Dear Colleagues

Public Health Accountability Review - Road Map for Change

We outline below a suggested approach to taking forward this important mahi. Recognising that this is a significant shift we tested this approach in principle with the governance group, with a view to taking through the steering group and nominated leads to shape and finalise a way forward.

We have undertaken extensive interviews and focus groups during the first two stages of this project. There seems to be broad agreement that the areas where tensions or ambiguities are impeding effective delivery of public health functions have been diagnosed.

The governance group agreed that the output from this stage of reshaping the project focus should be a contextualised high-level statement of the issues, together with a roadmap for work to address and resolve the key rub points. This statement and roadmap would be voiced as a collective communication by the three organisation leaders, which would demonstrate that issues have been heard and would create confidence in the commitment to an approach to resolution that is collaborative not transactional.

We set out below the seven topic areas outlining what was heard, and suggested goals of work to address them. *This is a view of what we recommend is done, not that Sapere should do it all.* We are happy to assist selectively where it will add value, but you might have other answers to the issues posed.

There are projects and initiatives underway in some of these areas. Where you feel assured that the existing team progressing existing plans will be effective and timely in addressing the identified issues, then signposting this work as part of resolution plans within the roadmap is the best way forward, without a requirement for further independent support. In other areas there are no projects or initiatives underway targeting these issues, so initiating work would be the best resolution path (whether with our team or another team). There may also be topics where you may judge that existing inflight initiatives are progressing, but independent support would better ensure they fully realise resolution of the co-ordination and role issues. In this situation, our team would be happy to augment the initiatives as needed.

Finally, given the sense of pressure on your teams the question of timing becomes important both to ensure there is capacity to engage, but also to reduce pressure through achieving cohesion by progressing the issues.

The table below provides an outline with a one-page summary for each issue detailing what we heard, what the goal would be for successful resolution, and what the work could include, subject to refining with the steering group and nominated leads.

Topic [issue]	Considerations	Resourcing
ACCOUNTABILITIES IN ACTION		
1. Agreed policymaking tikanga and expectations	Initiate now to inform policy programme 23/24.	Light
2. Surveillance functions and management interfaces with strategic partners	Links to PHKS work and provides independent option appraisal of contracting to meet distinct needs.	Moderate
3. Outbreak management swim lanes and operating procedures	New initiative including review of recent incidents and refresh of SOPs.	Moderate
4. Regulatory strategy, operations, and enforcement	Process mapping and swim lanes in priority areas e.g. environment and biosecurity, developing regulatory strategy to inform interventions, gaps, resourcing.	High
BUILDING COHESION		
5. Articulating shared near-term priorities and medium-term plans ahead of formal strategy	Noting work in train led by Ross Bell and his team for PHA, and Simon Everett for NPHS. with additional support if required.	Light to Moderate
6. Collaborative leadership mechanisms	Use of collective action framework to improve capacity to collaborate and resolve stalled and impasse issues.	Light
7. Collaborative clinical governance and clinical risk management	Potential to signpost or augment recently initiated work in this area.	Light to Moderate

Policymaking tikanga

What we found

1. There are real strengths to harness in all three organisations to create more transformative public health policy in NZ.
2. Shared expectations about reciprocal partnership working in policymaking have not been articulated or consistently adopted yet by teams.
3. Te Ao Māori policymaking capacity is a scarce and precious resource, and current policymaking processes are duplicating work, or leading to the need for rework through late involvement and lack of up-front co-design of the policy process.
4. Even with better processes there remain big differences in the bandwidth of PHA and Te Aka Whai Ora policy teams, so there needs to be an agreement, led by Te Aka Whai Ora, about strategies to handle overload, and when to enact them.
5. NPHS' role in policymaking is an omission in the PHAF, so understanding of and buy in to the purpose and benefit of NPHS policy input is variable.
6. The difference that moving to national partner organisations makes to establishing a policy position (including the role of boards) is not yet bedded into the policy development process.
7. The move to a functions-based approach in PHA to policymaking, together with known policy subject experts being dispersed across other functions, leads to partners not having a clear 'front door' and defaulting to informal networks in the absence of clarity.

At the end of work to address the issue you will have:

- A policy tikanga that reflects Te Tiriti, is agreed, and understood and can be articulated consistently by anyone working in the policy process and informs prospective work.
- Some clear and agreed solutions to the tricky issues that arise for legacy work.
- Better use of key experts' time, clear expectations at the inception of work and reduced friction in the process.
- Collateral that helps with stakeholders and sustains ways of working including for new joiners to the organisation.

Considerations

- We understand there may be some work underway by Maria Poynter and Ross Bell with Te Aka Whai Ora in this area, and an appointed Te Aka Whai Ora policy lead is to be collocated with the PHA for two days per week to enhance collaboration.

The approach could include:

1. An in-person workshop-based approach to resetting how policy processes need to happen, and ways to handle common scenarios.
2. A draft protocol including partnership expectations produced and then shared with staff.
3. A simple orientation/induction module for staff who join PHA, Te Aka Whai Ora, or NPHS in policy-related roles that communicates the commitment to, practicalities of, the protocol.
4. A straightforward guide, signed off by all three organisations, for the benefit of other national stakeholders, as to who does what in policymaking, and key first points of contact relating to national, regional, and local issues.

Surveillance

What we found

1. The legislation and Cabinet decisions about health intelligence and surveillance recognise it as a critical enabler to 'span' all three entities, underpinning functions in each organisation.
2. This complex arrangement was intended to lead to working through detail about which knowledge and surveillance functions sit in each entity and how information flows take place.
3. Despite early work by the Ministry of Health on a surveillance function, there is no jointly owned vision for how surveillance should operate between the entities, and the working definition of 'strategic surveillance' as a PHA function and 'operational surveillance' within NPHS can be elastic and create grey areas and anomalies.
4. There are significant differences of approach and needs from commissioned surveillance services with tensions about the sustainable strategic approach, the role of PHA in stewardship and assurance when it is a participant in the function, and the ability to address with urgency intentions for operational change by NPHS.
5. Operational users of surveillance in NPHS managing outbreaks do not have the timely access they need to support their work.

At the end of work to address the issue you will have

- A clear way forward with sign up to how surveillance is taken forward and addressed.
- The ability for NPHS to drive forward on improvement opportunities with pace whilst ensuring future arrangements are sustainable.
- Staff working in each organisation are in the right place and can articulate what falls inside and outside their remit and why.
- Clarity for suppliers about how they relate to each organisation and respond to distinct needs.
- It will be clear for NPHS staff how they commission ESR to undertake time-critical work with more direct channels of communication.

Considerations

- Joint work has been ongoing since late last year on the public health knowledge system with process and programme support by the Nimbl consultancy. The benefit of an independent view to resolve contentious issues was welcomed in our interviews so this area could either be for signposting or for augmenting as an add-on to the current work**.**

The approach could include

1. An independent assessment which applies a collective action framework to the surveillance function to test areas of contention and ensure boundaries are fit for purpose.
2. Application of strategic procurement frameworks for implementation of the key surveillance contracts to ensure all parties have responsive access to what they need and have agency to shape services appropriately.
3. An independent option appraisal of the different supplier management models to inform decision making about contract ownership and operation.

Outbreak management

What we found

1. There is a lack of clarity in outbreak response including a need for timely decision making and, possibly, a "break-glass" attitude.
2. Resourcing of outbreaks is not happening in a timely manner, meaning public health specialists are calling on help through informal, professional networks.
3. It is not clear who is on the ground and leading/ deciding meaning matters such as press releases are too slow and are time consuming.
4. The Director of Public Health is not able to have the situational awareness that is expected of him.
5. The standard operating procedures may not have been updated with sufficient clarity, given the changing organisation roles.

At the end work to address the issue you will have:

- A clear way forward with sign up by each organisation to how outbreak response is taken forward and addressed.
- Clear decision rights during the outbreak, including the ability to issue media statements.
- A clear decision-making pathway to ensure there is sufficient on the ground resource.
- Clear chains of communication ensuring there is confidence in the response.

Considerations

- There is recognition of the clinical issues within recent work on the ODPH operating model, but we are not aware of in-flight works on outbreak management, so it could be a candidate to initiate.
- The three leaders recognise that NPHS takes the lead role in outbreak management, so would lead work on the resolution with support as required from other agencies.

The approach could include:

1. Follow up to identify in more detail key issues in outbreak management and response through focus groups on recent events.
2. An assessment and refresh of the current standard operating procedures based on focus group insights.

Regulation

What we found

1. There is a need to establish a core capability within the NPHS for enforcement and regulatory functions.
2. There is a lack of clarity about why certain regulatory functions sit with a particular entity.
3. There is a degree of inconsistency as to how regulations are interpreted and applied by key decision-makers.
4. Accountability pathways for the regulatory workforce are cutting across the Office of the Director of Public Health and Manatū Hauora (e.g., Medical Officers of Health). This is creating uncertainty about the core competencies for delivering key statutory functions.

At the end of work to address the issue you will have:

- An overarching public health regulatory strategy that sets out:
    - The regulatory context and operating environment.
    - A commitment to a cohesive and co-ordinated regulatory approach. This will include key principles and behaviours, how/when regulatory tools will be used, key areas of harm that will be targeted and how resources will be prioritised. It will clearly define the respective areas of responsibility and how organisations will work together.
    - Key capability shifts that are needed to support this new environment – key changes and actions to get to the future state (including any realignment of functions/responsibilities).
    - What success looks like (how we know we have been successful).
- A commitment from relevant organisations to a new way or working together, with clearly defined responsibilities and a touchpoint for accountability.
- A case, if needed, to support any organisational or functional changes needed to give effect to the strategy.

Considerations

- There is recognition of the clinical issues within recent work on the ODPH operating model, but we understand there is no work in-flight on this, so it would be a candidate to initiate

The approach could include:

1. Mapping current regulatory functions across the respective organisations and document the institutional framework.
2. Interviews which capture:
    a. The priority regulatory public health functions across the system, including the extent to which the organisations are appropriately resourced and structured to deliver them (across the spectrum of functions from policy/strategy to compliance and enforcement).
    b. Any delivery issues – the pressure points, avoidable duplication, inefficiencies, and areas that are generating uncertainty.
    c. Areas where more could be done or where additional future investment might make a difference.

3. Data analysis to capture the respective resourcing being applied to regulatory functions across the organisations and highlight the extent to which these are aligned with key priority and delivery areas.
4. 2-3 workshops to develop a consensus on a way forward. These will focus on what regulatory success looks like and the key barriers/enablers to getting there. Strawman alternatives to the current way of working to help facilitate constructive input on what changes might be needed.
5. Pull together new way of working and responsibilities into a single overarching regulatory strategy for the public health system.

Articulating near-term priorities and medium-term plans ahead of formal strategy

What we found

1. For several areas of friction and ambiguity, having a clearly understood shared view of priorities helps with resolution or gives permission to put issues on the back burner.
2. There is a strongly expressed desire for a clearly voiced expression of priorities to build cohesion across teams.
3. The framework of collective action theory identifies common purpose and priorities as a particularly important element of successful collaborative governance and delivery across partners.
4. Respondents recognise the organisations are struggling to get to proactive ambitions such as addressing social determinants of health, in the face of reactive pressures.
5. The intent of transforming equity for Māori can easily be displaced, and an approach that centres on what will make the most difference for Māori and building out from there to the wider population could address this.
6. The highly professionalised culture of public health means strong clinical and technical convictions, but the collective action regime across the three organisations may not yet be mature enough to support the level of collective deliberation that will be possible in future years.

Considerations

- We understand Ross Bell and his team are leading in-flight work on near term priorities, with a three-year NPHS plan to inform Te Whatu Ora budgets due by October, so this is likely to be an initiative for signposting or augmenting.

At the end of work to address this issue you will have:

- Near term strategic narrative and priorities, ahead of formal strategy document production, that your leaders are confident to voice, that teams feel they had a voice in shaping, that support direction setting and handling of reactive pressures as they come in, and that inform interactions across wider organisations and external partners.
- A connection between near term priorities and the medium term plans for the NPHS informing future programmes and resourcing decisions.

The approach could include:

1. A consensus building process through a modified Delphic process, centred on what will achieve greatest impact on Māori public health.
2. With priorities identified, it would be possible to extend this work to reflect and enhance current action plans through a world café facilitation.
3. Reflection back to confirm the shared 'theory of action' for how change will be realised.
4. Partners use these priorities as a key input into business plan processes in each organisation.
5. Post-process evaluation and feedback to understand how well this approach has worked and how to adjust for future prioritisation processes

Collaborative leadership mechanisms

What we found

1. There are strong relationships at tier 2 level, and some mechanisms that are maturing such as the shared public health leadership group (SPHLG) and joint project groups on policy topic areas.
2. The intention of tier 2 leaders is that SPHLG signs off proposals reflecting pre-agreed consensus at working level, which means that where consensus is not achieved or partners do not engage, staff feel stranded and unable to resolve or escalate issues.
3. The pressures of formation and the dispersed team have led in some places to a culture of seeking resolution through emailed position statements rather than spending time together around a whiteboard to work things through collaboratively.
4. The SPHLG is perceived as a managerial process but does not have clinical/technical equivalent.
5. Staff would value strong and decisive communication from leaders to give a clear shared view of whether identified issues are a short-term priority.

At the end of work to address this issue you will have:

- Clearer mechanisms for timely resolution of stalled issues and impasses
- A clear approach to build over time of capacity for joint action and improve collaborative dynamics, mutual understanding, and mutual trust across senior leaders
- A stronger framework to take decisions
- Reduced friction and risk from joint action, making better use of combined resources where there is discretion to act alone or together
- Tools to identify and address the 3 collective action risks (co-ordination, division, defection)

Considerations

- We are not aware of in-flight work in this area but would expect this will be owned and led by the three agency leaders

The approach could include:

1. Consideration of current issues against the collaborative governance integrative framework to self-assess levels of maturity
2. Joint working session to formulate development plans that build capacity for joint action
3. Communication of expectations across senior leaders and into current shared leadership forums
4. Refreshed terms-of-reference and secretariat arrangements to align with the leadership intent

Collaborative clinical governance and clinical risk management

What we found

1. There was no clear expression of clinical governance considerations in the materials that were made available to us.
2. Respondents expressed concerns that clinical governance and clinical risk management frameworks are not clear or established.
3. One interviewee noted there was no foresight in clinical risk assessment now or, if it happened, it was because of professional input without process.
4. Clinical governance considerations stretch between organisations such as where infection disease clinical guidelines have both operational impacts and national policy implications, and the visibility of levels of risk and mitigation is not well developed.

At the end of work to address this issue you will have:

- A way of ensuring that clinical perspectives are taken account of
- An organised way of thinking about public health risk and therefore of planning mitigating actions

Considerations

- There is an existing initiative in progress overseen by Nick Jones and Maria Poynter with support from Saira Dayal so this is likely to be a candidate to signpost or augment.

The approach could include:

1. Develop options for clinical governance including whether the networks are consultative or have a say over resourcing, and what the boundary of the clinical network is
2. Discuss and clarify what sits within a public health clinical risk management system, review accountabilities and set out systems and resourcing
3. A clear articulation of clinical governance systems, statutory requirements and wider clinical leadership