for planned care delivery over the next 12-24 months. This Taskforce will be chaired by an experienced senior leader, to support the taskforce and work with the sector to make sure implementation is consistent across the country. This includes working with private hospital capacity in a more coordinated way, with subspecialty groups to advise on prioritisation and primary and community provider networks to add capacity to specialist assessment pathways. This Taskforce will be established until national and regional roles and functions are in place to take responsibility and accountability for delivery.
2. **The Workforce taskforce,** with a National Lead, will agree the key priority interventions for immediate workforce expansions where service failure is at risk if the workforce is not supported in the short term. This Taskforce will work with employee organisations, relevant union partners, tertiary training institutions and professional regulators to accelerate the need for trained workforce in priority service areas while national strategic workforce initiatives are being implemented.
3. **The Immunisation taskforce** aims to increase the uptake of seasonal flu and childhood immunisations. This will provide added protection to the system during winter. This Taskforce aims to work with existing ways of working established by the COVID-19 response, sustaining and continuing those models effective for COVID-19 vaccination to increase influenza, childhood immunisations and MMR vaccine uptake among young people. This includes community-based provider models that have reached out to Maori, Pacific, rural and other population groups.



The Māori Health Authority's organisational structure

4. Māori Health Authority

An effective health system for Māori and all New Zealanders requires the MHA to provide system leadership and direction, ensuring the system delivers high quality and equitable outcomes. To ensure this occurs, the MHA has a broad strategic remit to ensure the health system works well for Māori and all groups.

Information about the Māori Health Authority

The Māori Health Authority is responsible for:

- leading change in the way the entire health system understands and responds to Māori health needs
- developing strategy and policy which will drive better health outcomes for Māori, including advice to Ministers
- commissioning kaupapa Māori services and other services targeting Māori communities
- co-commissioning other services alongside HNZ
- monitoring the overall performance of the system to reduce health inequities for Māori.

Partnership with Māori and the integration of Māori voices into health planning and priorities will be an essential feature of the new system. Partnership and engagement with Pacific people, other communities and consumers of Health services in governance, prioritisation, planning and commissioning will also be essential to achieve equity of outcomes.

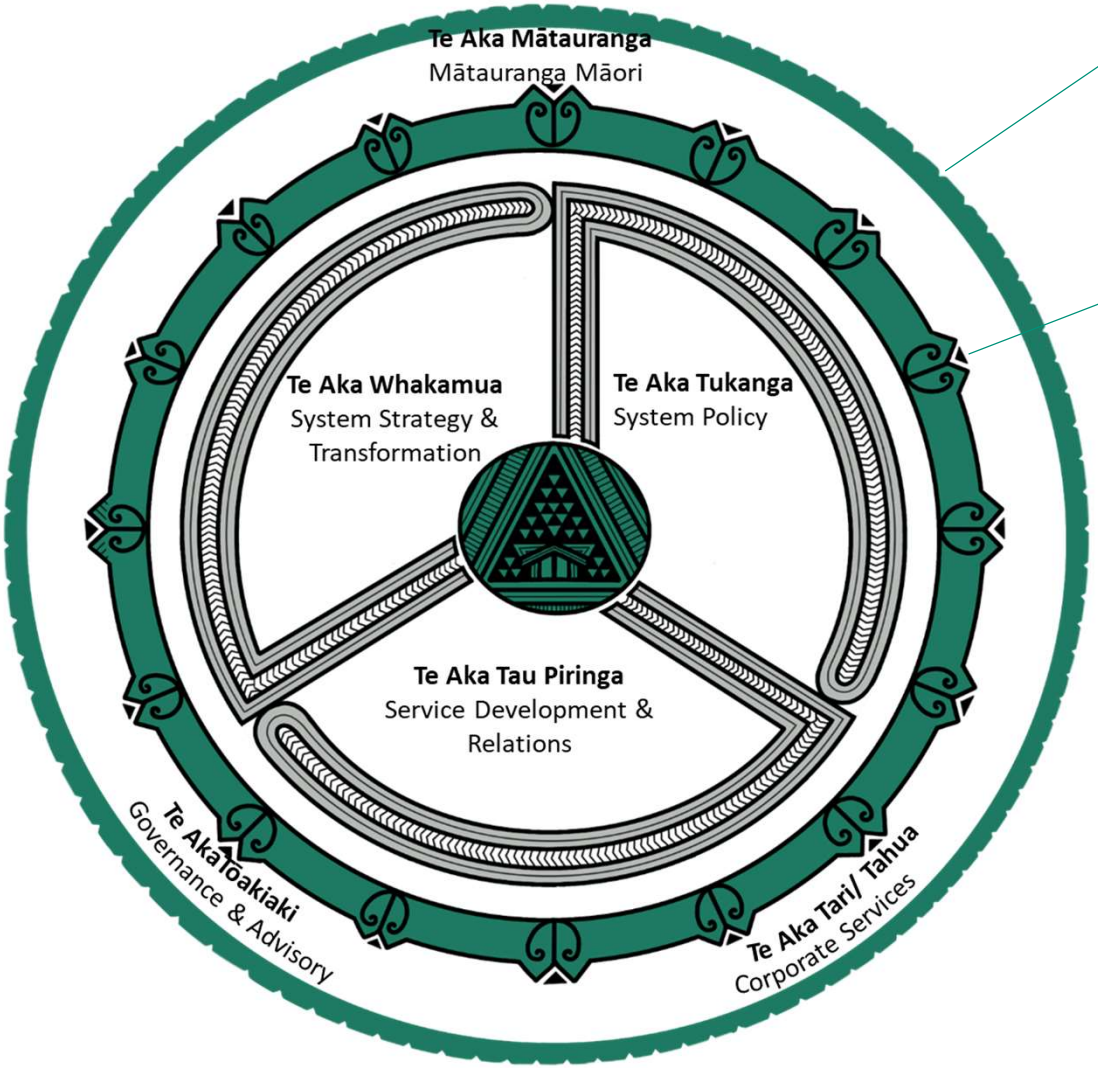
The Māori Health Authority cannot achieve this on its own

- The MHA will have a co-leadership role, jointly leading and agreeing with HNZ the national planning and key operating mechanisms that the system will use.
- The system needs to ensure that hauora Māori and Māori Health equity are front and centre in operations across our system – from the Ministry to hospitals, and across localities, kaupapa Māori providers, iwi and Māori providers and Māori communities. To do so, there is a clear requirement that outcomes and expectations for Māori health gains are set nationally and embedded into the objectives and accountabilities of HNZ, so that all Health services are designed and delivered in support of equity and in line with our Te Tiriti o Waitangi obligations.
- Iwi-Māori Partnership Boards (IMPBs) are a key feature of the reformed system. IMPBs will have decision-making roles at a local level, and jointly agree local priorities and delivery with Health New Zealand. They will also be the primary source of whānau voice in the system and be able to influence regional strategies through the MHA.
- From 1 July all Māori health functions within entities will transition to HNZ as part of its establishment. A working group will be established as a joint venture between MHA and HNZ to develop the operating model for MHA that may include the shifting of certain Māori health functions from HNZ to MHA. This will provide capacity for MHA to support commissioning and Māori health providers, and progress the establishment of delivery models that are responsive to Māori health needs. This group will be led by the MHA senior executives in joint leadership with HNZ.

The proposed future organisational structure for the Māori Health Authority

Our 16-point wind compass

- The MHA's proposed future organisational structure has been designed along functional lines and the five core functional building blocks. It has been organised into six proposed directorates, depicted by a sixteen-point wind compass.
- The organisational structure supports the analogy of a waka hourua on a journey to Pae Tawhiti using the traditional compass to help navigate. The design of the MHA on the traditional compass provides clear direction and purpose.



a. **Whakairo:** The first/outer porowhita depicts our people and is illustrated through the notches that our carvers make when developing our whakairo. This represents our **Te Aka Tari/Tahua** (Corporate Services) including finance, people and capability, our organisational (internal) facing strategy and performance management, and our shared services agreement with HNZ for back-office function delivery.

b. **Manu, Mangopare:** This porowhita depicts the manu and mako that were often tohu on our journeys. They provided insight and confirmation that our destination was near. This represents two key groups:

   i. **Te Aka Mātauranga** (Mātauranga Māori) is about a Māori way of being and engaging in the world. In its simplest form, it uses kawa (cultural practices) and tikanga (cultural principles) to critique, examine, analyse and understand the world. It is based on ancient values of the spiritual realm of Te Ao Mārama (the cosmic family of the natural world) and it is constantly evolving as Māori continue to make sense of their human existence within the world. The purpose of this group is to provide internal support to staff and the board with Mātauranga Māori, including tikanga and te reo coordination, supporting external communications, and providing leadership and direction to support MHA in the pursuit of its vision and objectives.

   ii. **Te Aka Tōakiaki** (Governance and Advisory), led by a DCE who will also be our Chief of Staff, exists to provide direct support to the Chief Executive and provide advisory, ministerial and executive services for the wider organisation. This group will be responsible for Board governance, organisational governance, ministerial services, communications and engagement and house the office of the Chief Executive.

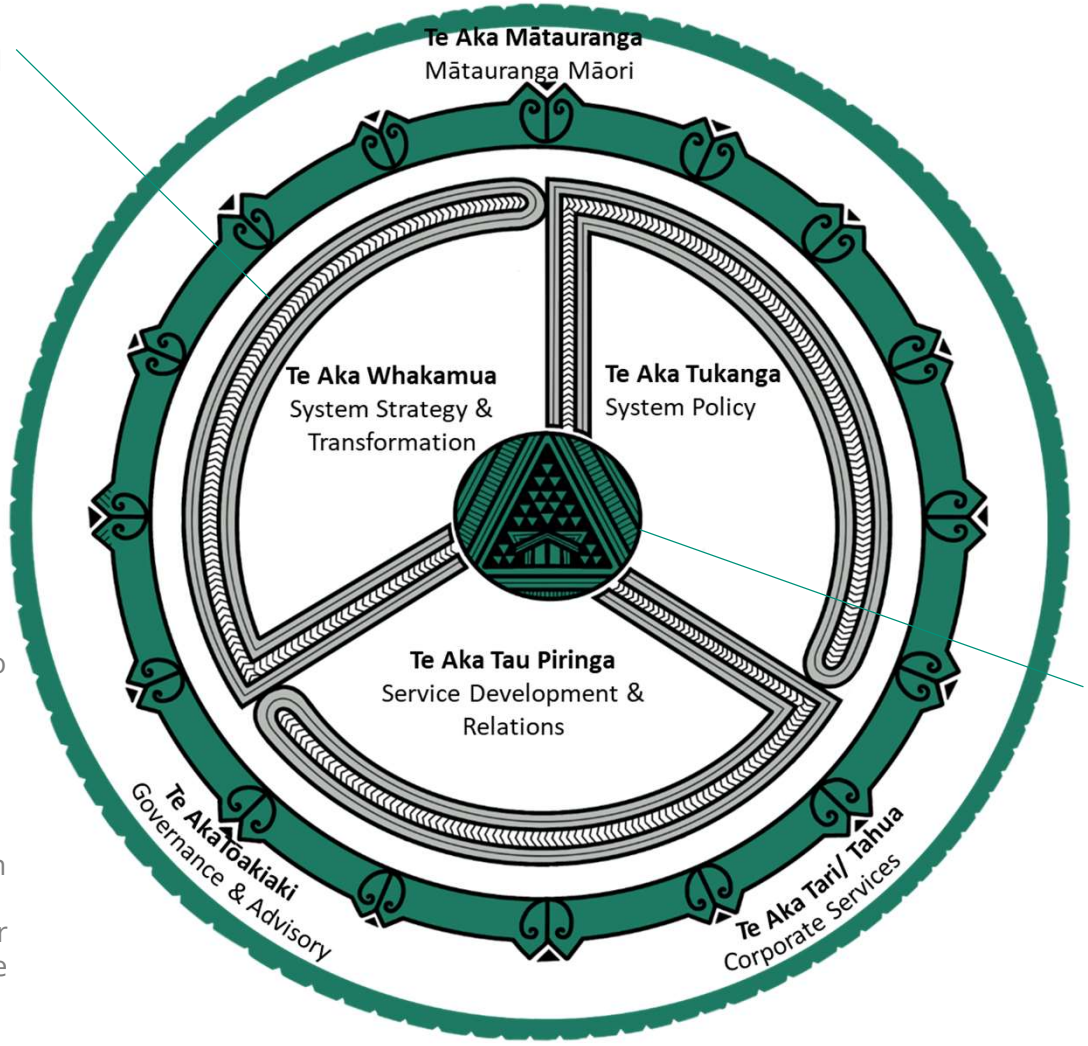
The proposed future organisational structure for the Māori Health Authority

Our 16-point wind compass

Haehae Pākiti: This porowhita depicts our fences and/or the pā tū that surround our kāinga. It also demonstrates direction and how we constantly move to address the needs of our organisation and journey. This concept is applied to our three organisational delivery groups:

i. **Te Aka Whakamua** (System Strategy and Transformation) will align the different components of the Health Sector and broader system around a set of shared objectives and priorities to achieve MHA's vision, and to encourage and enable delivery against them. They will lead strategy for hauora Māori, deliver hauora Māori research, evaluation and innovation, partner with HNZ on national health planning and will monitor the performance of the health system for equitable Māori health outcomes.

ii. **Te Aka Tukanga** (System Policy) exists to provide policy and strategic advice to the Minister on matters relevant to Hauora Māori (s.19(1)(h) Pae Ora Bill) to advance Oranga Whānau & achieve equity. They will drive system change to ensure the wider health system delivers for Māori, in a way that works for Māori, and influence all of government outcomes for Māori beyond the Health Sector to create environments that support Māori to be well and thrive. They will also lead strategic and operational updates for the Lead Minister.



iii. **Te Aka Tau Piringa** (Service Development and Relations) will span a range of delivery areas. Focus will be to design and invest in health services that work for Māori by ensuring strong iwi partnerships, developing a thriving Māori workforce, and funding Te Ao services. As such, this group will be responsible for the commissioning (co-commissioning, direct commissioning and partnered commissioning) of Te Ao Māori solutions, developing the Māori provider workforce, and establishing, supporting and maintaining Iwi-Māori Partnership Boards. Specific service-related functions in this group will include Primary and Community Care, Public Health, Oranga Hinengaro and Hospital and Specialist Services. This group will also include our regional relationship managers to co-lead with HNZ.

Pae Tawhiti/Pae ora: The final porowhita addresses our destination and in this illustration you can see the elements of our maunga, moana, awa and our wharenui/marae/waharoa. While this is not an organisational function of the MHA, it is our purpose and represents the requirements that once we reach our destination, we must walk through the doors of our whare and realise the desired outcomes.

4.1 Māori Health Authority further design work in progress

Over the coming months we will continue to design our operating environment, particularly our commissioning and co-commissioning responsibilities and regional structures with HNZ.

Additional information on the Māori Health Authority's commissioning responsibilities

The Māori Health Authority is continuing to work on the design for its regional operations and commissioning functions.

Regional working

- Regional managers / leadership will continue to evolve to determine how they will work with their regional counterparts at HNZ, including commissioners to shape and form strategy, monitor hospital delivery and operate cohesively as a region.

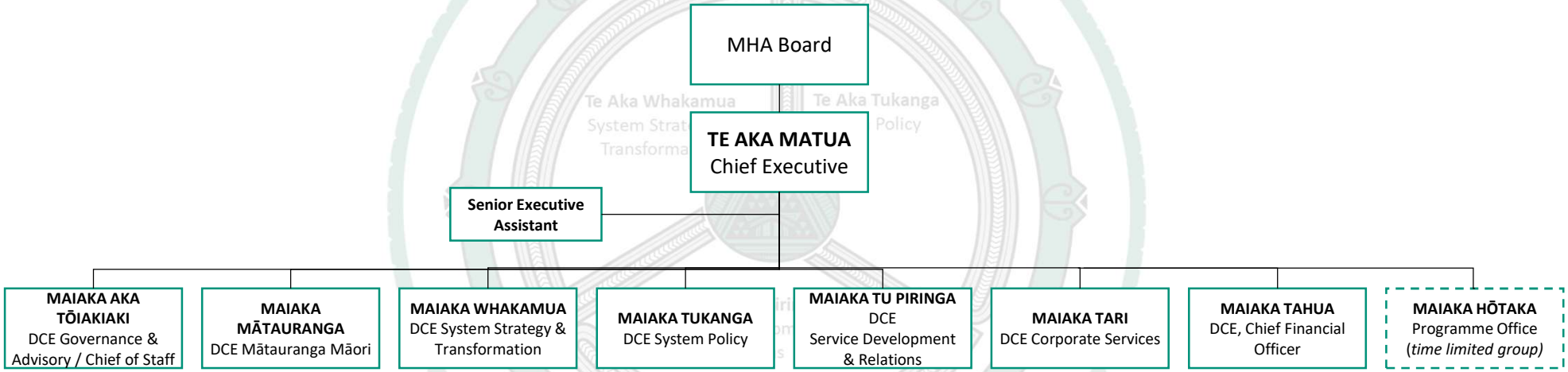
Commissioning

- MHA commissioning functions will directly fund and direct the provision of kaupapa Māori services and other services targeted at Māori communities, whether directly and/or jointly with HNZ.
- The MHA will also lead on nationwide Māori provider development and the expansion of kaupapa Māori services, as well as having a strong mandate to encourage and invest in innovation in delivery of local services and new service models to meet Māori Health needs.
- The MHA will have co-commissioning functions with HNZ in those services that have a significant impact on Māori Health outcomes. This includes, for instance, primary health services, population health screening and immunisation programmes. While HNZ will lead on operational matters relating to general health service commissioning, this responsibility will clearly entail delivery of improved health outcomes and equity for Māori. The MHA would influence and agree these intended outcomes, set services expectations and initiatives to reduce bias, undertake monitoring, engage with iwi/Māori and approve final plans and resource allocation.
- To ensure the MHA is sufficiently empowered, for instance if the services commissioned fail to deliver intended outcomes for Māori or address inequity, the MHA has an escalation pathway for resolution that could ultimately reach the Minister. Discharging the roles of a commissioner, co-commissioning and strategic system monitor will afford the MHA an unprecedented position with relation to hauora Māori.

The proposed future leadership structure for the Māori Health Authority

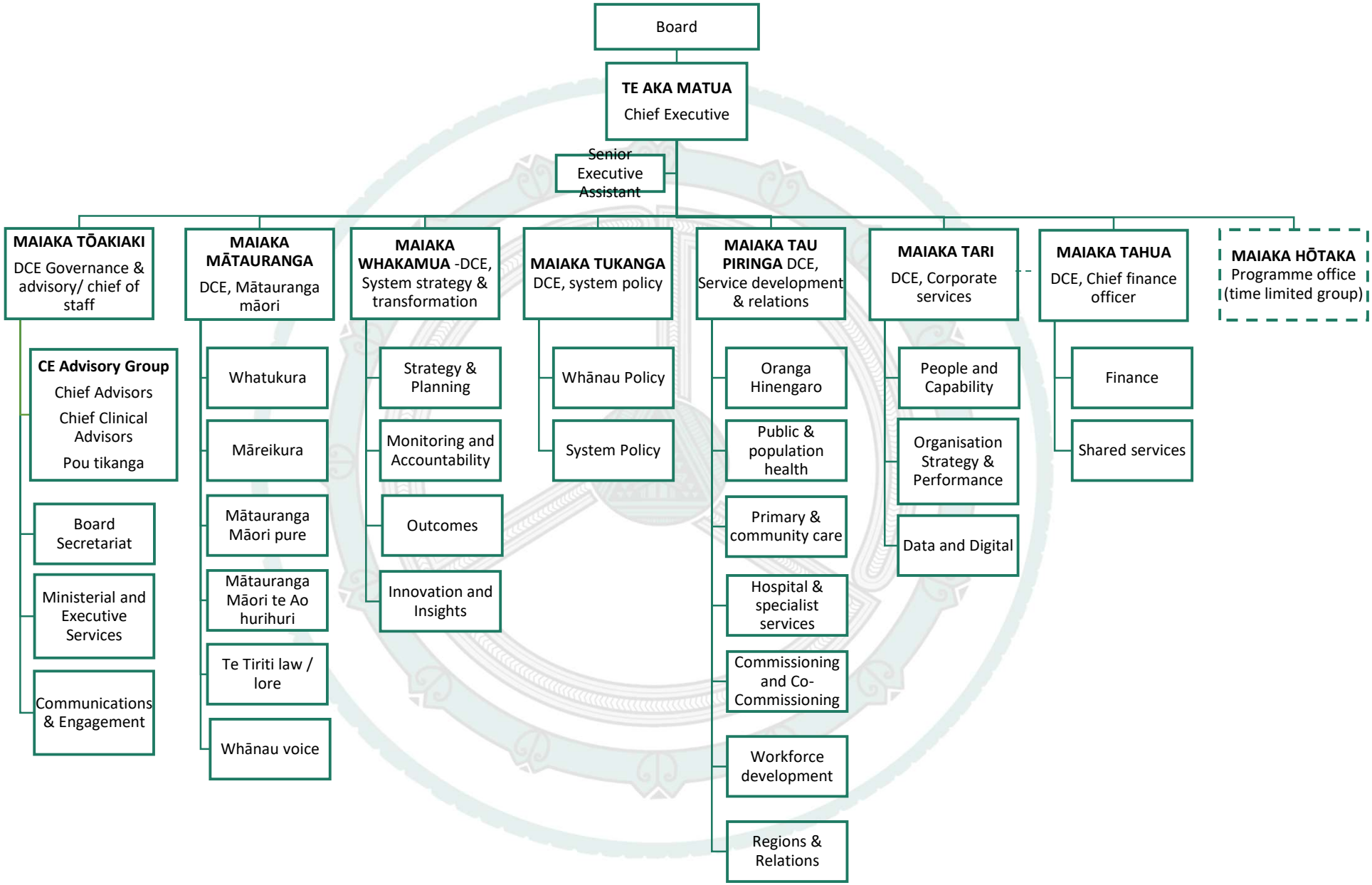
MHA Proposed organisation structure

- The MHA proposed organisation structure has been designed based on a 16-point wind compass to depict our anticipated work flow. While the standard organisational diagram doesn't feature in our design on purpose, we have provided one for shared understanding of the intended national leadership form and function of the MHA.



Interim Maori Health Authority

Our initial national organisation functional design



Note: We are continuing to work on the design of our regional and local structure in partnership with Health New Zealand and will communicate this in due course

5. System shifts and putting it together

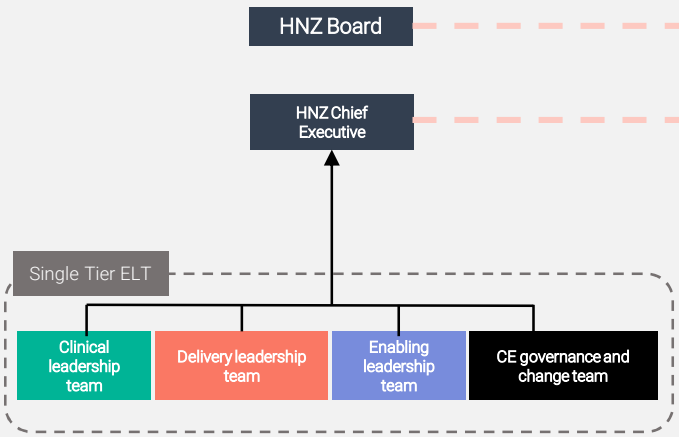
The Māori Health Authority also has a role to monitor HNZ delivery in partnership with the Ministry of Health.

To achieve the desired impact on Māori in some areas, the MHA and HNZ will have mechanisms for working together at all levels of both organisations.

Some of these mechanisms are part of the overarching system accountability framework, such as the Government Position Statement and the New Zealand Health Plan.

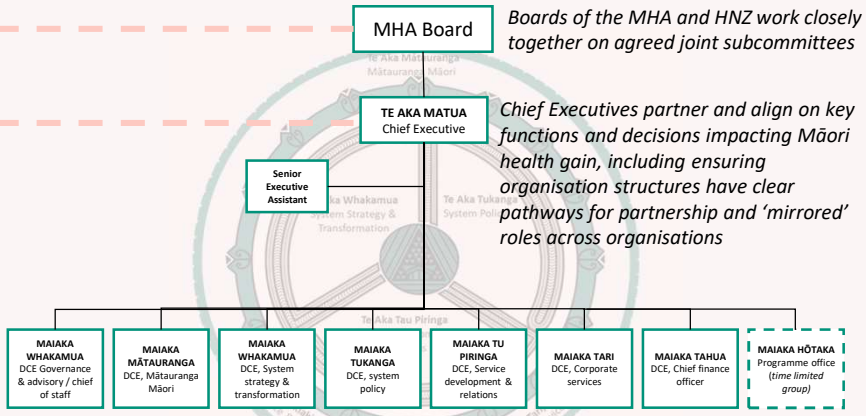
Health New Zealand and the Māori Health Authority will work together at multiple levels

Health New Zealand



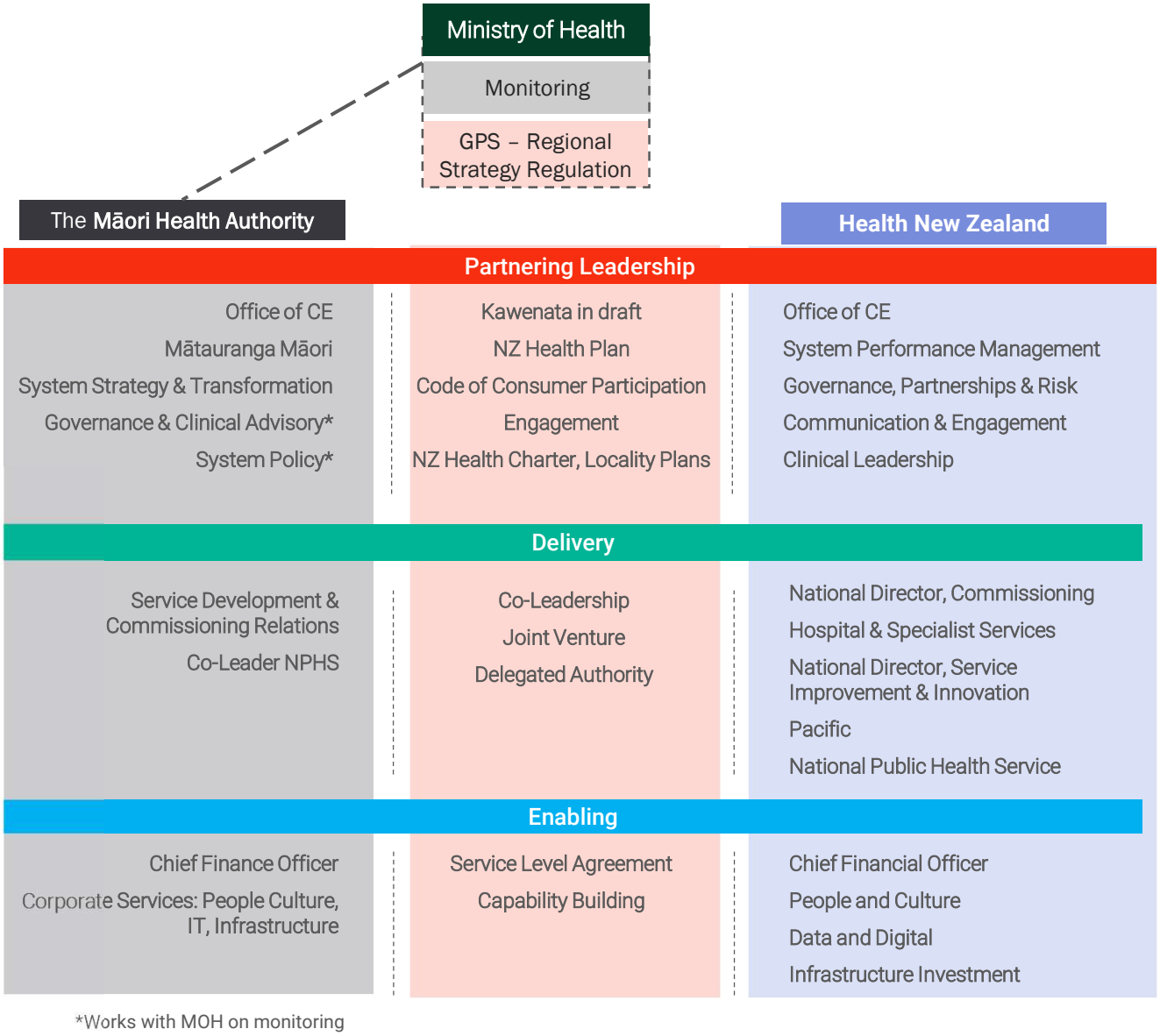
- Delivery and Leadership Teams work jointly with MHA counterparts
- MHA Executive role present in the Governance and Change team to ensure alignment and partnership

Māori Health Authority



- Some roles will have a partner in the MHA and some functions will agree a joint work programme with the MHA to ensure opportunities for Māori health gain are embedded.
  These include:
  - The National Commissioner
  - National Public Health Service
  - Innovation and Improvement
  - Roles within the regional management board

Putting it into practice



*Works with MOH on monitoring

5.2 Regional and local level functions

A number of assumptions were made by Cabinet on the regional and local level functions of both Health New Zealand and the Māori Health Authority.

Ongoing operating model development and organisation design builds on these assumptions to create something fit for purpose and that will deliver the transformation promised by the reforms.

Decisions that have been made by Cabinet relating to regional functionality

Assumptions around regional and local level functions include:

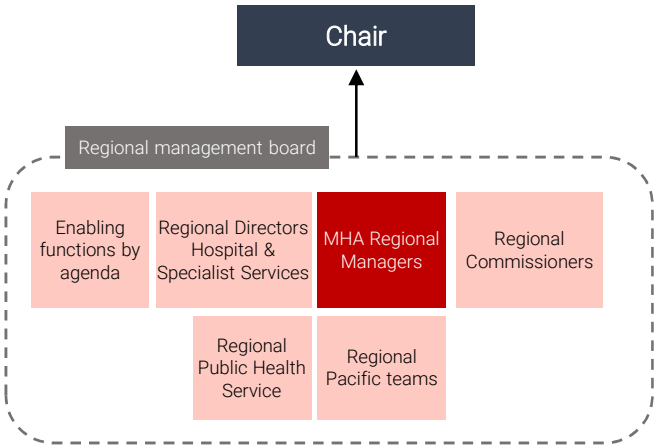
- HNZ and the MHA will work together at a regional level.
- HNZ will have **four regional divisions.** Each of these divisions will have two distinct arms:
    1. Commissioning primary and community services
    2. Managing the delivery of health services
- The HNZ regions will establish, within a national framework, analytics, monitoring, contract management and integration of planning for primary, community and hospital services.
- Each region will establish district offices that are located closer to communities. District offices will act as "population health and wellbeing networks". These District Offices will also be supported by the National Public Health Service regional leads.
- The MHA will have regional teams, co-located with HNZ and embedded in regional management arrangements to ensure partnership, with approval rights for all relevant strategies and plans at the regional and locality level.
- IMPBs will be able to voice the aspirations and priorities of Māori communities, agree locality plans and influence regionally through their relationship with the MHA.
- Primary and community care will, over time, serve communities through locality networks. Every locality will have a consistent range of core services, but how these services are delivered will be based on the needs and priorities of local communities.

How will regions work?

Regional integration through Regional Management Boards

Integration in the regions will be achieved by HNZ and the MHA establishing a regional management board that brings together the key regional leadership functions. The Regional Board may be chaired by the HNZ/MHA CE or a delegated Regional Director. This is to be determined. Together, the regional management board may undertake a whole of regional population health needs analysis to inform commissioning. We will undertake regional workshops with clinical, service and provider leadership to co-design how the region will work together. Functions brought together through this management board may include:

- **Enabling Regional Leaders**: business partner to enable delivery, achieve national consistency and spread of national guidance, provide capability for intelligence and analytics to support service planning and its delivery, support workforce development and people leadership, be responsible for delivery of major capital works* in region.
- **Regional Commissioners:** within delegations, commissioners fund regional and local provision of services consistent with the NZ Health Plan and service coverage expectations. They plan services, monitor, and performance manage variations in delivery. They commission private hospital capacity and are the direct reporting line for Locality leadership, supporting relationships with primary and community providers and leading regional service planning.
- **Regional Directors Hospital & Specialist Services:** potentially serve as the direct reporting line for local hospital and specialist service leaders. They establish a regional view of production capacity and its deployment, regionalise workforce development (e.g. training, clinical, education partnerships), identify variations in equity of access (shared wait lists) and deploy resources to address this, support clinical networks input to regional clinical service development, integrate capital planning for hospitals aligned with service planning** and lead execution of major capital works*. There is a presence of business partner support from enabling functions in this function.
- Regional Directors will work with National Clinical Leaders to establish, lead and manage regional clinical networks and their leadership in service planning, performance monitoring and outcome impacts, engage consumer views, establish MDTs and ensure input to capital and service developments.
- **Māori Health Authority regional managers** work with their HNZ counterparts to translate national Māori health priorities, support iwi engagement at the regional level, form the direct reporting line for local IMPB support teams and input priority equity gain initiatives. They also enable regional commissioning of Māori capacity and capability.
- **Regional Pacific teams** will be determined by the relevant operating model working group. This role may commission and locally deploy resources to Pacific providers and build their capacity for service provision. Working with the Regional Commissioner, they may commission services and form the reporting line for local Pacific teams within hospitals and coordinate their workforce with the Hospital & Specialist Services role.
- **Regional Public Health Service** will integrate public and population health input to regional decision making, service planning and integration to ensure equity of outcomes in population health programmes. They will also provide public health protection and health promotion services to the region, unifying public health units regionally to support workforce growth, health promotion and population health programmes in localities.
- The region may have programmes of action that drive the spread and diffusion of nationally-prioritised improvement and innovation and implement regionally-agreed initiatives across the system i.e. prevention, primary and community care, hospital/specialist, coordinate regional consumer voice networks.



*Joint responsibility between Regional Leader and Regional Hospital & Specialist Services
** Led by the Regional Commissioner with input from Hospital & Specialist Services and community-based providers

District integration through locality networks

Interfaces with IMPBs, Districts, Hospitals and Localities

Integration will be facilitated with and through district partners (in the interim, the current DHB areas). This may be part of the role of regional commissioners to chair and hold local relationships.

Key relationships and partners include:

Enablers business partner with local leaders to ensure resources are allocated appropriately and local managers and clinical leaders are supported through regional teams (i.e. HR). These regional teams provide local intelligence and analytics to support local/district planning and performance management, capital planning, procurement and logistics, and data and digital innovations.

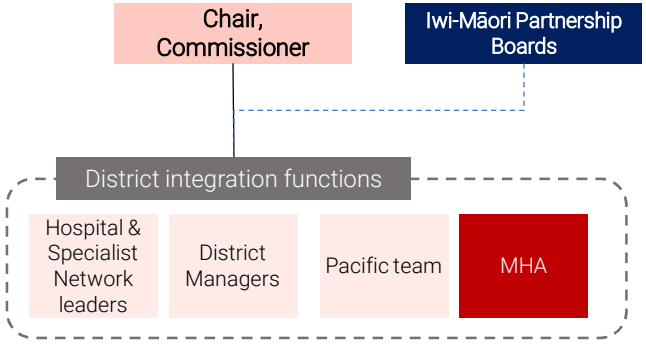
Hospital & Specialist Network leaders manage, lead and are accountable for hospital and specialist network delivery including community-based healthcare e.g. district nursing and services provided in community hubs. They also support regional clinical networks and service planning, manage acute demand, input to capital planning to support future growth and development, ensure and assure quality and safety of delivery, work with local commissioners and Māori partners to ensure responsiveness, and work with primary and community partners to support service integration, flow, and equity initiatives.

District Managers, under delegation of Regional Commissioners, manage local funding, work with and engage local provider networks and partners, support Locality networks including engagement and use of consumer voices in locality plans, integrate with hospital and specialist services, pool budgets and hold funding to support local initiatives.

Iwi-Māori Partnership Boards do not formally come into effect until 1 July 2022; however, as tangata whenua they are expected to partner in planning around health priorities and services at the Locality level within their rohe or coverage area; ensure the voices of whānau Māori are made visible within the health system; and embed mātauranga Māori within locality plans, which then influence and inform regional and national planning.

Pacific teams, where appropriate (i.e. dependent on population size and scale), work with local partners to support provider networks and Pacific access to services, and engage Pacific communities and consumers.

Consumer-led Innovation and Improvement support execution of national improvement and innovation priorities e.g. population health programmes, system flow initiatives such as acute demand, ambulatory care access, and support and enable whole-of-system engagement at the local level of consumer.



6. Next steps

1. “Sprints” to develop operating models will be established.

2. Recruitment for 2nd tier roles will commence.

Change Management

The Change Management Office is being established to work to the CEs of both HNZ and MHA. The CMO will oversee a portfolio of workstreams where each function will establish a working group to develop the next layer of detailed operating model, including functions that will be established nationally, regionally and locally, and an implementation plan.

Working groups will have independent Chairs and will include members from outside the health system to provide us with challenge and fresh perspectives. Working groups will be asked to ‘sprint’ or dedicate concentrated time to develop these models within 12 weeks or 3 months. Those workstreams are attached as Appendix 2. This is not a complete list and more may be added as the operating model needs of HNZ and MHA evolve.

The membership and contribution to working groups will be coordinated through national groups that bring together current DHB leaders and outside thinking for fresh perspectives. Some groups have been established e.g. Procurement and Supplies (working with Shared Services), and Data & Digital (working with CIOs in DHBs and Shared Services) and Hospital & Specialist Services. Remaining workstreams are in the process of being populated and established. We will publish regular updates and communications on how those groups are progressing on our website.

Channels for feedback, frequently asked questions and answers will be put in place to enable all interested groups to participate and offer advice. The interim websites are in place as a regular place for updates to be provided: **mha.govt.nz** and **hnz.govt.nz**

Selection and appointment process

Recruitment for 2nd tier leadership roles will commence immediately. The key leadership attributes we are seeking from those leaders are:

- The ability to work collaboratively as a Te Tiriti partner on behalf of the Crown, aligned with the values outlined in the Charter, and to proactively lead on initiatives and improvements that enable actions on equity;
- To be a whole-of-systems thinker, who can deliver and work across boundaries to break silos, and make collaboration across functional and geographical boundaries the easy and right thing to do;
- Able to engage people and support their leadership teams to work in partnership with their workforces and representatives to improve how we work and spread proven innovations effectively; and
- To value diversity of thought and experience in their teams with particular emphasis on services, users (consumers) and local/community-based experiences.

Mana and Kerridge & Partners have been engaged to deliver an external lens to the recruitment process. All roles will be contestable and advertised publicly.

Appendix A | Workstreams draft

A number of workstreams have been identified where further thinking and engagement must occur to progress operating model development.

Some streams have already been or are about to be established to begin their '12-week sprint'.

Summary of workstreams for ongoing operating model development

Leadership Function	Workstream
Māori Health Leadership and establishment of functions in the Māori Health Authority	Māori Health capacity and capability (to be established with Tumu Whakarae)
National and Regional Clinical Leadership	Clinical Leadership and Governance, Clinical Network Establishment, National Quality & Safety System establishment
Delivery Leadership	Hospital & Specialist (advisory group in place to be formalised as a working group)
	Commissioning (to be established)
	National Public Health Service (established and in progress)
	Service Improvement and Innovation (to be established)
	Pacific Health (to be established)
	System intelligence and analytics (to be established)
	Procurement & Supplies (established and in progress)
Enabling Leadership	Finance (to be established)
	People & Culture (to be established)
	Data & Digital (established and in progress)
	Health Infrastructure (established and in progress)
	Corporate Services – Sector Facing (audit and compliance, risk – to be established)
Integration	Regional and District functions (to be established)

Appendix B | Summary of functions transfer to HNZ

The aim is that most functions will transfer to the interim agencies in advance of 1 July 2022, which will help set up the new agencies for success.

Shared Service Agencies (SSAs) coming into HNZ

- NZ Health Partnerships Limited
- Central Region's Technical Advisory Services Limited (TAS)
- Health Alliance NZ Limited
- Health Source
- Northern Regional Alliance
- HealthShare Limited
- South Island Shared Service Agency Limited

We note that under the legislation Te Hiringa Hauora (HPA) will be disestablished and assumed by Health New Zealand. Some roles from Te Hiringa Hauora will transfer to the Public Health Agency (i.e. those working on the alcohol and advice functions).

Many individual DHBs also own or have joint ventures in organisations specific to their local needs. Ownership of these entities will transfer to HNZ as part of the transfers of DHB assets.

Functions already transferred from the Ministry of Health to iHNZ and iMHA

Teams within the following Ministry of Health functions have already transferred to iHNZ

- DHB Performance and Support
- Health Workforce
- Pacific Health
- System Strategy & Policy
- Data & Digital
- Infrastructure

In addition, the Māori Health Team Service Improvement (commissioning) team has transferred from MoH to iMHA.

Appendix B | Summary of functions transfer to HNZ

The aim is that most functions will transfer to the interim agencies in advance of 1 July 2022, which will help set up the new agencies for success.

Phase 2: Upcoming Function Transfers from Ministry of Health to iHNZ

- There will be further functions transferring from 1 June, but for now the immediate focus is on 1 May.
- The following table shows the directorates and business groups or teams from which positions (around 325) will be transferring to the interim entities from 1 May 2022.
- **Please note:** this does not mean that all positions within those busines groups are transferring. Everyone in a position that is transferring will have already been advised.

Directorate	Positions transferring from these business groups
Health System Innovation and Improvement	• Primary Health Care System Improvement and Innovation • Community Health System Improvement and Innovation
Population Health and Prevention	• Child and Community Health • Clinicians Screening • National Screening Unit • Population Health Programmes • Public Health • Office of the Deputy Director General
Infrastructure	• Investment Strategy (timing to be confirmed)
Health Workforce	• Health Workforce Commissioning • Analytics and Intelligence • Implementation • Employment Relations • Health Workforce Chief Advisors • Office of the Deputy Director-General
DHB Performance	• DHB Planning and Accountability
Data and Digital	• Security
Corporate Services	• Audit and Compliance • Facilities (1FTE)