



# Policy in the Ministry of Health

**First class policy • first class health outcomes**

## Decision Document

15 December 2010



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# Foreword

As incoming Director-General, one of my first tasks will be to continue implementing the decisions in this review of the Ministry's policy function.

It is vitally important that we deliver high-quality policy advice that is valued by our Ministers. I am committed to achieving this goal, and I believe that a single, dedicated Policy Business Unit is the best structure for delivering it. These decisions will also help us develop the leadership culture and capability that is the essential basis for first-class policy advice.

I understand that many of you contributed to the review process, and I thank you for that – the practical implementation issues that you raised are welcomed, and I know that your views have been carefully considered.

I was fortunate to be able to have some input into the review process, and I am familiar and comfortable with the report findings and decisions.

This review is an investment in our future – it provides the framework for us to deliver worthwhile change. The challenge now is for us to make it work.

Change is never easy, and some of you who are directly affected will face challenges and potentially difficult decisions in the weeks ahead. I wish you all the best as you work through your individual situations.

I look forward to joining you early in the New Year and getting to work on turning these decisions into action.

Kind Regards

Kevin Woods  
Director-General Designate  
Ministry of Health  
15 December 2010

# Introduction

This document presents the final decisions that will shape the future of policy within the Ministry of Health. Implementing the decisions in this document will deliver excellent policy advice – advice that will be more effectively and efficiently produced and more clearly driven by a strong strategic direction.

I want to thank you for your constructive and forthright participation in the review process. Your input has shaped the thinking in positive ways and led to a more robust programme of change. This document outlines the ways specific proposals have been amended to reflect your feedback.

## Achieving first-class policy advice

High quality policy advice is essential to the Ministry's purpose and credibility. We need to consistently do an excellent job so that we gain the confidence of Ministers and positively influence health outcomes.

The MartinJenkins assessment of the Ministry's policy advice made a number of conclusions as a result of assessing internal documentation and interviews with staff and external stakeholders (including Minister and central agencies). These are set out fully in the consultation document but the essence of their conclusion is that we do not develop strong public policy advice on health and disability issues as often as we need to. The review was initiated in response to expectations that something would be done sooner rather than later to change this state of affairs.

## Going Forward

I am looking forward to us working together to build a Policy Business Unit that actively encourages and builds the capability of staff, nurturing the craft of providing policy advice to government and delivering first class policy.

Over the next 2-3 years we need to create a policy function that has the following characteristics:

- responsiveness to Ministers and the Government, providing policy options, creative ideas and free and frank advice; anticipating issues and providing advice proactively
- collaboration across the Ministry, ensuring that key policy initiatives are developed in a way that incorporates input from all parts of the Ministry that have something to contribute; the quality of our advice is underpinned by excellent policy analysis skills, a strong evidence base, and the right technical input
- a clear view on policy priorities across the Ministry; active prioritisation of our work, so we are working on issues of long-term importance to Government and the sector
- making decisions and delivering on agreed priorities, avoiding processes and convoluted procedures that don't add value but cause frustration and delay.

Feedback from consultation with staff underscored the need to develop a tangible, well-prioritised and phased plan to address the critical drivers of performance beyond structure. I agree entirely. Therefore, developing a clear, holistic plan is a priority. Key elements of a proposed plan are signalled in section four of this document. Clearly we cannot deliver all aspects of this plan at once. We will need to build the right platform of leadership, culture, capability and structure and

ensure it is embedded. It is critical that this plan is owned by you, so it will be developed in the early part of next year with your input, through a number of forums.

As discussed in question and answer sessions with you, I emphasised that a revised organisational structure is only an initial enabler for driving improved policy performance. It is an important first step because it provides a single focussed policy group with a critical mass accountable for the development of policy advice within the organisation, as well as supporting 'professionalism' in policy and creating clearer accountabilities. However, the real changes in performance will not be seen unless we also build a collaborative, innovative and service-oriented culture and strengthen our capability. These elements need to be supported by the right operating models and governance.

The decisions will be put into action next year, coinciding with the arrival of the new Director-General. This provides an opportunity for genuine change – the new Director-General supports the decisions, and he will participate in pivotal appointment processes. He is committed to focusing on leadership, culture and capability and intends to give full support to these important areas as well as making sure that the structural changes are implemented smoothly.

Regards

A handwritten signature in black ink, appearing to read 'A. C. Bridgman', written in a cursive style.

Andrew Bridgman  
Acting Director-General  
Ministry of Health  
15 December 2010

# 1. Executive summary

This decision document sets out the decisions made following two consultation phases. The decisions draw on submissions from Ministry staff on the best way forward for the Ministry. Other inputs, including comments from staff in the question and answer sessions and comments from central agencies, informed the decisions. Full details of the change process and support that is available to you is outlined in this document.

Accompanying this decision document is a separate document detailing the impact of the changes. I recommend that you read both documents together to fully understand the changes.

The blueprint for change is wide-ranging and encompasses changes to culture, capability, leadership, strategy, systems and structure. While different components of the whole may be implemented at different times, it is important that they be seen as an overall package – no component can stand on its own.

An integrated approach requires shifts across a range of dimensions. Figure 1 below summarises the changes that will be needed to achieve the desired end point.

## Moving from the current state to the future state

**Figure 1: Current and future state**

Current State	Change	Future State
Silos and fragmented thinking sometimes driven by individual clinical areas of interest; tendency towards advocacy; reactive/slow to re-prioritise; not enough focus on Minister as a key client	<b>CULTURE</b> Clear expectations about behaviours, re-balanced skill mix, apprenticeship model, space for strategic thinking, strengthened leadership and accountability	Valuing the policy trade, critical thinking, forward thinking, responsiveness, working towards common goals
Overall lack of understanding of machinery of government, poorly written outputs, lack of specialist skills	<b>CAPABILITY</b> Professional development focused on building policy skills, seniors to mentor juniors; recruitment to focus on filling capability gaps	High quality, well evidenced outputs with clear recommendations; general policy skills supported by high quality input – health economists and technical/ clinical perspectives
Policy direction and priorities not clear or commonly agreed; lack of influence in the wider social sector; variable communication with key stakeholders	<b>LEADERSHIP AND STRATEGIC MANAGEMENT</b> ELT to set clear direction and priorities and to explicitly own and govern the work programme, stronger management culture and practices	Clear direction and prioritisation for the Ministry and the Sector; influential across the social sector; pride and ownership in the work of the Ministry
Unclear accountability for decisions and inadequate quality assurance allowing low quality papers to be released	<b>SYSTEMS</b> Strengthened quality assurance, simplified accountability; appropriate allocation of responsibility for quality outputs and widespread buy-in	Consistent high quality outputs, informed by coherent frameworks, clear priorities and strong evidence
Policy function fragmented and dispersed, strong subject based silos, lack of common definitions / frameworks, poor communication between policy teams, inadequate resourcing for strategic thinking, inflexibility in resourcing	<b>STRUCTURE</b> Strategic, systems and population health policy integrated into a single business unit, supported by a group providing high quality intelligence	Integration of key policy groups into a Policy business unit, with a strong mandate to set the policy direction and agenda; clear separation from operational policy and implementation

To achieve the shifts envisaged above, we need to exhibit strong leadership and a renewed focus on what we are trying to accomplish. The changes outlined in this document are designed to give us renewed confidence and credibility to genuinely lead policy for the sector.

## **Key aspects of the way forward**

### ***Approach to developing leadership, culture, capability and systems to support first class policy***

To improve our policy advice, we need to change a range of dimensions that influence the way we work. There is support for strengthening the Ministry's policy leadership and moving towards a more innovative and collaborative culture, with stronger capability and systems.

Completing this process will take several years. Initially we need to target the areas that are important foundations and progressively build on these. Improvements to the Ministry's policy leadership, including governance, are a critical first step and will set the scene for other changes, including to structure and staffing, by positively influencing an improved culture and giving clarity around our strategic direction. The arrival of the new Director-General will coincide with this renewed focus on leadership.

The Ministry needs to develop a well-prioritised, integrated and phased plan for development that addresses the different components. All policy staff (and staff interfacing with policy) need to be involved in the development of this plan. The plan needs to be tangible, and timed to not detract from delivery of the policy work programme. A three year programme will be developed early in the New Year. This will outline a series of phased initiatives designed to create the required shifts in the Ministry's policy leadership, capability, culture and systems.

### ***Policy Business Unit***

A Policy Business Unit will be established. Its role is to provide policy advice to our Minister/s and carry out related policy functions in the Ministry's areas of responsibility. The Policy Business Unit will house the vast majority of the Ministry's policy functions, and will comprise six third tier groups:

- Strategy
- Populations Policy
- Sector and Services Policy
- Health and Disability Intelligence
- Committee Support
- Business Services

The groups reflect the composition of the Policy Business Unit as it will be on 'day one' of the new structure. Divisions may change over time. In particular, there will need to be greater flexibility in our approach to deploying policy resources within and across the core policy groups of Populations Policy, and Sector and Services Policy. This is required to ensure that broader policy skills are built to complement our technical knowledge. The design of the policy groups and teams aims to avoid the trap of fragmenting our policy functions too much – lack of flexibility to respond to changing needs is one of our current problems to be addressed. In the future, policy analysts will be expected to translate their policy skills across different topic areas and projects and be adoptive and agile to ensure that we adequately resource changing priorities as they occur.

### ***Clinical Leadership, Protection and Regulation Business Unit***

A Clinical Leadership, Protection and Regulation Business Unit will also be established. Its roles are: providing clinical leadership within the Ministry and externally; ensuring regulatory obligations and functions are fulfilled; and carrying out a range of critical health protection functions, including some required by legislation. This Business Unit will be led by a Chief Medical Officer, supported by a General Manager.

### ***Chief Nurse***

The role of Chief Nurse will be established to provide professional leadership within the Ministry and the sector, and will also sit on ELT. The Chief Nurse will report directly to the Director-General, and will have a small group of staff to support the Chief Nurse role. The Chief Nurse will also be involved in, or lead, specific projects or programmes of work, as agreed with the Director-General.

### ***Impacts on other parts of the Ministry***

The separation of policy from other functions impacts on other parts of the Ministry – Sector Capability and Implementation, National Health Board, and Corporate Services. Each of these Business Units will receive some additional functions as a result of this review. The impacts on these Business Units are summarised in section 4 of this document.

### ***Ensuring clinical and technical support for policy development***

Submissions noted the importance of clinical and technical input into policy development. The establishment of a single Policy Business Unit, and the transparency of its work programme – to the whole of the Ministry – will make it easier to ensure the right clinical or specialist engagement occurs on issues that need that type of engagement. This is vital for credible and effective policy. This support for policy will be provided through a variety of means, including direct involvement of specialist expertise in particular projects. This includes expertise to be obtained as required through external clinical networks facilitated by the Chief Medical Officer, Chief Nurse, and a Clinical Leadership Group. The Chief Advisors will also continue to play a key role in policy development, alongside the new clinical leadership roles of the CMO and Chief Nurse.

## 2. Outline of the decision document

The decision document summarises the key decisions on the way forward to improve the quality of our policy advice. The change process will commence as soon as possible to bring the new structure into effect early next year, and to ensure the continuation of our work programme. We will work closely with all affected staff to provide them with as much support as possible.

Accompanying this decision document is a separate document detailing the impact of the changes, full details of the change process and support available to you. I recommend that you read both documents together to fully understand the impact of the changes.

The decision document summarises the key decisions I have made following the two consultation phases. The decisions draw on submissions from Ministry staff as well as other inputs on the best way forward for the Ministry, including comments from central agencies on the first consultation document.

The key sections of the report are:

### ***Section 3 - Changes following consultation***

This section provides an overview of the decisions and includes:

- an overview of the changes to be implemented within the Ministry
- a table summarising the key questions and responses raised in the submissions and responses
- a diagram presenting the confirmed structure for the Ministry's policy functions, in the context of the wider Ministry.

### ***Section 4 - Detailed decisions***

This section gives the detail behind the decisions and includes:

- non-structural elements: decisions relating to developing leadership, culture, capability and systems to support first class policy
- structural elements: details of decisions relating to specific Business Units, including:
  - confirmed roles and functions for groups
  - key linkages and relationships
  - summary of changes from the design proposed in the consultation documents for specific groups/units.

### ***Section 5 - Timeline for implementation and support***

#### ***Appendices***

- summary of themes that emerged from consultation
- design principles that informed the structural choices.

# 3. Changes following consultation

## Overview

Around 100 submissions were received on the Phase 1 proposals, and around 60 on the Phase 2 proposals. These included individual and group submissions. I was very pleased with the response to the consultation process - submissions were both comprehensive and constructive. I want to sincerely thank everyone who contributed their thoughts, time and effort.

In addition to staff submissions, a joint comment supporting the proposals contained in the first consultation document was received from the three central agencies. This endorsed the proposed direction and approach as well as making a number of suggestions.

There was a large range of feedback from staff on issues spanning all dimensions of the review, and a number of common themes emerged. A summary of submission themes is included in Appendix 1.

There was significant feedback acknowledging the current problem – that the Ministry is not seen as the leading player in the provision of health advice to the Minister, and that as an organisation we need to make changes. There was overall support for the establishment of a single business unit within the Ministry responsible for the development and provision of policy advice to Ministers. There was also a lot of support for the idea of creating a business unit led by a Chief Medical Officer, and for elevating the role of Chief Nurse to Tier 2. This was seen as supporting a strong Ministry-wide clinical leadership focus. Key issues were raised around the grouping of functions under these roles, as well as a number of practical considerations around how the arrangements would work.

Submissions relating to non-structural proposals contained widespread acknowledgement of the identified issues and support for constructive change. Feedback was clear that these proposals are vitally important to support changes made to the Ministry's structure, and that they must be well-supported and resourced to achieve real change.

On issues of organisational design, the feedback provided detail that has helped to challenge and test the proposed approach that was consulted on. The feedback on structure related to:

- the grouping of functions
- the location of functions within different Business Units
- clarity about functions and accountabilities (including the need to avoid duplication and overlap)
- composition of teams and staffing levels.

Several revisions to the design have been made to bring it into line with these realities, particularly the need for the structure to support close internal relationships and connections between certain functions, and to cluster 'like' functions and accountabilities together more effectively.

Some submitters suggested alternative structural options. These have been considered carefully and adopted in a number of areas.

Cross-cutting relationships are required no matter what structure is in place. It is important that we ensure that relationships are preserved and built across branches and groups, supported by a strong collaborative culture and collective leadership by ELT. Working positively together and sharing information constructively will be key to ensuring this is achieved.

## Summary of key issues and responses

The table below briefly summarises the key questions and choices raised in submissions and my response to these. Further details about decisions are contained in Section four - see Tables 5 and 6 in particular.

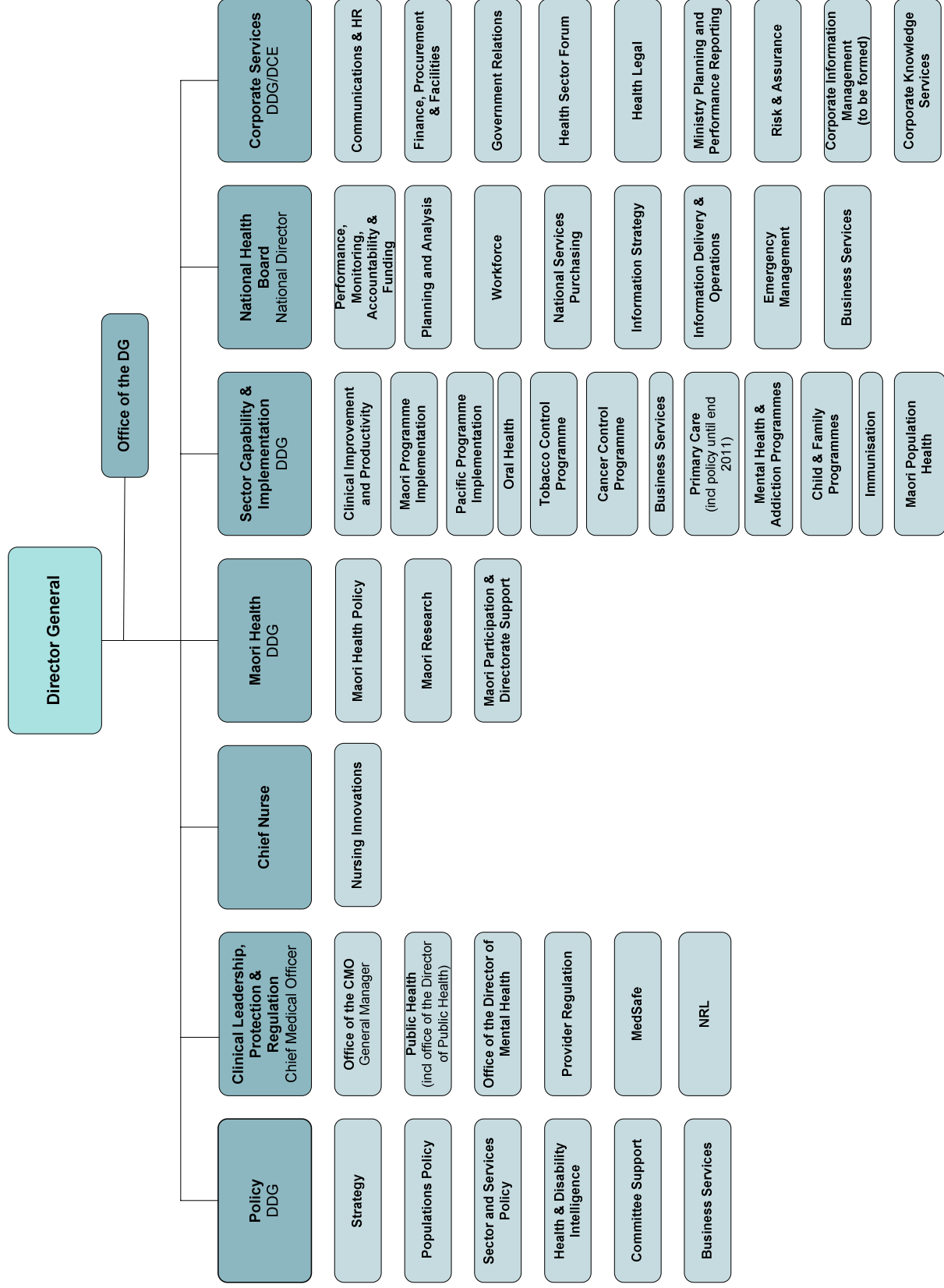
**Table 1: Summary of key issues and responses**

Issue	Change?	Decision
<b>General issues</b>		
Should the Population Health Policy group be subdivided into smaller groups?	Change	Yes. The functions of the originally proposed Population Health Policy Group will be subdivided into two groups: Populations Policy and Sector and Services Policy
<b>Issues relating to the Strategy Group</b>		
Should the Strategy Group be located in an Office of the Director-General or in the Policy Business Unit?	No change	The Strategy Group will be located in the Policy Business Unit as proposed
Should the Strategy Group or Corporate Services lead the Ministry's strategic planning?	No change	Ministry Planning and Performance Reporting in Corporate Services will continue to lead Ministry planning
Should there be a direct reporting line for the Chief Economist to the DDG Policy?	No change	The Chief Economist will report to the Group Manager, Strategy but will sit on the Management team for the Policy Business Unit and provide advice across the Policy Business Unit and to other Business Units
Should the functions of the proposed Strategy Group and System Policy Group be merged?	Change	Yes. Merge some functions of the proposed Systems Policy Group into the Strategy Group; merge other functions into the Sector and Services Policy group
Should there be a higher ratio of junior staff than proposed?	Change	Yes. The Strategy Group will comprise a balance of senior and less senior roles
<b>Issues relating to the location of particular policy functions</b>		
Where should national drug policy functions be located?	No change	Locate majority of national drug policy functions in Policy Business Unit as proposed

Where should Maori population health programmes be located?	Change	Responsibility for Maori population health programme implementation functions will rest with SCI
Where should mental health policy be located?	Change	Locate mental health policy functions in the Populations Policy group in the Policy Business Unit
Where should nutrition and physical activity functions be located?	Change	Locate nutrition and physical activity functions will be located in the Public Health group, CLPR Business Unit
Where should screening functions be located?	Change	Locate screening policy functions in the Policy Business Unit
Where should functions relating to older people be located?	Change	Locate policy functions relating to older people in the Populations Policy group, Policy Business Unit.
Where should functions related to child, youth and maternity be located?	Partial Change	Child, youth and maternity policy will be located in the Policy Business Unit; some operational functions will be located in a Child and Family team in SCI
Where should disability policy and other functions be located?	Partial Change	Locate disability policy in Policy Business Unit, positions to work closely with the Disability Support Services group in the NHB to implement the new model of care for disability support.
<b>Issues relating to committee support</b>		
Where should committee support be located?	Change	Locate policy committee support functions in the Policy Business Unit; locate support for the Cancer Control Council and Ethics Committees in the Clinical Leadership, Protection and Regulation Business Unit. Separate arrangements will be made for the transfer of Mortality Committee functions to the Health, Quality and Safety Commission by the end of February 2011.
<b>Issues relating to the Clinical Leadership, Protection and Regulation Business Unit (referred to as 'CMO Business Unit' in the consultation documents)</b>		
Should emergency management functions be located in NHB or CLPR?	No change	Locate emergency management functions in NHB
Should there be separate clinical leadership and protection vs regulation Business Units?	No change	Locate clinical leadership, protection and regulation functions together in a single Business Unit
Should the Population Health Chief Advisors be located in the Policy Business Unit or in CLPR?	Change	Locate chief advisors in CLPR reporting to the CMO.
Should mental health protection functions be located in SCI or in CLPR?	Change	Locate mental health protection functions in the Office of the Director of Mental Health in CLPR Business Unit

Where should Provider Regulation be located?	Change	Locate Provider Regulation in the CLPR Business Unit
Should public health legislation review functions be located in PBU or CLPR?	Clarify	Locate public health legislation functions in the Office of the Director of Public Health, with the focus of the team to be on the provision of advice on the administration of legislation.

Figure 2: Final Structure



## 4. Detailed Decisions

### Approach to developing leadership, culture, capability and systems to support first class policy

To achieve real change, improvements must be made in the way we work. Changes to our operating model and governance are needed to support changes to organisational structure. Neither will create lasting improvements to our work without the other.

Your submissions and comment from the central agencies demonstrated strong support for proposals to change the way we work. There was support for strengthening the Ministry's policy leadership and moving towards a more innovative and collaborative culture, with enhanced capability and systems.

Changing the way we work cannot be achieved overnight, and I expect the process will take several years. To begin the process, we need to target important areas as foundations and progressively build on these. Improvements to the Ministry's policy leadership, including governance, are a critical first step and will set the scene for other changes over time. The arrival of the new Director-General will coincide with this renewed focus on leadership, bringing even more vigour to this important task.

The Ministry needs to develop a well-prioritised, integrated and phased development plan that addresses the different components. The plan needs to be tangible, and timed to not detract from delivery of the policy work programme. The table at the end of this section provides details about key elements of a draft plan. A comprehensive three-year programme will be developed early in the New Year, outlining a series of phased initiatives designed to create the required shifts in the Ministry's policy leadership, capability, culture and systems. We will need to build the right platform of leadership, culture, capability and structure and ensure it is embedded. It is critical that this plan is owned by you - a Policy Staff Advisory Group will be established to help support and oversee the development and implementation of this work programme.

### Leadership and strategic management

There are a number of talented and committed leaders in the Ministry, currently operating within a management system that does not make optimum use of their talents. Strengthening and clarifying governance arrangements, ensuring that the right people are involved in making the right decisions at the right time, will give the Ministry's policy a focus and direction that is currently lacking. The submissions strongly validated the identified leadership issues and supported the need to strengthen our policy leadership.

### Consultation feedback and decisions

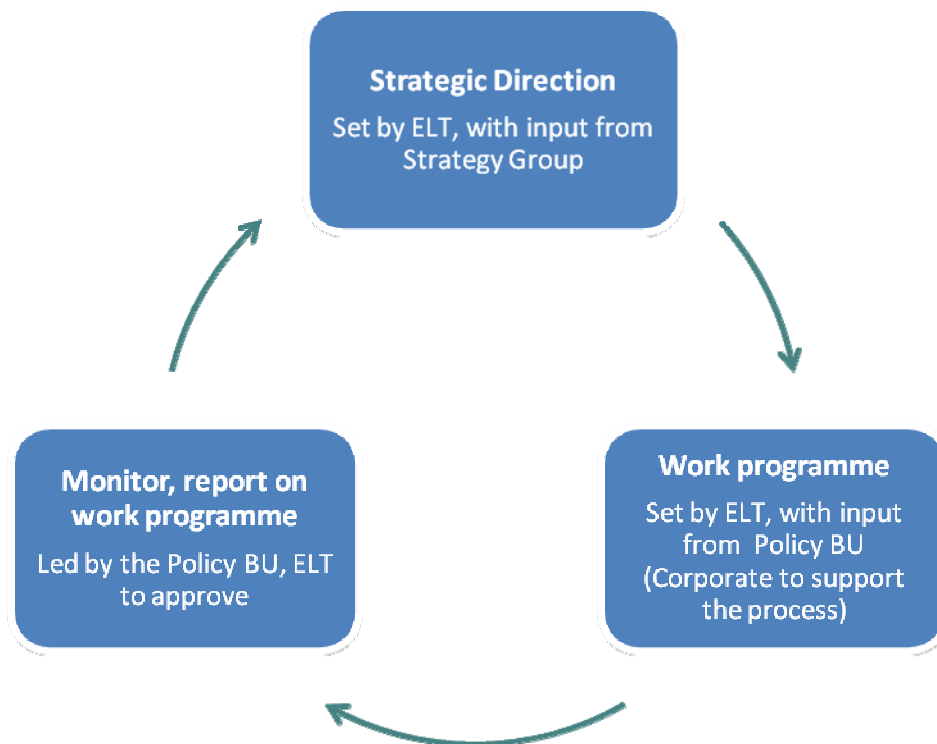
#### ***The Executive Leadership Team***

The Executive Leadership Team (ELT) is the primary leadership vehicle for the Ministry. As such it needs to provide a clear, consistent direction for the Ministry's policy focus. ELT needs to be responsible for setting the strategic direction and prioritising the overall work programme. The Strategy Group and the Corporate Services' Business Unit will ensure that ELT has the information

and tools to do this, but ELT will be required to own the process and judgements about direction and priorities. ELT will be expected to communicate consistent messages to the Ministry and demonstrate constructive, facilitative working relationships. It is not acceptable for staff to receive conflicting messages about priorities.

Tightening our focus to areas of highest strategic importance will ensure the Ministry has a strong influence across the wider health and social sectors. Prioritising our work programme more effectively will help us to produce higher quality policy advice, strengthening our position as a key advisor to the Minister and the health and disability sectors. ELT will also be expected to provide clear and consistent frameworks for policy development.

**Figure 3: strong direction and prioritisation to be set by ELT**



### ***Clinical leadership and policy development***

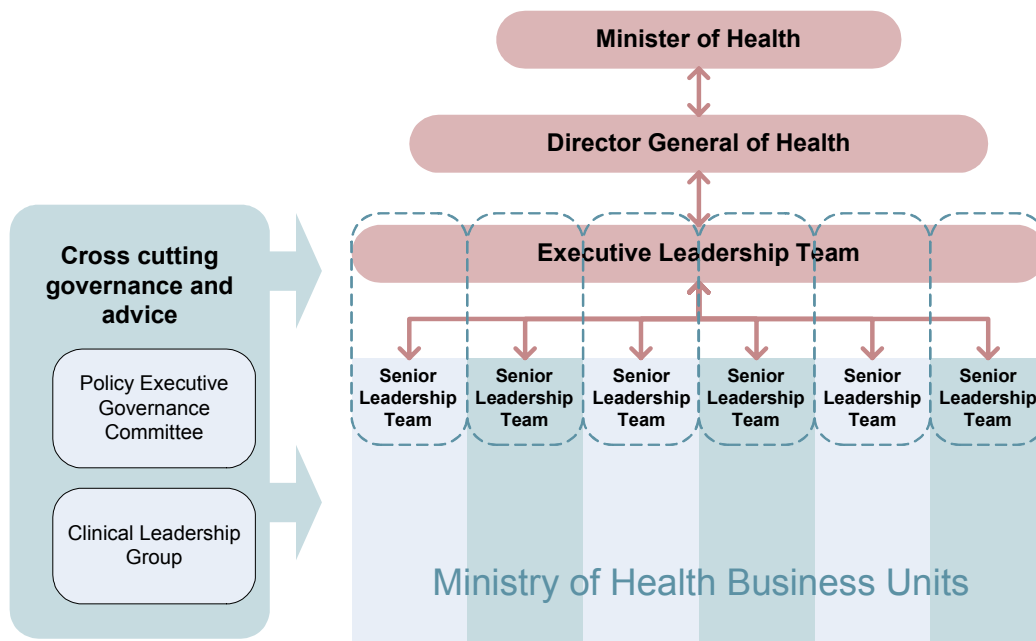
Submissions also strongly supported strengthening clinical leadership at ELT level, with the addition of the Chief Medical Officer and Chief Nurse welcomed. Active clinical leadership at the very top decision-making level will ensure that clinical perspectives inform the Ministry's strategic direction and prioritisation of the work programme. This will enhance the credibility of the Ministry's decision-making and relationships with key stakeholders across the Ministry and in the wider sector.

### ***Policy leadership and governance***

While ELT provides overall direction to the Ministry, policy leadership responsibilities also need to be clarified at other levels, with accountabilities, linkages and information flows between different groups and roles clearly delineated. Figure 4 shows the key governance and leadership relationships relating to policy that will be developed within the Ministry.

- ELT is at the centre of the diagram, showing the importance of its role in aligning the Ministry's work with the Minister's requirements. As outlined above, it will do this through setting a clear strategic direction and priorities for the Ministry, informed by appropriate and timely input and advice.
- Detailed consideration is being given to the Ministry's internal governance arrangements as part of Project Phoenix, including the type of committees the Ministry should have and their respective roles and functions. As part of this work consideration will be given to the establishment of:
  - a Policy Executive Governance Committee, to oversee the coordination and delivery of the policy work programme, taking an end-to-end view from policy formation through to implementation
  - a Clinical Leadership Group, to proactively ensure that appropriate clinical input is incorporated into policy from the beginning of the policy-making process. The group will include clinical advisors and the CMO and Chief Nurse as rotating chairs. It will also manage clinical relationships with the wider health and disability sectors.

**Figure 4: Policy leadership and governance in the Ministry**



## **Culture, capability and systems**

There are excellent networks and many positive ways of working within the Ministry. There are also many positive initiatives occurring in the Ministry that aim to improve the quality of policy advice. It is important that we build on these good examples while spreading a collaborative, effective approach to work across the Policy Business Unit and the wider Ministry. A process will be set up to identify the critical factors that underpinned our previous policy successes in the way we have worked to get the job done well. This will ensure we learn from what has worked so we embed our successes more widely.

## **Consultation feedback and decisions**

### **Culture and systems**

The Ministry culture needs to move to explicitly valuing and promoting quality policy analysis, with a widespread recognition of the Minister as the primary client. This will require maintaining health and disability sector linkages and input, serving the needs of the Minister, and looking towards long term strategic priorities.

Submissions generally agreed with the issues identified around the Ministry's culture and systems and that these areas require improvement. However clear feedback was given that improvements to culture and systems will require effort and resource allocation. Cultural change is also intrinsically linked to leadership. The style of leadership is a powerful influence on organisational culture. For this reason, leadership issues are being prioritised, with complementary initiatives to improve culture and systems being developed alongside this.

Improved leadership, resulting in clarity of direction, consistent prioritisation, and holding people accountable for quality, will inevitably change the way we work and produce policy. Clear and consistent signals around priorities will enable staff to produce the policy required by Ministers. Ensuring this is done efficiently requires coordination, networking and quality information inputs. Co-locating policy staff through structural changes will have immediate, positive impacts on workplace culture. Policy staff will be able to network and share information more readily.

Submissions also highlighted the need to make information more easily available, with lack of quality information commonly identified as a hindrance to quality work. Specific changes to overcome this are:

- more staff to be given the opportunity to have direct contact with Ministers (Tier 4 managers and seniors/principals leading work should be able to attend Ministerial meetings wherever possible)
- internal communications such as data and completed reports need to be more accessible.

Communication needs to be timely, persuasive, predictable and transparent. Details on how changes will be achieved are outlined in the table at the end of this section.

## **Quality assurance and systems**

There was general agreement that accountability for decision-making and quality assurance within the Ministry is confused, unwieldy and at times ineffective. In future, appropriate levels of accountability for quality will be explicit in performance agreements for all levels of policy staff.

The Internal Cabinet Paper Committee (ICPC) is an effective vehicle for improving the quality of advice to Cabinet, provided it is utilised and employed in a timely way. The ICPC will remain and continue to be resourced so it can perform its function adequately (i.e., through appropriate senior staff being given sufficient time to meet and review papers as required). Ensuring the quality of papers other than Cabinet papers is outside of the ICPC's scope. It is not acceptable that low quality papers be released by the Ministry under any circumstances, so peer review procedures for any externally released paper (including Cabinet papers) need to be improved.

Guidelines will be developed to outline sign-off procedures for different types of papers. Once agreed, it is expected that all papers will be signed out accordingly, with signatories being ultimately accountable for quality.

## **Capability**

### ***Generic policy skills to be prioritised within the Policy Business Unit, well supported by clinical input***

Submissions gave a wide range of perspectives on the Ministry's policy writing capability. A common concern was the proposal to build the skill mix to focus on generic policy skills. Sound public policy skills are not developed at the expense of specialist understanding in a particular field, although sound public policy skills are essential to providing policy advice. Our focus must be the production of high quality policy advice. Our policy analysts need an excellent understanding of the machinery of government and the policy process in general. To perform their jobs effectively, policy analysts need to write papers that contain a clear problem definition, summarise issues succinctly and provide robust options for Ministers.

Many submitters believe that the policy process within the health and disability fields require specialist inputs to be well informed. I agree with this. Clinical, technical and operational expertise needed to inform all our policy development, and it is important that this is done in a timely, proactive and professional way. It is not intended that these linkages be lost - rather, the structural and governance changes will improve these linkages. The changes will ensure that input is neither ad-hoc nor dependent on individual networks. Good quality input will ensure that policy advisors continue to build their own knowledge of health and disability issues as they grow networks and develop subject-based knowledge.

The structural changes are designed in part to improve the Ministry's clinical leadership. Key clinical leaders (the CMO and Chief Nurse) will be involved at the highest level of decision-making through ELT membership, and will be supported by the new Clinical Leadership, Protection and Regulation Business Unit (CLPR). A key focus of both the CLPR Business Unit and the Clinical Leadership Group will be on ensuring that policy is informed by quality clinical advice. Further, the Chief Advisors located in CLPR will remain tasked with providing clinical input, networks and advice to policy makers.

### ***Professional development for policy analysts to focus on improving generic policy skills***

Improving the public policy skills of our staff is expected to be a process rather than an instant 'fix,' within the overall context of a strengthened policy process and framework. The Ministry needs to more clearly communicate its expectations for policy analysts. Regular capability audits led by HR need to continue to identify skill gaps, and professional development will be specifically provided to help individual staff members continue to build policy skills. We will also continue to commission regular external reviews by NZIER of our policy advice to Ministers, to ensure we are making process and identifying capability gaps. We also need to build an environment that encourages and supports peer review – we need to seek feedback from others if we are to build our policy skills, and there needs to be support for developing skills in providing feedback to others.

Adopting an apprenticeship model focussing on policy as a craft is a constructive way for the Ministry to improve policy capability. This means that growing policy capability within individual teams will be the responsibility of third and fourth tier managers. Senior policy analysts and principal policy analysts will also be expected to actively mentor the development of junior staff.

Expectations of the required policy skills for policy staff will be clarified and incorporated into position descriptions. Promotion to more senior roles will be through contestable processes as roles become available.

A number of submissions identified existing initiatives that are working well to improve policy capability, such as the Brown Bag Lunches, Policy People Meetings and the Policy Accolade Awards. These play a valuable role and need to continue. To maximise their value they need to be more widely promoted, managers need to support and encourage attendance by staff.

### ***Changing the skill mix to include quality economic input***

Submissions validated a move to more explicitly incorporate economic input into the Ministry's policy analysis. Skilled health economists are in short supply, and I agree with submissions that suggest more effective use of economists generally will assist greatly in lifting performance in this area.

**Table 2: Summary of key decisions and initiatives relating to leadership, culture, capability and systems**

Issue/question	Decision / Initiative
<p>Prioritised, integrated and phased plan for improvements to support first class policy</p>	<p><b>Policy Staff Advisory Group on capability, systems and culture.</b></p> <p>This will involve policy staff from all levels advising on the development and implementation support of an integrated programme to successfully develop internal policy capability and deliver a positive working environment with appropriate systems within the new Policy Business Unit. The group will meet regularly to oversee a three year work programme, working closely with the workstream owners/leaders identified in this table. The group will oversee identified initiatives as well as suggest further initiatives to fill remaining gaps/needs.</p> <p>Work stream owner/leader: DDG Policy Business Unit</p> <p>Indicative timeline: Engagement to start early 2011.</p>
<p>ELT to own the policy work programme, supported by strong governance structures</p>	<p><b>Roles, expectations, and linkages between ELT and other governance and leadership groups within the Ministry to be clarified</b></p> <p>The role of ELT and associated expectations is being clarified as part of Project Phoenix. Key linkages to also be clarified. ELT's role is to include setting the strategic direction, prioritising the work programme and providing consistent frameworks.</p> <p>Work will continue to review and consider the types committees that will provide ELT with cross-cutting advice and governance perspectives, for example a Policy Executive Governance.</p> <p>Work stream owner/leader: DDG Corporate Services</p> <p>Indicative timeline: continuing</p>
<p>Clinical leadership to be added to ELT</p>	<p><b>ELT membership to include the CMO and the CN</b></p> <p>Clear linkages between the Clinical Leadership Group and ELT will ensure that these perspectives are able to appropriately inform and influence ELT decisions.</p> <p>Indicative timeline: this will coincide with the new structure taking effect, on 28 February 2011</p>
<p>Quality policy development requires the right information</p>	<p><b>Protocols and systems for information sharing to be developed</b></p> <p>Guidelines will be developed to identify what types of information should be available to who (weekly reports, Cabinet Papers and Cabinet Minutes), and who should meet with Ministers.</p> <p>Systems need to be improved to allow better access to data and completed Ministry reports.</p> <p>Work stream owner/leader: DDG Corporate Services</p> <p>Indicative timeline: first quarter 2011</p>
<p>Continue the ICPC as a key quality assurance initiative</p>	<p><b>ICPC to continue to be resourced at an adequate level</b></p> <p>All Cabinet papers need to be peer reviewed by ICPC. The committee will require adequate senior staff resource to allow this to happen. In addition, their remit and obligations need to be clearly identified and communicated.</p>

	<p>Work stream owner/leader: DDG Policy</p> <p>Indicative timeline: continuing</p>
Improved quality assurance	<p><b>Guidelines to be developed to improve sign-off for all papers sent externally</b></p> <p>Requirements/guidelines to reflect the different types of papers, and their relative level of risk.</p> <p>Work stream owner/leader: Business Manager, Policy</p> <p>Indicative timeline: work to start early 2011</p>
Generic policy skills to be prioritised within the Policy Business Unit	<p><b>Professional development to focus on policy skills</b></p> <p>HR will continue to conduct policy capability audits. Professional development will be customised to meet individuals' capability needs.</p> <p>Apprenticeship model to be implemented to develop the policy 'craft', to include guidelines on mentoring and induction, and performance expectations developed for relevant levels of management and senior staff. Guidelines, systems, resources and timings for all of these pieces of inter-related work to be developed.</p> <p>Work stream owner/leader: DDG Policy</p> <p>Indicative timeline: work to start early 2011</p>
Position Descriptions	<p><b>Position Descriptions to incorporate clear expectations of required policy skills for policy staff at all levels</b></p> <p>Work stream owner/leader: Policy Review Project Team</p> <p>Indicative timeline: Underway</p>
Capability Initiatives	<p><b>Existing capability initiatives to be continued and expanded.</b></p> <p>This includes Brown Bag Lunches, Policy People Meetings and Policy Accolade Awards. These need to be communicated, resourced and supported by managers and staff.</p> <p>Work stream owner/leader: Policy Business Unit Senior Management Team</p> <p>Indicative timeline: ongoing</p>
External reviews of papers	<p><b>External reviews of quality of policy advice.</b></p> <p>The New Zealand Institute of Economic Research will undertake quarterly reviews of advice provided to Ministers. The reviews will also include seminars and workshops on writing quality health reports and Cabinet papers. NZIER will work with policy teams to improve policy writing capability. This will continue over at least a two year period.</p> <p>Work stream owner/leader: Business Manager Policy Business Unit.</p> <p>Indicative timeline: work to start early 2011</p>
External Seminars	<p><b>External Seminars</b></p> <p>Seminars from external parties (e.g. Central Agencies and public policy commentators) on the provision of advice to Ministers and developing quality policy advice.</p> <p>Work stream owner/leader: Business Manager Policy Business Unit.</p> <p>Indicative timeline: work to start early 2011</p>

Work Programme Allocation	<b>Work Programme</b> Systems/processes will be established to support allocation of the policy work programme across the new Policy Business Unit structure and ongoing monitoring, prioritisation and allocation. Work stream owner/leader: Business Manager Policy Business Unit. Indicative timeline: work to start early 2011
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**Table 3: Indicative timing of key initiatives to improve leadership, culture, capability and systems**

Initiative	Immediate start	Jan-Mar 2011	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	2012 - 2013
Policy Staff Advisory Group Quarterly meetings – identifying additional initiatives to fill gaps, overseeing progress on all other initiatives Owner: DDG Policy		X	X	X	X	X
Professional development programme (includes development of apprenticeship model, training in peer review and seminars) Owner: DDG Policy (supported by Project Manager Changing the way we work)		Gap analysis (based on capability audit) and programme design	Implementation of professional development programme	X	X	Capability Audits (annual)
Work Programme management: includes ongoing monitoring and prioritisation Owner: Policy Review Project Team / ELT		Supporting systems/processes established Allocation of work across new teams	Quarterly review of work programme	Quarterly review of work programme	Quarterly review of work programme	Ongoing quarterly review of work programme
ELT and other governance groups – clarification of roles and linkages (underway - part of Project Phoenix) Owner: DDG Corporate Services	X	X				Revisit
ELT to include CMO and CN. To coincide with the implementation of the new structure Owner: DG		X				

Initiative	Immediate start	Jan-Mar 2011	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011	2012 - 2013
ICPC to continue Owner: DDG Policy	X	Systems and processes to be assessed for possible improvement				Revisit
Sign-off guidelines to be developed for all papers Owner: Policy Review Project Team		Project begins	Guidelines to be implemented			Revisit
Position descriptions modified Owner: Policy Review Project Team	X					
Brown Bag Lunches, Policy People Meetings, Policy Accolade Awards Owner: Policy BU SMT	X	X	X	X	X	X
External reviews of quality of policy advice, quarterly (NZIER) and coaching Owner: Business Manager, Policy BU		X	X	X	X	X

# Policy Business Unit

## Role and functions

The Policy Business Unit will be the lead Ministry business unit for developing and providing policy advice to Ministers and carrying out related policy functions in the Ministry's areas of responsibility. The Unit will comprise six groups. The key functions of each group are shown in the table below and described in more detail in the following sections.

**Table 4: Summary of functions of groups within the Policy Business Unit**

Group	Key functions
<b>Strategy</b>	The Strategy group will develop advice on improving the medium to long-term performance of the overall health and disability system, and advice on overarching health and disability strategy. Includes: developing high level direction, priorities, policy frameworks, high level system performance monitoring frameworks, and strategic health budget.
<b>Populations Policy</b>	The Populations Policy group will develop policy on issues that affect the health of particular ethnic and demographic groups in New Zealand. These groups include: disabilities; Pacific peoples; older people; children and youth; maternity; emerging populations. The group will also develop policy on key health issues including non-communicable disease (e.g cancer, CVD, unhealthy weight), promoting healthier lifestyles, screening, mental health, alcohol, drug and addiction.
<b>Sector and Services Policy</b>	The Sector and Services Policy group will develop policy on issues surrounding the service settings and frameworks within which health-related services are delivered in the sector. These include: <ul style="list-style-type: none"> <li>• the different systems and settings through which healthcare services are provided (e.g. primary, community, secondary, tertiary, specialist and electives)</li> <li>• a range of other health policy issues including specific legislative frameworks (e.g. medicines).</li> </ul>
<b>Health and Disability Intelligence</b>	The Health and Disability Intelligence group will provide focused, high quality information and analysis to support policy development and external sector information needs. Includes: providing information and analytical resources and tools; research and evaluation to support policy and decision-making; conducting population surveys; and input into development of performance measurement frameworks and monitoring.

<b>Committee Support</b>	The Committee Support group will provide secretariat and advisory support to the following health committees: the National Health Committee (NHC); the Advisory Committee on Assisted Reproductive Technology (ACART), the Ethics Committee on Assisted Reproductive Technology (ECART); and the National Ethic Advisory Committee (NEAC).
<b>Business Services</b>	The Business Services group will carry out core planning, business development, and business support functions for the Policy Business Unit and the Policy DDG.

### ***Improving flexibility to respond to changing demands***

There is currently a lack of flexibility to move policy resources to where they are needed to meet changing demands and priorities. People have tended to get locked into quite specific areas of focus, and some teams have been fragmented into small specialist units. Both features have sometimes made it hard for the Ministry to gear up quickly to respond to new policy challenges.

It is important that the structure and work allocation practices within the Policy Business Unit support more flexible allocation of policy resources. Particular areas of policy focus will wax and wane over time as issues move through a natural progression from policy advice through to programme development and implementation. This means the focus and emphasis of policy will change over time as well, sometimes on a cycle of several years. The structure of two key groups within the Policy Business Unit – the Populations Policy Group, and the Sector and Services Policy Group – is intended to group topic areas together into broader teams for greater flexibility.

In the short run, existing work programmes and projects will be allocated to these teams to ensure continuity and avoid unnecessary disruption to delivery. This means that staff in the new business unit who have been working on these programmes will generally continue to do so, particularly during the critical transitional period to the new Policy Business Unit. However, over time, policy staff may be working on projects in different topic areas. Policy managers within the groups will be asked to manage broader areas of focus. Project or team leaders will be assigned within teams as appropriate from time to time, depending on what is required. People may also work across teams.

The overall policy work programme will be owned at Group and Business Unit level within Policy. This will enable a clear view on resource requirements to be developed, and resources to be moved around to priority projects as things change.

### ***Māori Health***

A range of questions and divergent solutions were offered on the best location for Māori policy functions within the Ministry. The proposals acknowledged a range of possibilities. Feedback provided useful insights that have informed decisions on this critical area of policy responsibility.

It should be the responsibility of all policy groups to consider the Māori dimension of policy. However, it is important to maintain an integrated view of Māori health strategy, including a

clear view of priorities for Māori health policy – it is difficult to maintain this view without a group having this as a primary focus. It is also important that a critical mass of expertise and experience in Māori health be available to guide more general policy development.

It is important not to have undue fragmentation or duplication of accountability for Māori health policy within the Ministry. Currently the Māori Health directorate develops strategy and policy for Māori health and also carries out Māori health research and monitoring. There is also a Māori Population Health group within the Population Health directorate, providing advice on specific Māori population health issues to teams within that directorate, based on a 'portfolio' operating model where advisors work alongside particular teams and projects.

The Māori Health Business Unit (Te Kete Hauora) has primary responsibility for Māori health policy. This will include ensuring that general health and disability policy developed by the Policy Business Unit incorporates a Māori perspective where needed. This will require the unit to review the way its advisors engage with broader policy projects and staff in other business units. A process to identify this operating model will get underway early next year.

The Māori Population Health team within the Population Health directorate provides Māori advice on operational policy and programme-related issues. The team will transfer to SCI and compliment the work of the Maori Programme Implementation team. This will provide greater critical mass in the area of Māori advice on programmes and implementation, and ensure effective ongoing support for mental health and addiction treatment programmes from a Māori perspective. The Māori Population Health team will continue to work with the Communicable Disease and Environmental and Border Health teams that are transferring to CLPR to support implementation of their current work programmes.

### ***Legislative policy***

Consultation revealed that legislative projects do not always have a clear 'home' within the Ministry, and that our capability around development and review of legislation is not widespread enough.

The Policy Business Unit will take the lead on developing or reviewing any legislation required, supported by the Health Legal group in Corporate Services. Legislative policy development and maintaining an understanding of the legislative process are core policy skills required across the whole Policy Business Unit. For this reason, development of legislative policy will not be the domain of a particular group within the business unit. In practical terms, as part of the work programme, each piece of legislation to be developed or administered will be given a clear accountability within the new business unit.

The Policy Business Unit's leadership team will also have a clear overview of the legislative work programme so that resources can be allocated efficiently and effectively to these projects, recognising that some staff will have more regular experience than others on legislative projects. This may involve some cross-team projects to draw on the necessary experience, particularly during the period when capability in this area is still being built.

### **Cross-government work**

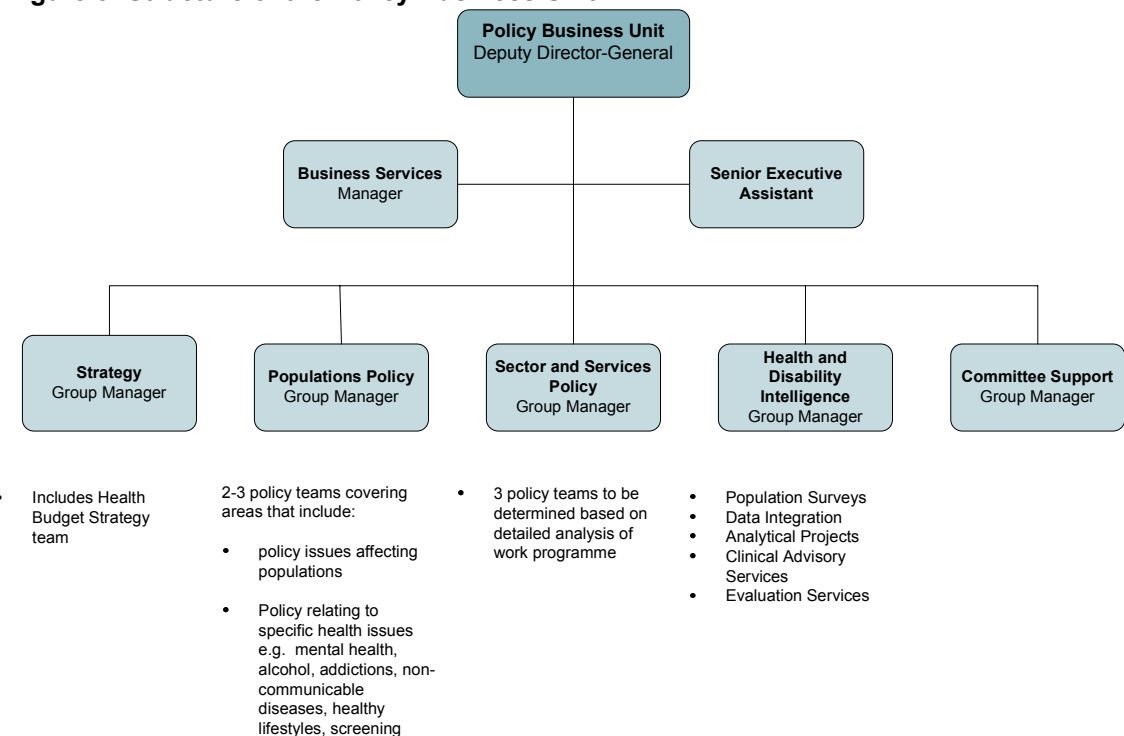
The assessment of our policy function revealed views that the Ministry has not been proactive enough in leading and engaging in cross-government work with health dimensions. Cross-government work has tended to be seen as the domain of very few policy teams, rather than as a general responsibility across the suite of policy topics we cover. A question was raised in feedback about which group would be responsible for cross-government policy work, including with the social sector. The answer is that working across government is a core expectation of all policy teams. Leadership or involvement in cross-government work will sit with the group most suited to provide leadership or input in each case, depending on the focus of the work. This will be determined by the Policy Business Unit’s leadership team as part of business planning and as issues and projects arise during the year.

### **Health Impact Assessment**

Health Impact Assessment (HIA) is a systematic way of identifying the potential impacts on the well-being and health of the population of any proposed policy, strategy, plan or project before implementation. In this respect it is similar to regulatory impact analysis.

Health Impact Assessment needs to be an integral part of policy development within the Ministry, applied by all groups who are providing policy advice and developing programmes to implement policy. The Policy Business Unit is the appropriate location for functions that seek to improve the quality of HIA within the Ministry and across government and the sector. Oversight of HIA will sit within the Business Services group of the Policy Business Unit, rather than transferring to the Clinical Leadership, Protection and Regulation Business Unit (with the transfer of the Office of the Director of Public Health to that business unit). This means that it is able to work across all policy teams in the Business Unit.

**Figure 5: Structure of the Policy Business Unit**



Text indicates areas of responsibility rather than team structure.

## Rationale and expected benefits

Improving the structure of the policy teams is integral to achieving sustainable change. The current structure fragments and disperses the policy function across teams and directorates – in some cases policy is split by subject area (e.g. mental health, maternity), and by function in others (strategic policy). This creates multiple inconsistencies and duplications around the way various teams, functions or subject areas are currently split between directorates.

As a result, current problems include:

- no common definition or understanding of the differences and linkages between strategy, policy and clinical advice
- policy issues not always receiving adequate focus because of the co-location of policy, operations and purchasing
- the Ministry not having clear shared frameworks to shape policy advice; with definitions and capability levels varying across teams
- linkages between individual policy teams not being strong, with deep-seated subject-based 'silos'
- difficulty with prioritising across these silos to form a strategic, focused work programme
- arbitrary, illogical and confusing allocation of projects, as accountabilities and roles are not entirely clear
- difficulty with moving policy resources across teams to respond to new priorities.

Bringing policy into a single business unit sends a clear message about who is responsible for forming quality policy. Expected benefits of the proposed structural changes include:

- creating a larger critical mass in the policy function, situating policy analysts together to improve communication and information flows internally
- enabling the development of a policy culture and capability with speciality in public policy and machinery of government issues
- allowing policy analysts to work more flexibly and move across policy issues depending on needs
- facilitating identification of a clear strategic direction for the health and disability system and the Ministry
- improving prioritisation of the policy work programme
- improving policy capability - better communication and information flows would result in greater understanding of cross-cutting issues and increased consistency of advice across policy as a whole
- better and more consistent external communication
- closer links between data, information and policy.

**Table 5: key changes from the design proposed in the consultation documents**

Issue/question	Change	Decision
<b>General issues</b>		
<p><b>Should the Population Health Policy group be subdivided into smaller groups?</b></p>	<p><b>Change</b></p>	<p><b>The functions of the originally proposed Population Health Policy Group will be subdivided into two groups: Populations Policy and Sector and Services Policy</b></p> <p>Feedback indicated that a single Population Health Policy group with the functions proposed would be too large in scope, leading to an unbalanced set of groupings within the Policy Business Unit, and not enough managerial representation of the wide range of different policy issues around the management team.</p>
<b>Issues relating to the Strategy Group</b>		
<p><b>Should the Strategy Group be located in an Office of the Director-General or in the Policy Business Unit?</b></p>	<p><b>No change</b></p>	<p><b>The Strategy Group will be located in the Policy Business Unit</b></p> <p>Some submissions suggested that the Strategy Group might be placed in an Office of the Director-General. There would be some benefits to this approach, including giving the group more direct influence over Ministry-wide strategic direction and prioritisation, supporting ELT to take a stronger collective strategic management role, and mitigating the risk of the group being drawn into more reactive, day to day policy and issues management.</p> <p>However, on balance it is considered that locating the group within the Policy Business Unit will provide the greatest benefits. Some separation from groups who focus on day-to-day policy work will help provide space and permission to concentrate on the 'big-picture', but location within the same Business Unit will ensure a close enough connection to other policy groups' work (through direct relationships and being on a common management team) to support translation of strategy into policy.</p> <p>I am expecting that the Strategy Group will lead thinking about strategic health and disability direction and priorities for the whole of the Ministry, as is conventionally the case.</p>
<p><b>Should the functions of the proposed Strategy Group and System Policy Group be merged?</b></p>	<p><b>Change</b></p>	<p><b>Merge some functions of the proposed Systems Policy Group into the Strategy Group; merge other functions into the Sector and Services Policy group</b></p> <p>A number of submissions observed the potential for overlap and lack of clarity between respective accountabilities of the Strategy Group and System Policy Group as proposed in the consultation document. A common view was that this division of functions would create more fragmentation than necessary.</p> <p>I agree with this view, and have decided to fold a range of the functions proposed for the System Policy Group into the Strategy Group, and other functions (such as</p>

		responsibility for primary, secondary care policy) into the Sector and Services Policy group discussed later in this document. This will dispense with the need for a separate System Policy group, and reduce the potential for duplication and unclear accountabilities. It will be important for the Strategy Group to avoid becoming involved in short term policy issues relating to the health system or settings. It is expected that these will be addressed in other groups within the Policy Business Unit, including the Sector and Services Policy group.
<b>Should the Strategy Group or Corporate Services lead the Ministry's strategic planning?</b>	<b>No change</b>	<p><b>Ministry Planning and Performance Reporting (MPPR) within Corporate Services will lead Ministry planning</b></p> <p>It was suggested that the Strategy Group could take lead responsibility in driving the Ministry's strategic planning. The Strategy Group will lead the Ministry's input into outward-facing health and disability strategy, and will play a critical role in informing the Ministry's own planning. It will do this by providing well-analysed input on direction and priorities to support ELT decisions. Ultimately, ELT needs to collectively own the Ministry's strategy. This includes agreeing on direction and priorities. MPPR will co-ordinate and support the process by which ELT makes these judgements, and related strategic thinking and planning processes. This will clearly involve significant input from the Strategy Group.</p>
<b>Should there be a higher ratio of junior staff than proposed in the Strategy group?</b>	<b>Change</b>	<p><b>The Strategy Group will comprise a balance of senior and less senior roles</b></p> <p>Submissions highlighted a need to include more junior roles in the composition of the Strategy Group. It was suggested that this would enable the time of very senior staff to be used more effectively, help build capability of less senior staff, and enable the group to produce more deliverables rather than functioning purely as thought leaders.</p>
<b>Should there be a direct reporting line for the Chief Economist to the DDG Policy?</b>	<b>No change</b>	<p><b>The Chief Economist will report to the Group Manager, Strategy but will sit on the Management team for the Policy Business Unit and provide advice across the Policy Business Unit and to other Business Units</b></p> <p>Several submissions suggested that the Chief Economist should be involved in a wide range of issues across policy, and needs to achieve influence without authority. Some suggested that this merits a direct reporting line to the DDG Policy or the Director-General. It was also suggested that to be successful, the Chief Economist needs good access to information (draft Cabinet and ELT papers), networks, key people and key meetings, and a means of working alongside a range of teams.</p> <p>I agree that the Chief Economist needs to have a good overview, particularly of the policy work programme and outputs. The Chief Economist will be part of the Management Team for the Policy Business Unit to ensure a good overview of and input into policy, and to</p>

		provide wider support to other groups in the Policy Business Unit and the wider Ministry as required. However, the Chief Economist will be located within the Strategy Group to ensure a close connection to the strategy work programme.
<b>Issues relating to the location of particular policy functions</b>		
<b>Where should Maori Population Health functions be located?</b>	<b>Change</b>	<b>The Maori Population Health team will transfer to SCI.</b> It is important that consideration of Māori health and disability issues is not seen as the sole responsibility of one team or business unit, but that it is understood to be integral to all that we do.
<b>Where should mental health policy be located?</b>	<b>Change</b>	<b>Locate mental health policy functions in the Populations Policy group in the Policy Business Unit</b> The proposal consulted on grouped mental health policy with mental health programmes in SCI as an interim measure while the Policy Business Unit is being established. Feedback on this proposal was mixed, with some submitters supportive and others questioning why the policy functions should not be located within the Policy Business Unit from day one. Some submissions were concerned about splitting the Director of Mental Health from the policy and programmes functions due to the need to ensure good integration.  In mental health, a clear view of policy, programmes and statutory responsibilities needs to be maintained. While structural separation of these components will require strong cross-Business Unit relationships, I consider that it will lead to a sharp focus on the different aspects of mental health policy and services. The role of the Director of Mental Health (to be located in the CLPR Business Unit) will remain a key point of integration across the mental health sphere, and it will be critical for this role to actively ensure that policy and programmes are well-connected and linked to changing strategic priorities. This will require strong links between mental health functions in the Policy Business Unit and the CLPR Business Unit.
<b>Where should national drug policy functions be located?</b>	<b>No change</b>	<b>Locate majority of national drug policy functions in Policy Business Unit</b> Submissions questioned the location of drug policy, with divergent views being expressed. Some thought that the functions were appropriately located in Policy, some thought that there would be a better fit with the regulatory focus of the CLPR Business Unit, and some advocating a mixed approach.  I consider that there needs to be a strong policy focus in this area, hence the location in the Policy Business Unit. These functions will include some legislative/regulatory functions but prefer that these (apart from the NDIB position to be located in SCI as proposed) be carried out from within the Policy Business Unit as they are only a small part of the overall work in this area.
<b>Where should nutrition and physical activity</b>	<b>Change</b>	<b>Locate all nutrition and physical activity policy functions in the Policy Business Unit; regulatory functions will be located in the Public Health group,</b>

<p><b>functions be located?</b></p>		<p><b>CLPR Business Unit</b></p> <p>A number of submissions favoured locating nutrition and physical activity functions in the CLPR Business Unit because of the connections with functions of the Office of the Director of Public Health and the regulatory functions involved. Submissions also recommended keeping the functions together because they are not resource intensive and splitting them could cause unnecessary fragmentation.</p> <p>On the other hand, nutrition and physical activity are important from a policy perspective because they provide ways of proactively managing the burden of cardiovascular disease, cancer and obesity, amongst other long term illnesses. On balance, there are synergies that can be gained from locating these functions in a group next to a focus on these non-communicable diseases. This will enable a more systemic focus on managing a range of long-term health issues from their root cause through to treatment.</p> <p>While the policy functions will be separated from regulatory functions, existing functions are primarily focused on regulatory and operational issues. These will be transferred to CLPR. Policy development will be picked up by the Policy Business Unit as issues arise.</p>
<p><b>Where should screening functions be located?</b></p>	<p><b>Change</b></p>	<p><b>Locate screening policy functions in the Policy Business Unit</b></p> <p>Submissions were mixed on the preferred location of screening policy functions. Some thought that the functions would sit best within the CLPR Business Unit because of their mixed functions (some policy, some more operational) and their focus on health protection. Others thought that they would sit well within the Policy Business Unit, because of the wide range of health issues covered in relation to screening, and the policy issues that this raises, particularly around identification of priorities.</p> <p>On balance there are good synergies and linkages from locating screening functions alongside non-communicable disease policy issues in the Policy Business Unit.</p>
<p><b>Where should functions relating to older people be located?</b></p>	<p><b>Change</b></p>	<p><b>Locate policy functions relating to older people in the Populations Policy group, Policy Business Unit</b></p> <p>Submissions indicated that the majority of work in relation to older peoples' health is still in the policy space, and that there is little operational work that could be transferred to CLPR. I agree with this approach.</p>
<p><b>Where should functions related to child, youth and maternity be</b></p>	<p><b>Change/no change</b></p>	<p><b>Child, youth and maternity policy will be located in the Policy Business Unit; some operational functions will be located in a Child &amp; Family team in SCI</b></p> <p>Submissions were concerned about the proposed</p>

<b>located?</b>		location of particular operational functions and suggested that the work was still in the programme development and implementation phase, and so was better aligned with SCI at this time.
<b>Where should disability policy and other functions be located?</b>	<b>Change</b>	<p><b>Locate disability policy in policy Business Unit</b></p> <p>Submissions indicated considerable concern about the separation of policy functions from the implementation the new model for disability services, which is nearing implementation and which will require clear focus and the right level of resourcing within DSS to ensure success.</p> <p>The Policy Business Unit will be responsible for disability policy and will continue to work closely with the Disability Support Services team in NHB to support implementation.</p>
<b>Issues relating to committee support</b>		
<b>Where should committee support be located?</b>	<b>Change</b>	<p><b>Locate policy committee support functions in the Policy Business Unit; locate support for the Cancer Control Council and Ethics Committees in the Clinical Leadership, Protection and Regulation Business Unit. Separate arrangements will be made for the Mortality Committee to facilitate its transfer out of the Ministry in February 2011.</b></p> <p>There was support from submitters for clustering committee support functions together to provide greater flexibility and sharing in use of resources, greater links between the functions of the committees, and shared support practices and arrangements leading to efficiencies.</p> <p>However, there were strong views that the proposed CMO Business Unit would not be the appropriate location for these functions, largely because of the policy-related advisory nature of many committee support functions, and the need to draw upon policy skills. There was a general view that policy committee support should be located in the Policy Business Unit, but as part of a separate group to the groups that develop policy advice. Submissions also indicated that the CLPR Business Unit would be an appropriate location for Ethics Committee and Cancer Control Council NZ secretariat functions.</p> <p>Feedback received acknowledged that secretariat support functions for the Mortality Committee will transfer to the Health, Quality and Safety Commission, but questions were raised about the timing for the transfer and if there was the potential for this to coincide with other changes to minimise disruption for staff. Work on the process for the transfer, including consultation with affected staff, will be completed by the end of February with the aim of responsibility transferring on 28 February 2011.</p>

## Strategy Group

### Role and functions

#### ***Specific functions and accountabilities***

The Strategy Group will sit inside the Policy Business Unit, reporting to the DDG Policy. It will focus on developing advice on improving the performance of the overall health and disability system by:

- developing strategic vision and direction for the system and sector
- identifying key medium to long-term system issues and opportunities affecting current and future performance of the system as a whole (including sustainability issues)
- identifying strategic priorities for the system, sector and Ministry – translating overall direction and understanding of strategic issues into key areas of short-medium term focus, including developing strategy relating to health and disability system design and performance
- ensuring the health system is designed to deliver on strategic priorities, including developing policy advice on institutions, roles, functions and accountabilities, systems and processes, service delivery models, and governance arrangements
- developing advice on improving performance within the current health system's parameters, e.g. through policy on pricing and incentives, regulatory design, performance and productivity measurement, and capital investment advice
- developing and clarifying high level policy frameworks
- identifying clear targets and results for the overall health system, and analysing the implications of changing results for overarching strategy
- contributing strongly to the process of Ministry strategic direction-setting and prioritisation of policy focus over the short, medium and long term
- identifying budget implications of longer term strategy and direction and translating this into annual input into the budget process, working with Corporate Services, to ensure spending is aligned with the strategic direction and priorities of the system, sector and Minister, including:
  - using analysis developed in the group to support systematic analysis of drivers of Health expenditure, which is required to support the budget process and develop strategic options for living within a lower funding growth path
  - proactive advice from the Ministry about next best spends in Health and next best disinvestments
  - a sharpened focus on value for money of wider sector spending.

### ***Relationship with NHB functions***

The Strategy Group will provide a strategic overview of issues and priorities for the whole Ministry, including the NHB, supporting ELT to maintain focus on the right things over time.

Submissions raised the question about whether the Strategy Group should assume responsibility for a range of strategic planning-related functions currently carried out by the NHB, including long term service planning, workforce planning, capital planning, and information technology strategy. The preference is to leave these accountabilities within the NHB. I would expect there to be a close link between the NHB and the Strategy Group on issues such as funding policy and prioritisation, and development of regional planning and network design.

### ***Maintaining relevance and headroom for strategic thinking***

Submissions reinforced particular challenges that the group are likely to confront. These include difficulties in maintaining the headroom to think 'long term and big picture' about the health and disability system and strategic priorities, in the face of pressing day-to-day demands in other parts of the Policy Business Unit.

Another challenge is to ensure that the group clearly demonstrates its relevance in the 'here and now'. Longer term thinking is essential to position the Ministry to anticipate and provide proactive advice on critical health and disability system issues that New Zealand will continue to face as the range and magnitude of demands on the health system increase over time. However, it will need to deliver a stream of deliverables that, while thinking longer term, translate back into policy and decisions that need to be made now to prepare for the future.

Ultimately the Strategy Group will ensure relevance and headroom through good management practices. Group members will not operate as roving internal expert consultants, which would render it more prone to becoming wrapped up in short-term policy work. Instead it will have a clear, prioritised strategic work programme developed in consultation with, and endorsed by, ELT. This programme will include tangible outputs delivering clear benefits in terms of sharpening the Ministry's short-to medium-term focus. The Strategy Group will provide regular reports to ELT on its work, clearly and proactively identifying changes in focus and priority as they emerge.

### **Structure**

The group will have a team specifically focused on the health budget strategy. It is likely that members of this team may rotate into the broader Strategy Group from time to time. It is also expected that the work of the team will need to draw upon other members of the Strategy group at particular times. It is not proposed to develop a detailed team structure for the rest of the group at this stage. To keep spans of management control sensible for the Group Manager, it is probable that one or more team leader/manager positions will be required beyond the Health Budget Strategy team, but it will be for the Group Manager to determine the most appropriate management structure once he or she is appointed and can assess the work programme and the composition of the group.

Refer to the Impact Document for further details on resourcing and allocations.

## Key linkages and relationships

The Strategy Group needs to be well-connected throughout the Ministry to be successful, through translating long term strategic priorities into realistic and relevant short term focus areas; strong leadership; networks and staff exchanges with other groups. Key relationships include:

- Health Minister(s): this group will be generally removed from day-to-day Ministerial interactions and deliverables. However, good relationships with Health Ministers will be essential, enabled by regular conversations with Ministers about strategic direction and priorities, and the key deliverables of the group
- Director-General and ELT: this group will work closely with the DG to inform the overall direction, framework and priorities of the Ministry along with ELT
- Populations Policy Group and Sector and Services Policy Group: a close relationship would be required to ensure that identification of priorities is translated into policy development
- Māori Health Business Unit: a close relationship will be required to ensure that both groups understand the other's direction and perspectives and that these are reflected in the work of both groups
- Health and Disability Intelligence Group: the Strategy Group will require high quality information to formulate quality policy advice. A dedicated account manager from the Health and Disability Intelligence Group will ensure information is timely and relevant
- Corporate Services: budget work will be conducted in close cooperation with the Finance team within Corporate Services (Corporate Services would be primarily responsible for in-year budget matters with Strategy providing the medium to long term thinking). The Strategy Group will also provide critical input into the Ministry's corporate direction, setting and prioritisation processes which will be led by the Ministry Planning and Performance Reporting team in Corporate Services and owned by ELT
- NHB: budget work will also have to be conducted in close consultation with the Funding team in the NHB. Wider strategy issues will need to be discussed with the NHB to ensure alignment. Other issues requiring close links include the development of regional planning and network design
- CLPR: the Strategy Group will need to ensure that its thinking is well informed by the clinical perspectives from CLPR Business Unit
- The health and wider public sector: current perspectives and networks will be maintained and built through the recruitment of thought leaders from the health and disability sector and wider public sector.

## Populations Policy

### Role and functions

The Populations Policy Group will develop policy on issues affecting the health of particular ethnic and demographic groups. These groups include: people with disabilities; Pacific peoples; older people; children and youth; maternity; and emerging populations. It will also develop policy on specific health issues including: non-communicable disease (e.g. cancer, CVD, unhealthy weight), promoting healthier lifestyles, screening, mental health, alcohol and addiction.

### Structure

A team structure will be put in place within the group to ensure appropriate spans of management control, and that key ongoing health and disability issues have a logical home. Based on the current work programme and indicative resourcing requirements, it is expected that there may be 2-3 policy teams, including responsibility for the following policy issues:

- Populations policy issues, including: people with disabilities, Pacific peoples, older people, children and youth, maternity, and emerging populations
- Health, including: non-communicable disease (e.g. cancer, CVD, unhealthy weight), promoting healthier lifestyles, screening, mental health, alcohol and addiction.

The precise allocation of work programmes to these teams is yet to be done. The intention is to create teams of roughly even size, with a policy manager responsible for each one.

As with other policy areas, it is expected that policy resources should be used flexibly to respond to changing needs and priorities. This means that from time to time staff may be called on to work on a project in a different topic area or work in a different group or team.

Refer to the Impact Document for further details on resourcing and allocations.

### Key linkages and relationships

- Health Minister(s): this group will be in regular contact with Ministers about health issues and populations policy, and key deliverables of the group
- Director-General and ELT: this group will work closely with the DG to inform the overall direction, framework and priorities of the Ministry along with ELT
- Strategy Group: this group will work with the Strategy Group to ensure that policy is developed to address health and disability priorities and to contribute to the development and review of the National Health and Disability Strategy
- Māori Health Business Unit: a close relationship will be required to ensure that both groups understand the other's direction and perspectives, and that these are reflected in the work of both groups
- Health and Disability Intelligence Group: the Group will require high quality information to formulate quality policy advice. A dedicated Account Manager from the Health and Disability Intelligence Group will ensure information is timely and relevant

- Corporate Services: The Populations Policy Group will provide input into the Ministry's corporate direction, setting and prioritisation processes led by the Ministry Planning and Performance Reporting team in Corporate Services and owned by ELT
- CLPR: this Group's work will need to be closely connected to the CLPR Business Unit, in particular for mental health, which will need good collaborative relationships with the Director of Mental Health
- NHB: strong relationships will be needed with areas of the NHB in planning, purchasing and service delivery
- SCI: parts of the Populations Policy group will need to maintain close relationships with relevant parts of SCI from time to time. For example, staff working on Pacific policy will need to be closely connected with the Pacific Programme Implementation team. The same applies for staff working on mental health, alcohol and addictions policy.

## Sector and Services Policy

### Role and functions

The Sector and Services Policy group will develop policy on issues surrounding the service settings and frameworks within which health-related services are delivered in the sector. These include:

- the systems and settings through which healthcare services are provided (e.g. primary, community, secondary, tertiary, specialist and electives)
- a range of other health policy issues including specific legislative frameworks (e.g. medicines).

### Structure

As with the Populations Policy Group, a policy team structure will be put in place within the group to ensure that there are appropriate spans of management control, and that policy issues have a clear home.

The appropriate team structure is slightly more complex in this area of policy where current activities and projects are more difficult to cluster along particular topic lines. There will be three teams of roughly even size, each with a policy manager and staff. The work to determine allocation of work programmes to the group will help identify the most sensible unit structure, and hence the reporting lines for staff on 'day one'. This means that while relevant staff will know by the end of this year whether they will be located in this group, their reporting lines may not be determined until sometime in January.

As with other areas of policy, it is expected that policy resources should be used flexibly to respond to changing needs and priorities. This means that from time to time staff may be called upon to work on a project in a different topic area, or to work in a different unit.

Refer to the Impact Document for further details on resourcing and allocations.

## Key linkages and relationships

- Health Minister(s): this group will be in regular contact with Ministers about populations policy issues, and key deliverables of the group
- Director-General and ELT: this group will work closely with the DG to inform the overall direction, framework and priorities of the Ministry along with ELT
- Strategy Group: this group will work with the Strategy Group to ensure policy is developed to address health and disability priorities and to contribute to the development and review of health and disability strategy
- Māori Health Business Unit: a close relationship will be required to ensure both groups understand the other's direction and perspectives, and that these are reflected in the work of both groups
- Health and Disability Intelligence Group: the Sector and Services Policy Group will require high quality information to formulate quality policy advice. A dedicated account manager from the Health and Disability Intelligence Group will ensure information is timely and relevant
- Corporate Services: The Sector and Services Policy group will provide input into the Ministry's corporate direction, setting and prioritisation processes led by the Ministry Planning and Performance Reporting team in Corporate Services and owned by ELT
- CLPR: the work of the Sector and Services Policy group will need to be closely connected to the CLPR Business Unit
- NHB: there will need to be strong relationships with areas of the NHB in planning, purchasing and service delivery
- SCI: Sector and Services Policy group will need to maintain close relationships with relevant parts of SCI.

## Health and Disability Intelligence Group

### Role and functions

#### ***Specific functions and accountabilities***

This group will provide focused, high quality information and analysis to support policy development and external sector information needs. The group will be located in the Policy Business Unit, reporting directly to the DDG Policy. It needs to be seen as a provider of quality information for the whole of the sector, and to disseminate fit-for-purpose value-added information.

The group will be responsible for:

- providing an information resource tailored to policy and strategy groups and sector needs, ensuring that relevant, high quality information is available in a timely way to inform all aspects of strategy, policy and decision-making
- providing support to policy groups and other parts of the Ministry to develop monitoring, performance and reporting frameworks. This includes helping develop intervention

logic models, key indicators and performance measures, and identifying information and data requirements to support performance measurement and reporting

- implementing health-related performance monitoring frameworks and systems – producing and providing analysis on performance information based on performance frameworks to feed into policy development and other decision processes
- advising on and conducting research and evaluation (programme and strategic) as required to meet priority information needs. The group will also manage and/or provide advice and quality assurance on external research and evaluation contracts and deliverables
- conducting population surveys.

### ***Conditions for success***

In order to operate successfully, the Health and Disability Intelligence Group must:

- focus primarily on serving the needs of the priorities on the policy work programme
- be responsive to information requests and able to coordinate multiple inputs to provide high quality information
- have excellent working relationships with policy groups, and with information and analytical groups in NHB
- clearly understand the information needed to inform strategy and policy development and review, and the sources of this information, including from within the NHB, so that it can direct policy staff to the best source of information where it is not provided directly by HDI
- become experts in making use of the full range of existing data and data sources, including national collections, to support analysis and policy development in priority areas of focus.

### ***Details of the Group's operating model***

Details of the operating model for the Group will need to be worked through by the Group Manager, the team, and the wider Policy Business Unit management team and DDG Policy. It is expected that the use of dedicated account managers will help ensure that information is useful and timely to inform policy development. It is also anticipated that HDI group members might be part of policy project teams from time to time. Clearly there will be a need to prioritise the group's work programme, which will require close involvement of the DDG Policy and other group managers within the Policy Business Unit.

### ***Relationship with other data and information functions in the Ministry***

Some submitters commented on the risk of this group duplicating data functions existing within the NHB, leading to variations in methodology and production of different figures. This will need to be managed well, including by:

- working collaboratively with NHB information and analysis teams (particularly Analytical Services)
- developing a clear view on boundaries of roles and accountabilities in respect of providing information to inform policy

- examining options for standard processes to collect, create, manage and disseminate intelligence across groups.

These issues will need to be worked through in detail by the manager of the HDI group in conjunction with the DDG Policy and relevant groups in the NHB.

### ***Evaluation functions***

Stronger evaluation functions extend the existing HDI group accountabilities. Many submitters supported establishing a stronger centre of evaluation expertise within the Ministry. The group will not have sufficient resources to conduct a large number of evaluations itself. However, there is a need to ensure that the policy groups and wider Ministry have a clear, prioritised and agreed evaluation programme in place. The group will develop this programme in a way that reflects the needs of strategy and policy as these needs change over time. Once agreed, the work on the programme would be undertaken by a combination of evaluation and research staff within the group, and external resource that is contracted to carry out specific projects. The HDI group will also provide advice to policy groups on evaluation, including at the front end of the policy development process. This will ensure that the need for evaluation is actively considered as policy is being developed, and that intervention logic is clearly articulated during the process of developing advice.

### **Structure**

The HDI group will comprise the following teams:

- Population Surveys
- Data Integration
- Analytical Projects
- Clinical Advisory Services
- Evaluation Services.

Refer to the Impact Document for further details on resourcing and allocations.

### **Key linkages and relationships**

The group will need to obtain data from a range of sources and supply information to a range of customers to provide high quality, timely information to support policy development within the Ministry. Utilising an account manager models will help HDI build good relationships and understanding of the business of the following key clients:

- policy groups within the Policy Business Unit
- Māori Health Business Unit
- NHB data collection and analysis teams
- Statistics New Zealand.

In addition to this, the group will need to maintain good linkages with the NHB, SCI and Health Minister(s).

## **Committee Support**

### **Role and functions**

The Committee Support group will support to a range of policy-oriented health committees:

- NHC
- NEAC
- ACART

Specific individuals will remain assigned to support each committee, to ensure continuity of relationships between the committees and the committee support staff. Allocation of staff to positions in this group will be considered as part of the work programme allocation process. The co-location of several committee support functions in a single group will enable some shared administrative processes and support to be provided, and will enable linkages between the work of different committees to be made where appropriate.

Staff who support committees may be rotated in and out of these roles from time to time, to balance the need for professional development and variety of work for committee support staff with the need for continuity of relationships and maintenance of specialist knowledge in the committee support role.

While it is valuable for committee support functions to be located next to policy functions (as one needs to inform the other, and they draw on a similar base of skills), committee support remains structurally separate from policy advice to ensure an arms-length relationship between the two functions. This mirrors the current arrangements, and ensures a degree of independence from the Ministry's policy advice in the support that committees receive.

### **Structure**

The group will be led by a Group Manager. There will be a Manager for the National Health Committee. Positions supporting NEAC and ACART will report directly to the Group Manager.

# Clinical Leadership, Protection and Regulation Business Unit

## Overview

The consultation document included a proposal to establish a Chief Medical Officer Business Unit, with the following key roles: clinical leadership within the Ministry; ensuring regulatory obligations and functions are fulfilled; and giving critical mass to committees supported by the Ministry. There was a high degree of support for a CMO-type function and grouping. However, feedback from consultation has provided a number of specific suggestions and comments that have led to a revised approach set out below.

## Role and functions

The core roles and functions of the Clinical Leadership, Protection and Regulation Business Unit (CLPR) are clinical leadership, health protection core statutory functions, and specific regulatory functions. These are further outlined below.

### ***Clinical leadership***

The CLPR Unit will provide leadership and advice on overarching clinical matters within the Ministry and provide clinical leadership and interface on key issues in the sector. This role will be primarily carried out by the CMO, supported by an Office of the CMO. The location of a number of the chief advisors in the CLPR will also strengthen the Ministry's focus on clinical leadership and input into policy and operational work.

A key aspect of this role and associated functions will be ensuring that appropriate clinical and professional advice is available where needed in the Ministry. This does not mean that the individuals in the CLPR have to be the primary source of that advice. Instead they may be a conduit for advice, including through professional networks facilitated through the CMO and the CLPR Unit.

The deployment of clinical and professional advice throughout the Ministry will be co-ordinated and supported by the CLPR Unit, chaired by the CMO in conjunction with the Chief Nurse. The primary purpose of this group will be to develop collective perspectives and advice on key clinical issues, and to provide this advice to the Director-General, ELT and Business Units. This managed internal and external network approach may reduce the need to contract in external clinical/professional advice.

The clinical leadership functions will also include dealing with 'medical management' questions requiring system responses, including advice on dealing with Health and Disability Commissioner and coroners' reports, ACC treatment injury notifications, and maintaining a national overview of clinical quality improvement from the Ministry's perspective.

### ***Health protection and core statutory functions***

The Ministry carries out several key statutory functions related to health protection. This includes the roles of the Directors of Public Health and Mental Health, which both carry important leadership and decision-making responsibilities. There is a cluster of regulatory and

operational policy functions around these roles that will be included in the relevant groups. The Ministry also carries out related functions to improve, promote and protect the health of New Zealanders from potential harm caused by communicable diseases and environmental hazards. The range of functions to be included in the CLPR Business Unit are:

#### Public and population health protection and regulatory functions

- Director of Public Health role and support
- management of communicable diseases
- environmental and border health
- aspects of public health legislation relating to interpretation and administration flowing from this legislation
- nutrition and physical activity regulatory and operational functions

#### Mental health regulatory functions

- Director of Mental Health role and support
- mental health protection.

#### ***Regulatory functions***

The Ministry has responsibility for several core regulatory functions located within the new Business Unit:

- National Radiation Laboratory
- Medsafe
- Provider Regulation (HealthCert, and Medicines Control).

#### ***The role of the CMO***

The role of the CMO will be to:

- provide support and advice to the DG on clinical matters that are important to the Ministry, the Minister of Health and the health and disability sector
- provide expert input into health services planning through collaborative clinical leadership
- chair (alternating with the Chief Nurse) the Clinical Leadership Group within the Ministry
- provide clinical leadership and advice to the Ministry through active participation in ELT
- provide clinical leadership and advice across government and the health and disability sector.

In addition, the CMO will also be the second tier manager (DDG) of the Clinical Leadership, Protection and Regulation Business Unit. Feedback from consultation indicated a number of practical challenges to be addressed for this dual role to be workable, including:

- challenges in finding a suitably qualified and experienced candidate for the CMO position (someone who has the right professional clinical experience as well as strong executive management skills)
- potential for the CMO position to be less attractive to potential candidates as it would also come with line management responsibility for a range of regulatory functions.

I expect that the CMO will need to be able to balance the independent clinical leadership role with managing a team of senior managers across the protection and regulation functions. The semi-independent nature of the functions in the CLPR Unit will mean that less of the CMO's time will be required in managing the day to day issues arising out of these groups. In addition, a general manager role and support team to look after many of the day to day management issues.

### ***Office of the CMO***

The Office of the CMO will be managed by the General Manager. Beyond a range of general management responsibilities for the Business Unit, the group's functions will include:

- general support for the CMO and clinical leadership functions
- a small enforcement function. Once a person is appointed to the role of Manager Enforcement, consideration will be given to the potential of transferring, in consultation with staff, enforcement functions from other parts of the Ministry (for example Health Legal)
- support functions for the Ethics Committee and the Cancer Control Council (the latter will operate as a stand-alone group with the Manager of CCCNZ Secretariat reporting to the General Manager of the CMO Office).

### ***Chief Advisors***

There are currently a number of Chief Advisors in the Population Health Directorates who are connected to policy development functions, as well as broader functions. In line with most feedback on this subject, I have decided to group these Chief Advisors together, reporting to the CMO. This will provide:

- an enhanced ability for these roles to work more across the Ministry, including in policy and programme development depending on the need
- collegial support and opportunity for more co-ordinated input into policy
- stronger direct support for the CMO clinical leadership role.

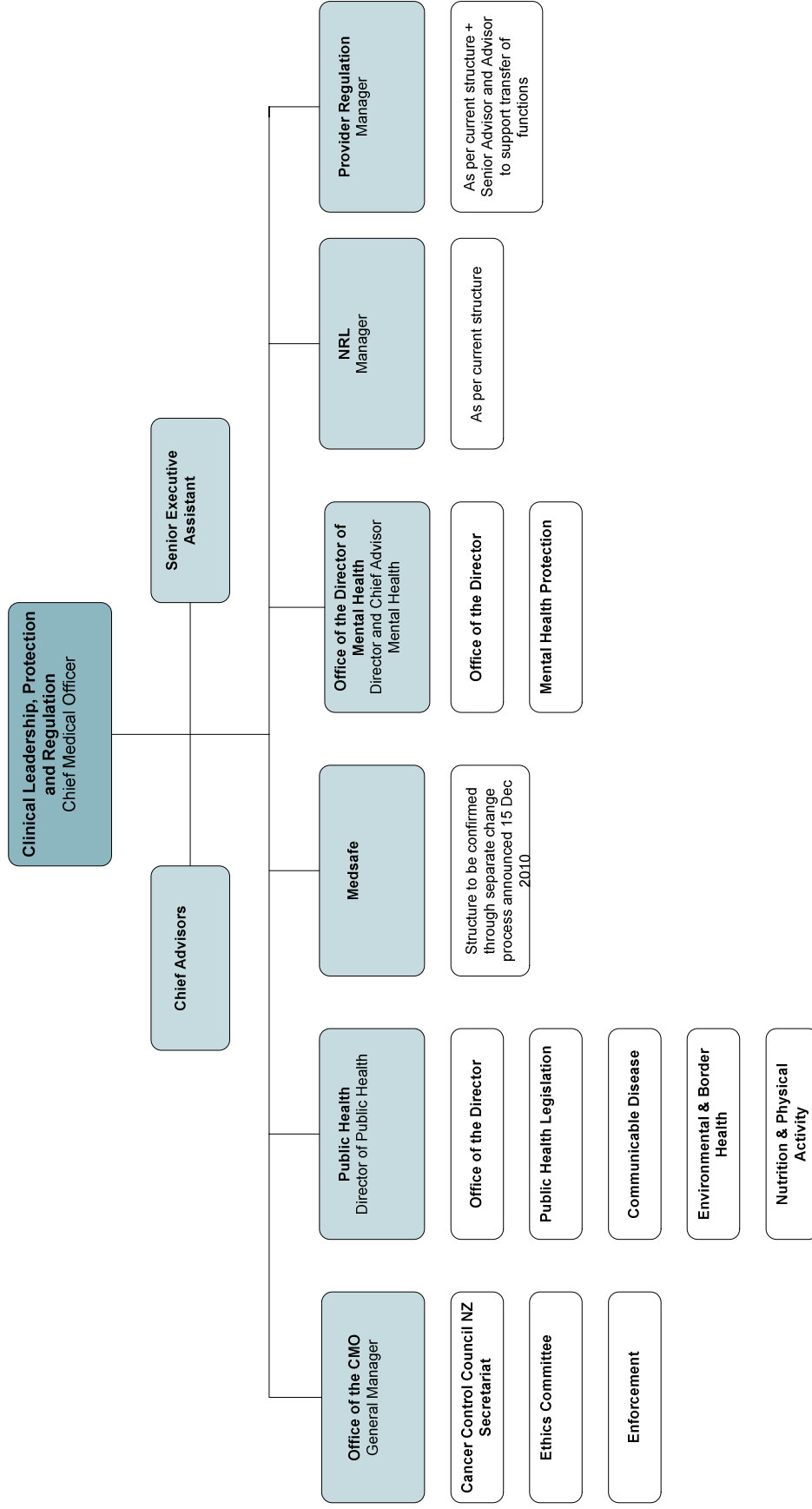
There is a risk that moving these Chief Advisors out of the Policy Business Unit will mean they are less well connected into policy development, which would not be the case if they reported to line managers of policy teams. This will need to be managed through other arrangements, such as ensuring that Chief Advisors are able to attend senior management team meetings of other Business Units, that they are involved in work programme planning for other Business Units, and that Chief Advisors have a clearly defined programme of work agreed with the CMO and visible to ELT.

## Structure

There will be six third tier groups within the CLPR Business Unit (in addition to the Chief Advisors):

- Office of the Chief Medical Officer
- Public Health
- Office of the Director of Mental Health
- Medsafe
- National Radiation Laboratory
- Provider Regulation.

**Figure 6: Structure of the Clinical Leadership, Protection and Regulation Business Unit**



## Changes from the design proposed in the consultation document

Key changes from the design originally proposed in the consultation documents are:

- Location of policy committee support functions in the Policy Business Unit (originally proposed for the CMO Business Unit); location of Ethics Committee support and support for the Cancer Control Council in the CLPR Business Unit
- Location of Nutrition and Physical Activity with the Office of the Director of Public Health
- Public Health Legislation Review team not to be disestablished
- Location of the Strategic Advisor, Māori Public Health in the Office of the Director of Public Health (originally proposed for Māori Population Health Policy in the Policy Business Unit)
- Location of Mental Health Protection functions in the Office of the Director of Mental Health (originally proposed for SCI )
- Location of Chief Advisors in CLPR (originally proposed for the Policy Business Unit).

**Table 6: Comments on changes to proposed design in the CLPR Business Unit**

Issue/question	Change	Decision
<p><b>Should emergency management functions be located in NHB or CLPR?</b></p>	<p><b>No change</b></p>	<p><b>Locate Emergency Management functions in NHB</b></p> <p>Some submissions suggested that emergency management functions have a strong synergy with public health functions – when there is an emergency, there are typically public health implications that need to be managed and co-ordinated as part of the overall response. On the other hand, during an emergency there are significant calls on DHBs so the current position of the emergency management functions within the NHB helps provide coordination and oversight of demands and pressure on DHBs, including identification of requirements for resources.</p> <p>For now I have decided to leave emergency management functions in NHB. It will be important that the team works closely with the health protection functions in the CLPR Business Unit to understand potential future pressures and ensure preparedness to respond to emergencies.</p>
<p><b>Should there be separate clinical leadership and protection vs regulation Business Units?</b></p>	<p><b>No change</b></p>	<p><b>Locate clinical leadership, protection and regulation functions together in a single Business Unit</b></p> <p>Some submissions suggested creating two separate Business Units: one for clinical leadership and protection functions, and another for regulation functions. This would enable a clear focus on each set of functions and enable the CMO to focus more easily on clinical leadership rather than general management responsibilities.</p> <p>I can appreciate the rationale for this suggestion. However, I do not consider that it is necessary at this stage. The key concern is around the ability of a CMO to carry out both a clinical leadership role and a substantive executive management role effectively. In practice the regulatory agencies that would be part of the group are largely self-managing and do not require significant managerial input at</p>

		second tier level. However, to enable the CMO to be focused on the clinical leadership role, this Business Unit will have a business services group (as with other Business Units) that will be led by a general manager tasked with managing many of the day-to-day issues that would otherwise fall to the CMO/DDG.
<b>Should the Chief Advisors be located in the Policy Business Unit or in CLPR?</b>	<b>Change</b>	<p><b>Locate (most) chief advisors in CLPR, reporting to the CMO</b></p> <p>A number of Chief Advisor roles are currently embedded within the Population Health directorate. Feedback has indicated that there would be greater benefits in locating these Chief Advisors (and the Principal Advisor) together, reporting to the Chief Medical Officer in the CLPR Business Unit.</p>
<b>Should mental health protection functions be located in SCI or in CLPR?</b>	<b>Change</b>	<p><b>Locate mental health protection functions in the Office of the Director of Mental Health</b></p> <p>Submissions indicated that mental health protection functions are integral to the execution of the role of the Director of Mental Health. It is therefore desirable for these functions to be located close to the Director.</p>
<b>Where should Provider Regulation be located?</b>	<b>Change</b>	<p><b>Locate Provider Regulation in the CLPR Business Unit</b></p> <p>Many submitters noted that Provider Regulation seemed to be an odd fit with a Chief Nurse Business Unit, and suggested that there would be benefits in grouping regulatory functions together in one Business Unit. This would give them a defined home, and enable them to share practice and synergies around processes and approaches. I agree with this suggested approach and rationale.</p>
<b>Should public health legislation functions be located in PBU or CLPR?</b>	<b>Clarify</b>	<p><b>Locate public health legislation functions in the Office of the Director of Public Health</b></p> <p>It was noted in submissions that the Public Health Legislation team in ODPH has expertise in the day to day management of public health legislative frameworks and is important to the statutory, leadership and operational role of the DPH. These functions will remain linked into the role of the DPH. In the past the team as carried out some ad-hoc legislative policy support for other directorates. This will become the role of the groups in the Policy Business Unit, meaning that the public health legislation functions will focus on administration and advice around public health legislation.</p>

# Chief Nurse

## Overview

The consultation document proposed that a business unit be established around the functions of a Chief Nurse. Feedback from submissions supported this proposal but questioned the allocation of regulatory functions (provider regulation) to this business unit.

In light of consultation feedback, the role and functions of the Chief Nurse have been revised and are described below.

## Roles and functions

The Chief Nurse will report to the Director-General, with a strong focus on providing clinical leadership across the Ministry and the sector.

The role of the Chief Nurse will be to:

- provide support and advice to the DG on clinical nursing issues that are important to the Ministry, the Minister of Health and the health and disability sector
- provide expert input into health services planning through collaborative clinical leadership
- play a role as alternating chair (with the CMO) of the Clinical Leadership Group within the Ministry
- provide clinical leadership and advice to the Ministry through active participation in ELT
- provide clinical leadership and advice across government and the health and disability sector.

The Chief Nurse will have limited line management responsibilities, focused on programme/project leadership, based on a work programme to be agreed with the Director-General and ELT. The Chief Nurse will assume responsibility for the Nursing Innovations work programme, which will be transferred from the SCI directorate.

## Changes from the design proposed in the consultation document

The key change from the consultation document is that the Chief Nurse will not be responsible for provider regulation functions, which will be located within the Clinical Leadership, Protection and Regulation Business Unit, alongside other regulatory functions.

## Impacts on other Business Units

### Sector Capability and Implementation

SCI is responsible for functions and activities relating to programme development and implementation. SCI is also currently responsible for a limited amount of policy work. This policy work relates to two areas, primary care and tobacco. In order to best support continuing delivery of these important work programmes, SCI will continue to be responsible for policy in these two areas for a limited time as transitional arrangements:

- tobacco policy will remain in SCI until June 2011 when the current policy work is scheduled to end
- primary health care policy will remain in SCI until December 2011.

The name of the Tobacco Policy & Implementation team will change to Tobacco Programme Implementation. Once the current policy work is completed for primary health, the policy resourcing associated with this project will move to the Policy Business Unit (3 FTE). Following the completion of policy work for tobacco, the resource will remain in SCI to support implementation.

SCI will take responsibility for immunisation functions, which were previously located in the Population Health Protection group in the Population Health Directorate. Feedback indicated considerable support for locating immunisation functions in SCI as a core work programme. Some submitters suggested locating these functions with communicable disease functions in CLPR, as immunisation is effectively an operational strategy to prevent vaccine preventable communicable diseases. There is merit to both approaches. On balance, locating the functions in SCI is aligned with the programme focus of this business unit. It was also suggested that vaccine procurement functions could transfer to NHB, which would free up immunisation policy resources to focus on a cohesive, consistent immunisation delivery system. The location of procurement functions may warrant further examination in due course.

The Māori Population Health team within the current Population Health Directorate will also transfer to SCI's. As outlined previously, this will provide greater critical mass in the area of Māori advice and provision of a Māori perspective for both programmes and implementation. A Child and Family team will be established to support programme development associated with Well Child, Be4 School Checks and the Maternity Quality Initiative.

The Mental Health Programme Development, Addiction Treatment Services and Problem Gambling teams from the Population Health directorate will transfer to SCI. These teams will report to a Manager Mental Health and Addiction Programmes. Following feedback received through the submission process it has been decided that responsibility for Mental Health Policy will not transfer as a transitional arrangement. The Mental Health Protection will transfer to CLPR reporting to the Director of Mental Health. Feedback received through the submission process suggested this was a more appropriate location for these functions.

Staff in SCI work flexibly to respond to the changing needs of the work programmes and priorities. This means that staff may be reallocated to a project in a different topic area, or to

work in a different team, as programmes end and new priorities are agreed with Ministers. Staff transferring into SCI will also be expected to work in this model. SCI's business systems will also apply.

## National Health Board

The National Health Board is responsible for:

- funding, monitoring and planning of District Health Boards (DHBs), including the annual funding and planning rounds
- planning and funding of designated national services.

The Phase 2 consultation document proposed that that a new Family/Whanau Services team should be established within the Performance, Accountability, Monitoring and Funding group. Following consultation it has been decided not to proceed with this proposal.

Submissions were concerned at the placement of child, youth and maternity and other operational policy functions within a new Family and Whanau services team in Performance, Accountability and Monitoring group of NHB. It was suggested that:

- There is better alignment of child, youth and maternity operational functions with SCI as the work is currently in the programme development phase
- Disability services development is at an important stage of implementation requiring close collaboration between the Disability Services Policy team and the DSS, National Services Purchasing. In line with submissions, it has been decided that the Senior Advisor, Disability position will transfer to Disability Support Services group as this is a technical role. Policy work will be undertaken by the Policy Business Unit and the business units will continue to work closely together to deliver on the work programme.

## Corporate Services

A number of submitters questioned the proposed location of the Manager Global Health in the Health Sector Forum group within Corporate Services, on the basis that most of the international organisations MoH engages with are overwhelmingly concerned with public health (i.e placing global health in corporate would split 'like' functions). Moving the functions to the Health Sector Forum group would remove the added value gained from being embedded in the most directly relevant team.

There is an important connection between global health functions and public health functions. It will be vital to ensure that these connections are maintained. However, I consider that the proposed location in the Health Sector Forum group within Corporate Services enables a better co-ordinated approach to the Ministry's participation in international fora. Looking forward, a clear prioritised view on international health forum engagement is essential given the pressure on Ministry resources.

Comments were received on the pros and cons of the location of governance and Crown Entity monitoring functions in the Corporate Services directorate. After considering the feedback I have decided to proceed with the initial proposal and the team will transfer to Corporate Services reporting the Executive Director of the Health Sector Forum.

## 5. Implementation of Decision

### Change Protocol

The implementation of the new structure will be conducted in accordance with the Ministry's 2010 Change Protocol. A copy of the protocol can be viewed on the Portal.

In regard to policy roles, there have been changes to the Policy Analyst, Senior Policy Analyst and Principal Policy Analyst positions. Senior Policy Analyst and Principal Policy Analyst positions have changed more significantly than the Policy Analyst roles.

In addition, the Impact Analysis Document describes the optimal anticipated Analyst resourcing levels and configuration that will be required.

Policy Analysts will be confirmed in their positions but will have slightly revised position descriptions. Once an assessment of the work programme is completed, and prior to the new structure coming into effect on 28 February, Policy Analysts will be assigned to a specific Policy Analyst role in the new structure.

A matching panel will be convened in the New Year to determine whether there is a match between the current Senior Policy Analysts and Principal Policy Analysts positions and the new positions. Given there are currently more staff in policy roles compared to the optimal configuration of roles in the new structure, it is anticipated that an assessment process will be required. This will take place either as part of a contestable process (if the matching panel's assessment finds there is a change of up to 25% in the roles), or as part of a redeployment process (if the matching panel's assessment finds there is a change of more than 25% in the roles). The outcomes of the assessment process will guide how quickly we move as an organisation toward the optimal resourcing levels and configuration.

While the details of the matching panel's assessment will be advised to staff early in the New Year, the type of indicative criteria that may be used to assess policy staff could include factors such as:

- skill in policy development and research
- ability to work in any policy area as required
- effectiveness in relationship management (internally and externally)
- performance in current position

In addition, the Ministry may require an interview and/or conduct testing of incumbents as part of the contestability process.

## Timeline

The timeline below details the steps in the process in accordance with the change protocol.

**Table 7: Timeline for implementation**

Date	Stage
16 Dec 2010 – 11 Jan 2011	Affected staff elect to complete a matching template to provide any further information they consider relevant for the matching panel to consider. The Matching Template is available on the Portal. For those who have previously needed to prepare this analysis, they may choose to forward a copy of this if it is still an accurate reflection of their role.
13-18 Jan 2011	Matching panels meet to compare current positions with new positions
21 Jan 2011	Staff advised of outcome of matching process
1 – 11 Feb 2011	Contestability process occurs. This process applies where there are more staff in a particular position compared to the number of positions in the new structure
14 Feb-25 March (approximate)	Advertising commences for remaining positions in the new structure
28 Feb 2011	New structure commences

## Staff Support

I appreciate that this can be an unsettling time and would like to ensure that staff have the support they need.

We all have our own support networks and I would encourage staff to make the most of them. You may want to talk to your manager, colleague or union representative, or to a member of the Project Team. Please refer to the Portal for the Project Team's contact details.

The Ministry also has a confidential and free employee assistance support service, accessible through SEED. The SEED staff are qualified and skilled in helping people deal with change and can be contacted at any time (7 days, 24 hours) on their free phone 0508 664 981.

In addition, a number of workshops have been arranged to assist staff in working through change at a personal level. At this stage, workshops have been arranged for Friday 17 December 10am – 12pm and Monday 20 December 10am – 12pm. Please contact [leone\\_andrews@moh.govt.nz](mailto:leone_andrews@moh.govt.nz) if you would like to participate in one of these workshops. Additional workshops will also be available in the New Year and details will be advised closer to the time.

# Appendix 1 – Summary of themes that emerged from consultation

## High level summary of themes from consultation feedback

### Overall Comments

- There was a significant level of feedback acknowledging the current problem - that the Ministry is not seen as the leading player in the provision of health advice to the Minister, and that as an organisation we need to make changes.
- There was overall support for the establishment of a single business unit within the Ministry responsible for the development and provision of policy advice to Ministers.
- A lot of useful feedback and detailed information was received on the workability of some proposals, including alternative approaches. Questions were raised about the consequential implications of proposals for operational functions (for example service development).
- Concerns were raised about the timeframes and potential for further change.
- A number of submitters supported the principles for separating policy from other functions, but noted that the principles have been inconsistently applied to the proposals relating to SCI. It was suggested that many of the functions currently in SCI would fit more logically into the National Health Board, with the remaining functions moving the CMO or Policy Business Unit. Concerns were raised that the success of the proposal will be compromised because of policy functions elsewhere in the Ministry not being considered at the same time (e.g. NHB and SCI).
- A number of risks were identified that will need to be managed to ensure integrated services in the proposed new structure. These included: less connectedness between policy and implementation; capacity issues; and isolation/agility barriers to engaging with sector groups. Several also noted that there is a real risk that this functional approach will simply shift silos from subject areas to functional areas - policy vs. operations vs implementation.
- A number of suggestions were put forward to help with integration of services, including: mixing up the membership of each business unit's Senior Management Team; project teams working on issues across groups; the principles being applied to project management practices; and clearly mapping out the functional responsibilities of each work unit including boundaries.

### Culture

- There was widespread acknowledgement of the cultural issues identified. Submitters noted that it was unclear how the proposed cultural changes would be achieved, and cautioned that if there was lack of immediate action it would be met with increased cynicism.

- Feedback was received that more than just structural change was needed to achieve the desired outcome – this was also discussed widely in meetings with Andrew Bridgman and was acknowledged as a priority area to be progressed in tandem with any structural changes.

### Capability

- There was support for the proposed strengthening of health economics capability. It was also suggested that a focus on economic skills in general (rather than just health economics) may be more useful or realistic when recruiting as there is a limited pool of health economists in New Zealand.
- Feedback was received that continuing to recruit clinical/technical expertise and providing better training on generic policy skills would be more effective than recruiting generic policy skills and trying to develop technical/clinical expertise.
- Concerns were raised that the changes could result in reduced capacity at senior and principal analyst level.

### Leadership and management

- Feedback was generally supportive for strengthening the leadership of ELT, but comments were made on the lack of detail as to how this will come about. Changes to the management culture were suggested, including addressing the risk averse approach to providing free and frank advice to Ministers, and moving to an output focus rather than micro-managing inputs.
- Suggestions were put forward for strengthening the clinical leadership of ELT, such as adding the Director of Public Health, and clarifying the role of Executive Governance Committees.

### Systems

- There was widespread support for the systems proposals put forward, with many seeking more detail on how the improvements will be implemented. A wide range of systems improvement suggestions were put forward.
- The need for a robust quality assurance process for policy work was highlighted, with the usefulness of the Internal Cabinet Paper Committee (ICPC) process noted, along with the suggestion that this could be expanded.

### Technical and Clinical Advisors

- Submitters noted the importance of ensuring adequate input and testing of policy from technical/clinical leaders. A number of suggestions were put forward for ensuring that this occurred, including clinical and sector advice hubs or the establishment of a clinical governance group.
- The comment was made that it is important that existing synergies within teams among the technical and regulatory specialists are recognised and supported. It was suggested that there will need to be a well supported mechanism for the technical and clinical expertise in the CMO Business Unit to provide input.

- It was proposed that rotating these positions between the Policy Business Unit and other areas would facilitate strong working relationships across the Ministry and ensure adequate technical/clinical input into policy development.
- The comment was made that the five Chief Advisors from Population Health Directorate do not have the expertise required in all the areas the Ministry is required to develop policy in (e.g. there are very few technical advisors for Maternity/Midwifery and Disability). It was proposed that a Chief Maternity/Midwifery Advisor position be established.
- Several commented that many of the issues dealt with by Chief Advisors are more operationally focused than around policy development. Consequently, many suggested that the Chief Advisor positions would be best located in the Business Unit headed by the CMO.

### Strategy group and systems policy group

- There was a high degree of support for a Strategy Group.
- Several commented that there is not a clear difference between the proposed Strategy and Systems group. It was suggested that these two groups be combined and/or that the respective accountabilities be clarified.
- Feedback was received about the need to clarify the roles and responsibilities of the proposed Strategy Group in relation to the NHB and Corporate Services, given that there are currently a number of key areas of strategic focus within these groups.
- There was a concern raised that removing strategy from day-to-day work risks losing sector linkages and producing strategy disconnected from the here and now. An opposing view was that a key challenge for this group will be avoiding getting involved in issues around day-to-day policy, meaning it could struggle to get traction on the critical longer term policy issues relating to the health system.
- There were suggestions that the Policy Business Unit may not be the best place for the Strategy group, with the Office of the Director-General of Health suggested as an alternative.
- Concern was raised that number and mix of staff proposed does not seem sufficient to carry out the role, and suggested a higher ratio of junior staff.
- Others suggested a direct reporting line for the Chief Economist to the DG or DDG, and queried how clinical/sector perspectives will be incorporated.

### Maori health policy

- There were a number of options suggested on where Māori health policy should be placed, and the Māori Population Health team in particular. Suggestions included placing some Māori Population Health policy functions into NHB, the Maori Health directorate, and/or merging the functions with the Maori Implementation team in SCI.
- The lack of Māori capacity across NHB, CMO and CNO units was noted as a concern as it reduces the units' abilities to effectively engage with Māori stakeholders and communities. It was noted that the Māori Programme Implementation team currently provides support to the Chief Nurse, and the team offered to extend their services to the CMO and NHB.

## Health Committee support

- Submitters generally supported grouping health committee support functions together in the proposed structure, to make the most of shared practice and resources. However, many commented on practical difficulties in locating these functions within the CMO Business Unit due to issues around required skill sets, suggesting a closer alignment with policy, and potential conflicts of interest with the role of the CMO. Many suggested locating support for policy advisory committees in the Policy Business Unit instead.

## Population Health Policy Group

### **Groupings**

- A number of submissions struggled with the rationale for the teams comprising the proposed group and noted that clarity might be gained by replacing the term 'Population Health' with 'Sector Policy'. A number of possible alternative clusters of functions were proposed, including splitting the proposed Population Health Policy Group into different, smaller groupings of functions, with the eventual staffing numbers in the Policy Business Unit being an important consideration.

### **Maori and Pasifika policy**

- Submissions noted the lack of justification for rolling together Māori and Pasifika issues into one team, with concerns that this was unlikely to produce better results as the two areas were different in terms of required cultural understanding, and the practical focus is different.

### **Flexible use of resources**

- Some commented on how resources would be used more flexibly in practice given the implied reduction in policy resource. Related to this were concerns about the Group's workload, and the apparent lack of Principal Analysts within this area.

### **Mental health, drug and alcohol**

- It was suggested that there is considerable risk in transferring the mental health and problem gambling policy work to SCI, as this would create further barriers for engagement with other social agencies over inter-sectoral policy.
- Not all agreed with the proposal that mental health functions be split up due to limited resources and capacity. It was proposed that mental health staff should stay together with the Director of MH.
- It was also suggested that having the regulatory Mental Health Protection team in SCI was not compatible with the purpose of the SCI directorate set out in the proposals. Many suggested that at least some of the Mental Health Protection team also be located in the CMO BU.
- Many noted that the area of alcohol and other drugs has a significant regulatory function and disagreed with having this function split up to sit in the Policy Business Unit. However, there was some support for the location of the National Drug Policy team in the Policy Business Unit. An alternative recommendation was that the legislative functions held by the National Drug Policy Business Unit go to either Medsafe or the Medicines Control Team under Provider Regulation.

### ***Health and Disability services functions***

- The comment was made that the work programme of Child Youth and Maternity is not understood well enough to make the structural changes without significant risks to the ability of the Ministry to progress the current work. It was recommended that there should be some capacity in the Policy Business Unit to respond to youth health related issues in particular, since these arise frequently.
- It was proposed that the Health of Older People Policy team be kept together in one Business Unit, ideally in SCI.
- In relation to the Health in the Community team, there was support for the proposal to move regulatory activities to the Provider Regulation group. It was suggested that policy advice on specific populations should go to the new Policy Business Unit and the operational functions would seem to fit best with the NHB.
- It was suggested that disability policy functions remain closely aligned with the new model implementation work
- There were strong suggestions that the Nutrition and Physical Activity team transfer in its entirety to the CMO BU in the Office of the Director of Public Health rather than being split. Alternative locations for the Nutrition and Physical Activity team suggested included the Policy Business Unit and SCI.

### **Health and Disability Intelligence Group**

- It was agreed that the Ministry needs to evaluate policy better. Some were not convinced that this function is a natural fit with HDI.
- It was noted that the proposal to move the BSI Infrastructure and Improvement functions out of Policy is likely to further weaken Health Intelligence capacity.
- Submissions noted that this section of the Policy Business Unit could be a duplication of some of the data functions within the NHB, and that respective functions and accountabilities needed clarification.
- There was concern that the HDI would have a very substantially expanded role, but without additional resources (general resourcing and Principal/Technical specialists).

### **Chief Medical Officer and Chief Nurse Business Units**

- There was strong support for establishing a separate Chief Medical Officer unit and having a Chief Nurse on ELT. However, several questioned the value in having separate units. A suggestion was made that the CMO and CN should be joint directors of a single clinical Business Unit/clinical governance/clinical advisory group.
- It was argued by many submitters that other functions need to be included to achieve the potential of grouping regulatory and protection functions under the CMO. Suggested additions included: Tobacco, Alcohol and Drugs; Emergency Management Team; Nutrition and Physical Activity team; Mental Health; The Director of IDCC&R/Chief Advisor Disability. Questions were also raised about where particular functions should be located in relation to the CMO, CN and SCI, including: Cancer Control Council New Zealand Secretariat; Provider Regulation; Health Impact Assessment.

- On the roles and functions of the CMO and CN Business Units, several commented that it was not ideal to separate provider regulation from other regulatory functions and place it in the CN unit.
- It was also suggested that the Public Health Legislation Review team should be retained within the ODPH in the CMO.
- The suggestion was made to set up a team in the CMO supporting promotion and implementation of clinical leadership, evidence-based management and medicine in health sector.
- There was good support for the clinical leadership focus of the CMO unit, but several were concerned that the line-management responsibilities for the CMO might not be practical or attractive to potential candidates unless a strong management support structure is put in place (e.g. the current Business Services team). Comments were also made that the CMO Unit looks possibly too big as the span of control for the CMO position is very large (particularly given the suggested additions outlined above). The suggestion was made to balance the workload more between the CMO and CN.
- There was strong support for the proposal that Medsafe and NRL be located in the business unit headed by the CMO.
- It was suggested that some committees and their secretariats (such as NEAC and ACART) are policy focused rather than operationally focused and should be placed in the business team that supports the Policy Business Unit. It was suggested that the Mortality Review Committee would seem to fit more logically in the CMO Unit rather than the PBU. Others also argued that the Ethics Committee team would be best under a committee support team in the CMO. Another recommendation was that the Committees transfer to the Chief Nurse Business Unit.
- There was good support for locating the Environment and Border Health Team in the business unit headed by the CMO.
- There was support for the proposal to include the Communicable Diseases team in its entirety in the business unit headed by the CMO.
- Another proposed location for the Immunisation team was the CMO Unit based upon the links with other teams to be located there.
- It was suggested that a Screening development and advisory function needs a dedicated team consisting of at least three FTEs analysts. Some suggested that the work programme best sits in the CMO Unit, while others suggested the Chief Nurse and Policy Business Unit.

## Sector Capability and Implementation

- There was strong support to clarify the function and role of SCI moving forward, including the linkages with the NHB. It was noted that there are a number of elements of both SCI and NHB that cover sector capability and support, with no clear distinction between the two directorates/Business Units. The question was raised whether SCI will be required in future given the perceived overlap
- It was argued that there is no logic to placing the Tobacco team in SCI. There was strong support instead for the Tobacco Team to be located in the business unit headed by the CMO.

## National Health Board

- Submissions commented on the perceived lack of clarity around certain functions within the NHB, particularly in relation to the role of HDI as a 'port of call' for information. It was suggested that there are teams in the NHB that are better placed to provide certain analyses.
- It was recommended that NHB capacity and functionality needs to be considered as part of the whole consideration of Ministry policy requirements, not as an afterthought.
- It was argued that Emergency Management is primarily a regulatory based function. Several submitters suggested that the Emergency Management team be located within the CMO Unit.
- The proposed placement of the Family/Whanau services team within the Performance Accountability Monitoring and Funding (PAMF) directorate of the NHB was viewed as problematic. An alternative proposal was to align the roles within the Family/Whanau services team to corresponding functional areas.

## Corporate Services

- A number of comments were received regarding the functions that should be included in Corporate Services:
  - some supported the establishment of the Health Sector Forum, while others wanted more information on its role and function
  - some noted that the placement of the Manager Global Health role with HSF seemed unconventional
  - comments were received on the pros and cons of the location of Governance and Crown Entity monitoring functions in the Corporate directorate.

## Rotation

- There was widespread support for the proposals around staff rotation. However many noted potential issues that need to be resolved in order to ensure that any rotation system actually achieves the desired outcomes. These include:
  - lack of knowledge transfer
  - confusion in the sector regarding key points of contact
  - reduced output while newly rotated staff get up to speed
  - managers not releasing high performing staff
  - lack of IT systems and support for enabling regular rotation
  - HR policies that make it hard to transfer and rotate staff.

## Position and Team Title Changes

- There were concerns raised about the proposal to limit policy job titles to only those in the Policy Business Unit for the following reasons:
  - 1.) Other teams (e.g. Immunisation Team) will always need some staff with policy skills and also policy training.
  - 2.) It will be important in an organisation with a policy/operations split to encourage staff

members to move between the groups to build relationships and share knowledge across the divide.

3.) People with policy skills will want career options in other policy roles.

- Others did not agree that 'policy' should be removed from job titles of the ACART/NEAC secretariat if these are moved to the CMO unit.
- An alternative approach suggested was to have three groups:
  - 1.) Analysts (ie policy analysts) with regular, senior and principal levels.
  - 2.) Advisors (ie non-clinical technical analysts) again with regular, senior and principal levels).
  - 3.) Clinical advisors, with (given their pre training) regular (ie senior) and principal levels.
- Others supported the recognition of Analysts having a specialised regulatory/operational policy role that includes analytical and technical functions.
- The comment was made that many job descriptions are outdated and frequently do not reflect the work currently being undertaken. It was recommended that work is undertaken as soon as possible with line/team managers to properly identify staff responsibilities to ensure an accurate and appropriate matching process.

# Appendix 2 – Design principles

## Introduction

Design principles have been used to guide the development and testing of organisational design options. The principles set out below have been derived from well-accepted organisational design theory and practice.

An organisation's design comprises a range of interdependent elements that collectively shape the performance of the organisation. These include structure (functions, roles, accountabilities, and management groupings), shared values and culture, systems and processes, capabilities, skills, infrastructure, resources and strategy. In addition to these core elements, design can be considered through different perspectives, including customer groups, service channels, products, business processes and core functions. Ultimately it is necessary to consider the organisational design 'in the round', balancing the different elements and perspectives.

The principles set out below are focused in the first instance towards guiding decisions about structure. In many cases the same principles will guide the design of other dimensions of the organisation. For example, systems and culture need to be aligned towards ensuring the right people and parts of the organisation are well-connected where they need to be, even where these connections are not prescribed through structure.

Each principle is framed as an 'ideal' state in its own right. In practice, determining the optimal organisational design will involve balancing these principles and making trade-offs between them.

For example, a design that connects closely-related activities together in discrete, self-sufficient management groupings can ensure that all the necessary activities to support effective and efficient delivery are well joined-up within a business group. However, when seen from the whole organisation's perspective, this could lead to fragmentation, duplication of resources, siloisation, a lack of flexibility to move resources around as needs change, and a lost opportunity in terms of leveraging critical mass.

For this reason, the analysis of organisational design options has considered where particular principles are being traded off against each other, rather than mechanistically weighing the options against the entire list of principles.

## Summary of principles

### 1. Grouping functions together

Choices about how to group functions and accountabilities together are at the core of organisational design. These decisions impact on how well different functions are performed, including by influencing the degree of focus on activities at different levels, the degree of connectedness between different parts of a 'value chain', the evolution of organisational sub-cultures, and the ability of the organisation to respond to new demands.

- *The breadth of functions being managed by a single person should be appropriate and 'manageable'.*

This means that the functions for which a person is accountable should not be so diverse that the management task is too complex or that focus on performance of each function becomes too fragmented or diluted.

- *'Like' functions and/or skill sets should be grouped together in a way that promotes efficient and effective performance of functions.*

Clustering similar functions or skill sets together can promote sharing and building of knowledge and expertise that improves performance around the function or area of practice, build critical mass of knowledge and resources that can be leveraged in different ways, and provide broader professional development opportunities. In this case, there is potential benefit to be realised from the increased critical mass and wider scope in relation to policy development within the Ministry.

- *Future proofing: there needs to be enough flexibility and agility to redeploy and/or scale up resources to respond to new opportunities and demands without requiring organisational re-design.*

While specialised groupings can provide a sharp, dedicated focus on performing particular tasks, too much fragmentation 'hard wired' into the structure can limit an organisation's ability to move resources around as needs change. There is a cost in terms of flexible use of resources if some functions and accountabilities are too fragmented and specialised.

- *An integrated 'end-to-end' accountability and joined-up approach towards closely related or inter-dependent activities.*

This means that there should ideally be a single point of accountability for those functions that need to be managed together as an integrated set of activities in order for delivery to be efficient and effective. As part of this:

- important dependencies and relationships that are a critical part of a value chain should not be disconnected, and
- specialised roles and groupings should be retained where the level of specialisation is an important part of performing the function.

In reality there are value chains at different levels within the organisation. Judgements about which functions and activities should be joined up closely as part of the organisational design need to consider where the important working relationships and synergies need to be at a day to day level.

## **2. Spans of management control and job complexity**

- *The number of staff assigned to each manager needs to be appropriate for the function in question and manageable from a practical point of view.*

This means that managers should have a manageable number of direct reports. This needs to consider the complexity and diversity of the functions being managed.

- *Management roles are comparable across the same tier of the organisational structure, in terms of workload and complexity.*

The grouping of functions and accountabilities into management roles needs to be comparable across the organisation at different levels of the management hierarchy. In other words, second tier roles need to be similar in size and complexity, and so on. The design of the second tier roles, in particular, needs to assist in creating career paths for senior managers and enable effective succession at senior management levels.

- *The design should eliminate unnecessary management hierarchy.*

'Span-breaker' management roles are a legitimate way of managing spans of control that would otherwise make particular management roles too difficult. However, they should be used sparingly and avoided if possible as they add an additional layer that both increases cost and can hinder communication and the flow of information up and down the line of management.

### **3. Clear roles and accountabilities**

- *Lines of accountability and reporting are clear.*

The lines of accountability should be as clear and easy to operate as possible. Dotted-line relationship and matrixed approaches are reasonably common and are often necessary, but whatever the arrangement in place, the reporting lines need to be clear to all concerned.

- *Individual and team roles, functions and accountabilities (at all levels) are clear.*

Clear roles, functions and accountabilities are essential to the performance of tasks at all levels. They enable performance measures to be created, and performance at all levels to be monitored. Crucially, clarity ensures that people understand what they and others are responsible for, and where they need to work with others to get the job done.

- *Teams and individuals should have sufficient influence over resources required to deliver on their accountabilities.*

Managers and staff require sufficient influence over the resources required for them to carry out the tasks that they are accountable for. While this does not necessarily mean having direct control in all cases, there needs to be some assurance that resources will be available when required.

### **4. Specialist capabilities and cultures**

- *The design should protect and maintain the development of specialist capabilities and cultures that are required to perform functions efficiently and effectively.*

There will be a range of specialist functions and expertise required to perform those functions. These professional skills often align with particular professional standards. The design needs to ensure that specialist skills and cultures are preserved and maintained where these are essential to the delivery of high quality policy outputs.

- *The design should provide a clear career path related to technical/professional skills.*

The design needs to recognise and provide for career opportunities and progression for technical and professional specialists, to ensure job satisfaction, career opportunity within the organisation, and the development of professional leadership and succession.

## 5. Communication

- *The design supports good cross-Ministry communication, as well as good communication up and down the management line.*

An overly fragmented design can lead to the formation of silos that hinder cross-team working and information flows. Similarly, too many layers of management can impede flows of information up and down the management line. The design should also consider other, non-structural means of ensuring that those people who need to be working together and sharing ideas are able to do so in practice.

## 6. Alignment with sector expectations

- *Organisational design is aligned with the needs and expectations of sector stakeholders, so that expectations are met.*

The design needs to optimise the delivery of services and information to the sector, in a way that is relevant to the sector's changing needs.

## 7. Efficiency and financial sustainability

- *The design supports efficient use of resources with no overlaps and duplication, and supports flexible use of resources where required.*

This principle means that the efficient use of resources across the Ministry needs to be considered, as well as the use of resources within Business Units. A design that is consistent with this principle will need to carefully consider the balance between de-centralisation vs. centralisation of functions.

- *The design enables the Ministry to realise savings and improve cost effectiveness.*

This principle reflects a fundamental expectation that Ministers have of all departments, in the context of the need to continue to provide high quality services in an environment of fiscal restraint.

## 8. Alignment with purpose, outcomes, government priorities and statutory roles

- *The design is well-aligned with the performance of purposes and achievement of desired outcomes*

Design should facilitate delivery on the purposes that the Ministry exists to carry out and the outcomes that the Ministry is seeking to achieve over time. An outcomes-based view provides another lens through which to consider the optimal design.

- *The design is well-aligned with the delivery of government priorities*

The design needs to enable delivery on government priorities. This means it also needs to be flexible enough to accommodate a shift in priorities over time, without requiring constant re-design. In this way, 'structure' should follow 'strategy', but preferably not at the expense of a stable structure.

- *The design is aligned with the delivery of legislated roles and responsibilities.*

The design needs to be consistent with, and enable, the effective and efficient performance of the range of statutory roles and responsibilities of the Ministry.

- *The design recognises and supports the responsibilities of statutory officers within the Ministry and legislated committees that are supported by the Ministry.*

There are a range of statutory officers with particular roles in the Ministry, and also a range of committees that are supported and serviced directly by the Ministry. The design needs to ensure that these roles and support requirements continue to be met.