DEPARTMENT OF THE
PRIME MINISTER AND **CABINET**
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform Briefings February – June 2022

The following documents have been included in this release:

Title of paper: Policy Decisions for Pae Ora Bill Departmental Report: Talking Points

Title of paper: Health Reforms: Quality Functions in the Future System

Title of paper: Progress on Health System Functions Transfer

Title of paper: Health Reforms: Policy Critical Path to Day 1

Title of paper: Health Reforms: Key Policy Decisions and Delegation

Title of paper: Implementing the Intervention Framework for the Reformed Health System

Title of paper: Health Research in the Future System

Title of paper: Progress Update on Public Health Transformation Programme

Title of paper: Pae Ora Legislation Committee Report

Title of paper: Supplementary Order Paper for Pae Ora (Healthy Futures) Bill

Title of paper: Update on the Transfer of Functions from Ministry of Health to New Entities

Title of paper: Appendices to the Interim Government Policy Statement

Title of paper: Health Reforms: Role of Localities in the Reformed System

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

- Section 9(2)(a), to protect the privacy of individuals;
- Section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials;
- Section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion; and
- Section 9(2)(h), to maintain legal professional privilege.

© Crown Copyright, Creative Commons Attribution 4.0 International (CC BY 4.0)

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

IMPLEMENTING THE INTERVENTION FRAMEWORK FOR THE REFORMED HEALTH SYSTEM

To: Hon Andrew Little, Minister of Health; Hon Grant Robertson, Minister of Finance; Hon Chris Hipkins, Minister for the Public Service; Hon Peeni Henare, Associate Minister of Health.

Date	14/03/2022	**Priority**	Routine
Deadline	18/03/2022	**Briefing Number**	DPMC-2021/22-1691 MOH/20220458

Proactively Released

Purpose

This paper describes the framework for how the reformed health system will identify and address issues, and how Ministers, the Ministry and other monitors will ensure visibility and necessary actions. It sets out the escalation pathway and intervention toolkit for Ministers at an entity and cross-system level. This advice does not cover how the Ministry will carry out its role to monitor system performance – further advice on this, with a focus on expectations in the first year, will be provided in April 2022.

Recommendations

a. **Note** that you agreed in July 2021 that a multi-year funding approach for Vote Health at Budget 2022 "should only be implemented once Ministers have confidence that adequate system settings to support improved planning and financial control will be in place" [T2021/1579 refers].

b. **Note** that a key feature of the system operating model is that a majority of responses to emerging or potential issues should be managed by frontline agencies, particularly Health NZ, with only a minority of the highest-risk issues requiring intervention employing statutory levers.

c. **Note** that the performance improvement mechanisms which frontline agencies will use to intervene in emerging or potential issues include those described in previous briefings about monitoring arrangements and quality functions in the future system [DPMC-2021/22-996; DPMC-2021/22-1390 refers].

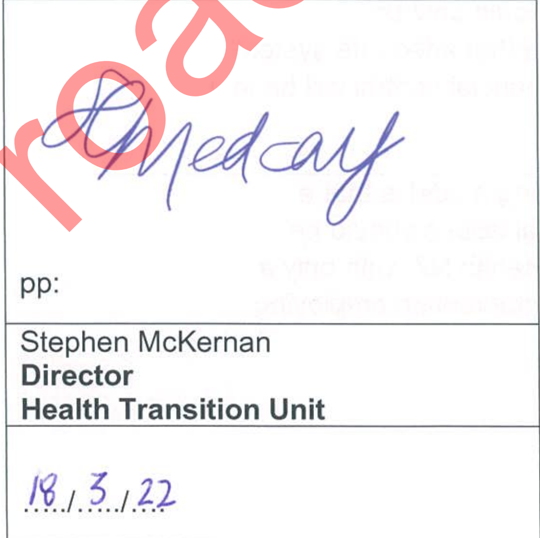
d. **Agree** to the described graduated intervention framework in this paper as the basis for interventions in the future health system, noting that the specific methodologies and approaches used to navigate this framework will evolve over time as you work with the Ministry, agency boards and officials. **YES / NO**

e. **Agree** for the Ministry of Health and Transition Unit to provide an update to interim boards of Health NZ and the Māori Health Authority based on the framework outlined in this paper, to inform discussions about your expectations for future system performance, and signalling the culture shift that is expected within monitoring and delivery entities across the new system from Day 1. **YES / NO**

f. **Note** this paper outlines the framework for interventions to address performance issues that may occur in individual health entities or across multiple entities, but does not include the full breadth of the Ministry's potential interventions in system performance, which may also include policy interventions.

g. **Note** the Ministry will provide a separate briefing to Ministers on its future system performance role and the use of intervention tools, including options for the ongoing use of such interventions on Day 1 to support managing risk through the transition period for the reformed system.

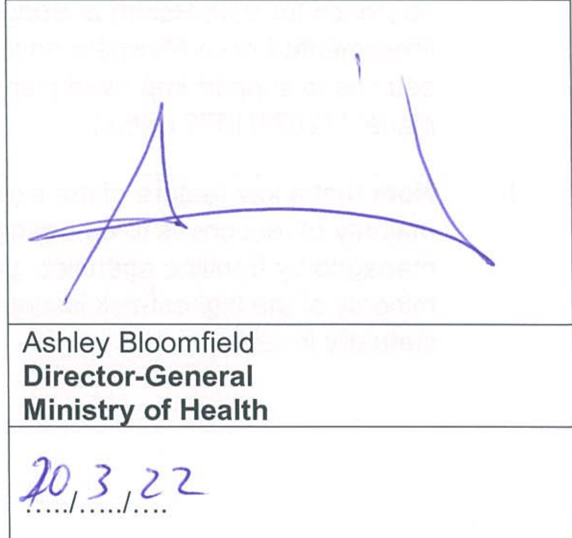
h. **Agree** to discuss the approach to interventions for Day 1 at the next Joint Ministers Health Check-up, as part of advice that you will receive from the Ministry of Health and Treasury around analysis of Budget 2022 and the interim Health Plan, so that management of existing risks through the transition can be considered. **YES / NO**



pp:

Stephen McKernan
Director
Health Transition Unit

18/3/22



Ashley Bloomfield
Director-General
Ministry of Health

20/3/22

Proactively Released

Hon Grant Robertson **Minister of Finance**
..../..../....

Hon Andrew Little **Minister of Health**
..../..../....

Hon Chris Hipkins **Minister for the Public Service**
..../..../....

Hon Peeni Henare **Associate Minister of Health**
..../..../....

Contact for telephone discussion if required:

Name	Position	Telephone	1st contact
Stephen McKernan	Director, Transition Unit	s9(2)(a)	
Simon Medcalf	Health Team Lead Transition Unit		✓

Proactively Released

Minister's office comments:

- ☐ Noted
- ☐ Seen
- ☐ Approved
- ☐ Needs change
- ☐ Withdrawn
- ☐ Not seen by Minister
- ☐ Overtaken by events
- ☐ Referred to

Proactively Released

IMPLEMENTING THE INTERVENTION FRAMEWORK FOR THE REFORMED HEALTH SYSTEM

Executive summary

1. Achieving the aims of the health system reform will require improved intervention arrangements to ensure that when things go wrong in the system, entities respond appropriately. The reformed system model agreed by Cabinet will provide important benefits that support the way entities intervene in the system, and strengthen the ability of Ministers to hold leaders across the sector to account.

2. An effective intervention framework is a key element of accountability. It sets out how the reformed health system will address issues, including how agencies on the frontline will identify and tackle performance issues, and how Ministers, the Ministry and other monitors will ensure visibility and action where problems escalate. Legislation including the Crown Entities Act 2004 sets out various existing powers and responsibilities that apply to Ministers and Crown entities. In the new health system, these arrangements will be supplemented by the Pae Ora (Healthy Futures) Bill which will provide for additional powers and responsibilities specific to the health system.

3. The approach to intervention must reinforce the ethos underpinning the reforms to create a system that is focused on quality, learning, and improvement. In order to support and realise this goal, it will be essential to focus on the establishment and careful maintenance of close working relationships with and across the sector.

4. The tone of an intervention framework needs to mirror this attitude of cooperation – with the Ministry of Health in its strengthened role as system steward assisting Health NZ, the Māori Health Authority and other sector entities to resolve issues, as opposed to independently presenting the Minister with advice on problems. This will require that entity boards and executive leadership are escalating issues where necessary, while having strong monitoring systems in place to verify these activities.

5. Interventions should begin with non-statutory levers – starting with agencies themselves tackling potential issues at the lowest level, with internal escalation while keeping Ministers informed as appropriate – before proceeding to stronger interventions. This framework broadly recognises three levels of intervention:

   a. Internal performance improvement. Entities are equipped to manage issues themselves, with appropriate supervision and support from monitoring agencies, and updates to Ministers on a "no surprises" basis.

   b. Cross-agency involvement. Monitors become formally involved in responding to the issue at hand, taking on roles in providing the expertise and levers to identify, understand and tackle issues. Ministers are kept regularly informed, and may need to make key decisions.

   c. Statutory intervention. Where levels of confidence in responding agencies do not meet Ministerial or public expectations, statutory intervention uses legal powers to offer Ministers more direct control over responses to issues.

Proactively Released

9. On Day 1 of the reformed system, the new entities will inherit a range of existing system risks; and it may be expected to take time to respond adequately to all of these. There will be options for Ministers as to how this intervention framework is deployed from Day 1 to provide sufficient oversight and support for known risks. Further advice on this will be provided by the Ministry of Health.

10. Our view is that the proposed intervention framework, in combination with the new operating model and refreshed monitoring arrangements and quality functions, will be adequate to protect Ministerial and public interests in the context of multi-year funding. Subject to your comfort with our proposed approach, the Ministry of Health and Transition Unit will continue to refine how this framework will operate in practice, and will brief the boards of the interim agencies to ensure a common understanding of expectations.

Background

11. You have already received advice on various components of the accountability settings for the reformed health system, including:

    a. The legislative framework underlying intervention in the reformed system, including the Pae Ora (Healthy Futures) Bill and Crown Entities Act 2004;

    b. overall future system structures, roles, and responsibilities, and key direction-setting artefacts [CAB-21-MIN-0092; DPMC-2020/21-1128 refers];

    c. the accountability framework and monitoring arrangements for the new system [DPMC-2021/22-292; DPMC-2021/22-996 refers];

    d. the quality functions in the new system [DPMC-2021/22-1390 refers];

    e. the approach to an outcomes framework for the future health system [DPMC-2021/22-1550].

12. Amongst these other matters, our advice identified the need for a robust intervention framework to replace the existing District Health Board Monitoring Intervention Framework set out in the Ministry's Operational Policy Guidelines, and form a critical part of the wider system-level approach to accountability.

13. The Ministers of Finance and Health agreed in July 2021 that a multi-year funding approach for Vote Health at Budget 2022 "should only be implemented once Ministers have confidence that adequate system settings to support improved planning and financial control will be in place" [T2021/1579 refers]. This paper has been prepared to outline the intervention framework for the new system, and to provide you with confidence that adequate intervention settings are or will be in place to protect the investment of multi-year funding in the new system.

Context and principles for intervention

14. The future health system has been designed to give Government much greater confidence that local, regional and national issues will be appropriately identified, solved and escalated where needed. Four features of the system operating model particularly inform our approach to intervention:

Proactively Released

a. The future health system will have clearer collective parameters and expectations for operational agencies than today's system. The Government Policy Statement sets the high-level expectations about system priorities and outcomes (as well as Ministerial, Cabinet and policy commitments), and the NZ Health Plan will respond to these expectations, determining the delivery expectations tied to funding. In specific areas of risk or pressure, there will be expectations on agencies to agree the parameters of their decisions in advance. This lends itself to a higher-confidence model, where agencies have more operational freedom in exchange for Ministers assuring the parameters within which they will operate.

b. The shift to national boards governing Health NZ and the Māori Health Authority provide inherent new operational levers compared with the DHB structure. National agencies will be able to make better use of the capability and capacity across the system and develop a whole-of-system view – meaning that Health NZ and the Māori Health Authority will be much better placed to identify emergent challenges and address them than DHBs are today.

c. The design of the system operating model emphasises a learning approach that is informed by robust benchmarking, shared oversight and challenge, networking and support. This will allow local, regional and national issues to be identified and addressed at the lowest level, but with greater internal assurance, support and escalation available – as well as better levers to identify and address more systemic or widespread challenges.

d. The separation of policy and stewardship from operational delivery lends strength to monitoring and reduces the potential for conflicts of interest. By strengthening the Ministry's role as steward and lead monitor of the system, with the addition of the Māori Health Authority and Public Health Agency and continued contribution from the Health Quality Safety Commission, Health and Disability Commissioner and others – Ministers can have greater certainty in evaluation of the system's performance and identification of areas of concern, particularly in equity for Māori. Ensuring strong leadership across the system will be fundamental to the success of the reforms.

15. Even in a system performing well, intervention will at times be needed – ranging from internal actions taken by agencies to avoid poor outcomes (e.g., identifying and addressing local quality issues, or escalating a decision or issue to the board), through to cross-agency responses or more public, statutory interventions which are available to Ministers. The intervention framework described by this paper is intended to articulate when and how different kinds of intervention should occur in the future system, so that the use of different powers and approaches is predictable, well-managed and well-understood.

16. To capitalise on the design of the reformed system operating model, the intervention framework has been designed in line with the following principles:

a. Ensure problems continue to be owned close to the source. This means empowering delivery agencies, which understand the context they operate in best, to take ownership for challenges in the health system at the appropriate level. There will always be risks and issues facing the health system, and it is vital that there are strong first lines of response within agencies to identify, resolve and appropriately escalate issues wherever possible.

Proactively Released

b. Operating on a 'no surprises' basis – if an issue emerges, a collaborative and timely response is best to drive a high-performing system. This includes both the Ministerial 'no surprises' convention, and the desirability of having open and frank sharing between agencies to deliver coherent responses to issues.

c. Systemic problems are addressed through systemic responses – i.e., symptoms are not just addressed in one place, but we identify and tackle root causes where problems have effect across the system. This means that most complex or national issues will require some degree of cross-agency response.

d. Intervention should not be seen as purely punitive, and should be normalised to drive a culture of openness and transparency, learning, appropriate challenge, high performance and improvement, and collaboration. It will be pivotal to ensure people feel safe to report things, not hide poor performance and trust that when they report (or issues are found), this leads to evaluation of underlying causes, appropriate action and learning for the whole system. A persistent challenge in our current health system is that intervention can be seen as draconian or overbearing; we want to establish a norm that it is a standard tool to better understand and influence how the system is working.

17. Achieving the above relies not only on a reset of our formal approach to intervention, but also on shifting the culture of intervention. In the new system, non-statutory levers should be used more proactively, effectively, and with more regularity to ultimately lessen the need for the deployment of the 'harder' end of statutory powers. For example, respective boards would be expected to seek independent advice on their own operations where risks and challenges emerge in advance of involvement by the Ministry. This will create a culture of accountability for performance, where key actors across the system work together to ultimately drive better outcomes.

Roles of entities in identifying and addressing emerging issues

18. You have already made a number of fundamental decisions governing which agencies will hold which functions in the reformed health system. These are highly relevant to how interventions occur, and when. Broadly speaking, agencies operate as either:

a. **monitors and strategy / policy agencies**, including the Ministry of Health, the Māori Health Authority, the Health Quality and Safety Commission and the Cancer Control Agency. These agencies will provide visibility and advice to Ministers on whether the system is delivering on its objectives, and on policy and strategic settings to address issues. They will not ordinarily be primarily responsible for the delivery of services that may require intervention; or

b. **service delivery agencies**, including Health NZ, the Māori Health Authority and the NZ Blood and Organ Service, which do have primary responsibility for planning, commissioning, funding and managing frontline services – and will have in-house performance monitoring and improvement functions to support quality.

19. The roles agencies play in intervention is described in **Annex A**.

20. For the purposes of this paper, we broadly refer to these two categories of agencies – as generally service delivery agencies will have a role as a first line of response to service failures or risks, whereas monitors will generally have greater system oversight, and be involved in cross-agency efforts to respond to more systemic challenges.

Proactively Released

21. We note in particular that the Māori Health Authority occupies a unique role with elements of both categories. It will simultaneously be a major service commissioner – responsible, for example, for managing contracts with Māori providers for a range of primary care services – and also for monitoring the system's performance for Māori. For the purposes of this paper, we generally treat those functions as separable, noting that different parts of the business will be managing each. However, we also further discuss the implications of this potential conflict for interventions below.

22. While we are presenting the intervention framework using the above classifications, this does not limit the Ministry or Minister in only intervening in issues in the service delivery agencies. All health entities (including the Health Quality and Safety Commission and Cancer Control Agency) will also be monitored as part of the Ministry's broader role as lead system monitor.

The intervention framework

23. The range of interventions must reinforce the ethos underpinning the reforms of creating a system focused on quality, learning, and improvement. In order to support and realise this goal, it will be essential to focus on the establishment and careful maintenance of close working relationships with and across the sector.

24. The tone of an intervention framework needs to mirror this attitude of cooperation – with the Ministry of Health assisting Health NZ and the MHA (and other sector entities) to resolve issues, as opposed to presenting the Minister with problems independently. This will require that entity boards and executive leadership escalate issues where necessary, while having strong monitoring systems in place to verify their activities. At times, the Ministry's involvement may be limited to its role as a monitor (keeping an eye on agencies' responses to operational issues), and at other times they may predominantly act as a policy and strategy agency (such as in helping address systematic challenges by using policy levers).

25. Interventions will begin with non-statutory levers – starting with agencies themselves tackling potential issues at the local level, before proceeding to internal escalation while keeping Ministers informed as appropriate – before proceeding to stronger interventions. This framework broadly recognises three levels of intervention:

    a. **Internal performance improvement**. Service delivery entities (i.e., Health NZ and Māori Health Authority) are equipped to manage issues themselves, with appropriate supervision and support from monitoring agencies, and updates to Ministers as appropriate.

    b. **Cross-agency involvement**. Monitors become formally involved in responding to the issue at hand, taking on roles in providing the expertise and levers to identify, understand and tackle issues. Ministers are kept regularly informed, and may need to make key decisions.

    c. **Statutory intervention**. Where levels of confidence in responding agencies do not meet Ministerial or public expectations, statutory intervention uses legal powers to offer Ministers more direct control over responses to issues, including institutional failings.

26. A summary table detailing these levels of intervention, their responses, and triggers/criteria for escalating through each is found in **Annex B**. The progression

Proactively Released

between these levels of intervention will not be strictly linear; there will be issues which require systemic responses from the outset, and in rare cases, an immediate shift to statutory intervention may be needed (where an issue significantly affects trust in boards, or where a clear public signal of intervention is needed).

27. It is noted that these intervention tools are not significantly different to those currently available, however the way they are used should reset our formal approach to intervention, and help shift the culture of intervention to one of collaboration, embodying the emphasis on performance improvement and quality.

28. The future intervention framework will also need to be driven at all levels through the use of robust data sets, including greater predictive tools and artificial intelligence – all of which create the opportunity to improve quality and safety through better understanding of issues and the ability to better identify emerging trends.

Internal performance improvement

29. As outlined above, the first response to any risks or issues that are attributable to agency performance should be for Health NZ and the Māori Health Authority (or any other service delivery entities in the system) to understand, escalate where necessary, and intervene to ensure patient safety and system performance.

30. Issues of this nature will be inevitably regular, and might include:

    a. local issues with a provider failing to deliver on contractual or community expectations, or problems with the performance of a hospital or specialist service;

    b. data on patient outcomes for a particular service providing early signs of declining performance, or stalled inequities in care outcomes; or

    c. initial trends in uptake of a new service exceeding expectations, creating a risk of cost overrun.

31. Such issues will be largely identified by frontline service providers or commissioners, or through internal performance management activities – but may at times also be identified by monitors looking at overall performance data. The approach Health NZ, Māori Health Authority and other service delivery agencies take toward quality in the future health system has been outlined in recent advice [DPMC-2021/22-1390 refers]. Quality improvement functions will be designed to create a culture of learning and continuous improvement, ensure space for benchmarking and sharing good practice, and will be a major contributor to identifying emerging issues in the system.

32. In most instances, agencies will have a range of internal mechanisms available to address issues, starting with local management levers, quality improvement processes, managing or enforcing contracts or investigating service performance. Internal escalation within delivery agencies will move from frontline staff, who are able to manage emergent issues within their delegations (e.g. locality commissioning teams directly managing local contracts) up service management and commissioning management lines. The design of Health NZ in particular is intended to ensure that when escalation occurs, it both brings a wider geographic and system focus (i.e. locality commissioning teams report to regional commissioners, and so on) and offers access to specialist expertise located at the national and regional level.

33. Following internal escalation, internal expertise can be brought to bear to deliver

Proactively Released

targeted improvement, such as involving clinical governance, utilising clinical networks representing key clinical pathways or specialisms, or drawing on best-practice expertise held by specialist teams or regional and national leadership. In a system working well, the operation of these internal processes would not – and would not need to be – ordinarily visible to Ministers or the Ministry of Health. However, the Ministry will have good understanding of how these processes work to assure itself, and Ministers, that appropriate processes are in place and these are used appropriately by the agencies.

Escalating to cross-agency involvement

34. Cross-agency involvement occurs when the response to an issue requires more than the focus of a single organisation. It does not always indicate that problems require a wide-ranging or systemic response – in some cases, it may require only the temporary support of another agency or input of a system monitor.

35. There are a few factors which should precipitate escalation from internal performance improvement to cross-agency involvement:

    a. When following diagnosis problems are found to be systematic and complex – i.e., they are not readily solvable by agencies' own levers, and require a blend of policy and system interventions to address. Here, escalation is intended to ensure that we solve the root causes of problems from the outset, rather than only addressing symptoms while the problem becomes more severe.

    b. When issues are the right combination of serious and widespread. Local problems should be escalated if they have outcomes which put people at serious risk (e.g., a provider which is undertaking dangerous activities). Here, escalation ensures that there is sufficient visibility and oversight of 'big' problems – which both assures an effective response, and gives Ministers and monitors appropriate oversight to manage flow-on risks.

    c. When a risk or issue means that agencies consider they may not deliver on an expectation set by the GPS or NZ Health Plan, including a risk that makes non-delivery of a proposed service or outcome likely, or a risk of cost overrun. Here, escalation is needed to ensure that Ministers have oversight of the potential deviation from their expectations.

    d. Where the response to an issue at the local or regional level presents the opportunity for significant learning for the system to improve wider functions. In these cases, wider involvement of agencies would be helpful to promote best practice and harness the benefits of a response taken within the system to an issue or risk – though in such instances monitoring agencies' involvement should be focused on identifying and sharing information about these practices.

36. In such instances, issues and risks should be escalated to involve monitoring agencies, which might choose to bring a combination of monitoring oversight and analysis and policy and strategy capability to bear. This both equips them to better understand and track potential issues, and support systematic responses by using the full range of needed levers.

37. The Ministry of Health will have regular conversations with key leaders within delivery agencies, particularly Health NZ, to identify potential issues for escalation early, how well internal mitigation or improvement is working, and ensure serious problems do not

Proactively Released

slip through the cracks. Ministers will continue to receive information through no-surprises updates (such as where there might be media risk relating to a specific service or incident, but no systemic intervention is necessary) as well as regular updates through the general accountability and monitoring arrangements.

Cross-agency involvement

38. Cross-agency responses should be the future system's usual way of managing more serious or vexing problems, as they allow delivery agencies to retain responsibility for resolving challenges, while ensuring that all needed levers are brought to bear, and giving appropriate oversight and influence to the Ministry and monitors to assure good outcomes.

39. The Ministry should be routinely informed of cross-agency responses, given its roles as steward, monitor, and chief policy and strategy agency for the health system. The Ministry may also offer some direct support depending on the circumstances, such as taking a facilitation role to broker a cross-agency intervention. However, many kinds of issues are likely to be addressed directly between other agencies – particularly service-level problems, which will often be addressed between Health NZ and the Māori Health Authority through their co-commissioning relationship. Other agencies, such as the Health and Disability Commissioner and monitors outside of the health system should be involved on an as-needed basis.

40. It is crucial that cross-agency responses still plant responsibility for initial response firmly with delivery agencies. This ensures that boards take ownership of regular problem-solving, while recognising the necessary roles of monitors and policy agencies in helping respond to more serious or complex issues. Early involvement of these wider agencies should not usually include the exercise of hard or formal levers, and should be grounded in strong relationships and open sharing of information.

41. Following diagnosis by delivery agencies and monitors, a series of approaches might be appropriate:

    a. Where monitors have confidence that agencies have the necessary tools and approach to successfully address the problem, agencies should be free to manage the issue without undue intervention. If this occurs, internal performance improvement should be permitted, but with more regular reporting to agencies (and Ministers as required). In a system working well, this should be a regularly used approach for problems such as operational underperformance in an area of the system.

    b. Where an agency cannot respond alone – typically because some levers sit with other agencies – monitors should work with the agency to agree a cross-agency response. While this may not require formal governance, it should at least involve a small, informal cross-agency steering group which ensures regular reporting to the Minister of Health and supports decisions about how agencies will jointly contribute to the response.

    c. Where monitors have concerns about an agency's response, or about their evaluation of a problem's severity (i.e., they do not have confidence in the joint response), agencies should formally escalate the problem for Ministerial attention. Subject to Ministerial input, further steps may involve adopting cross-agency steering or governance, or requiring external parties to work alongside

Proactively Released

response teams (e.g., from the HDC, HQSC or an external consultant or auditor), with Ministers making their expectations clear to boards through regular conversations.

42. Significant issues requiring a cross-agency response will include at least some correspondence to Ministers. This ensures a dialogue between Ministers and agencies about the severity of the issue at hand, the nature and success of the response, and whether escalation has been appropriate. This also ensures that any Ministerial decisions which may be appropriate or needed – for example, where the response involves some deviation from the NZ Health Plan, or requires a change in policy – are signalled early.

43. We consider that in a system performing well, even the most serious and systemic issues can – and should – be solved through monitoring and delivery agencies working in partnership, without formal intervention from Ministers or deployment of statutory powers. With open sharing across agencies, and Ministers' closer relationship with the boards, there are opportunities to assure an effective response while leaving delivery agencies primarily responsible and accountable.

Escalating to statutory intervention

44. The above mechanisms should address emergent problems (recognising that even high-performing systems will face problems). Formal, statutory intervention should therefore be reserved for rare circumstances where:

    a. Ministers have lost confidence in the capability or transparency of agencies. While at first instance discussions up to board level should be used to ensure agencies are bringing the right resources and capability to bear on problems (i.e., escalation should not be a response to staff-level issues), this model cannot be sustained if confidence in boards is lost.

    b. There is a very serious or immediate risk to the Crown, which might include a significant threat to public safety which cannot be immediately managed within agencies (e.g., if a key service were to collapse, or be found to be fundamentally unsafe), a material fiscal risk (e.g., a breach of appropriations or major cost overrun), or there is a matter which suggests the dishonesty of directors. In some instances, sufficiently severe problems may necessitate a visible, formal response from Ministers.

45. We note that this intervention framework is premised on even serious matters being able to be managed without resort to statutory intervention. We consider this a desirable feature of this framework: wherever possible, ownership and accountability are bolstered by agencies responding to even serious problems in concert with Ministerial support and with the involvement of monitors.

46. Statutory interventions are powerful but also carry with them a public perception of a loss of trust and confidence in agencies to deliver. We therefore recommend that prior to statutory intervention, it should be usual practice to meet with the chairs and / or chief executives of agencies to directly discuss areas for improvement or lifting performance – unless urgency or the severity of concerns dictates otherwise.

Statutory intervention

47. Should more significant issues be identified, or earlier non-statutory levers fail to

Proactively Released

mitigate risks, Ministers will have a suite of statutory powers which may be used. These include:

a. Powers derived from the Crown Entities Act 2004: including powers to require information from health entities to support analysis of risk, and powers to issue directions for entities to give effect to Government policy. This latter power provides scope for a wide range of potential actions to be required (although its use in relation to the Māori Health Authority is subject to a requirement to consult with the new Māori Health Advisory Committee, and must relate to improving equity of access and outcomes for Māori).

b. Powers to be included in the Pae Ora (Healthy Futures) Bill: these have been designed to replicate effective elements from the previous legislation (e.g., powers to remove board members or replace them with commissioners) and to supplement these with new powers that provide for a more rounded suite.

48. A full description of these powers is set out in **Annex C**.

49. The primary challenge with some statutory levers is that they may be difficult to deploy in some circumstances, both due to the relational implications of their use. However, this framework is intended to provide for the Minister of Health to have good information and clear gateways for when such escalation is needed.

50. As with non-statutory levers, where statutory powers are used they will generally adhere to a graduated pathway to ensure interventions are taken that are proportionate to emerging risks:

a. Statutory interventions available in the first instance may include requiring information for the purpose of monitoring the performance of any health entity, or to provide information to support sufficient oversight of the entity's response to an issue. These powers may be used in an investigative manner, to help understand an issue and provide evidence to justify other interventions, in particular where the regular flow of information from entities is not sufficient.

b. Intermediary measures may include giving directions about the New Zealand Health Plan, or issuing a Ministerial Direction to give effect to government policy. These may also include requiring a performance improvement plan in relation to a specific issue. These mechanisms tend to operate to require entities to respond to a specific Ministerial request, while leaving agencies with a measure of autonomy as to how they deliver them. These are useful to make your expectations explicit and to provide a public signal that you are taking action.

c. Where deeper understanding, oversight and influence is required in an entity's functions, you will also have powers to appoint a Crown Observer to a board, sub-board or executive group. While the precise use of this power will determine how "hard" a lever it is perceived to be, this measure continues to allow for entities' operational autonomy while providing greater direct assurance to Ministers.

d. You also have access to a range of harder levers, including appointing a Crown Manager (in the case of Health NZ only) to the board, or the appointment and removal of board members. We consider these last resorts, if mutually agreed or directed actions have failed. However, we consider that the above escalation

Proactively Released

framework provides for a clear pathway for the use of these powers if necessary, and ensures that agencies have every opportunity to engage in lifting performance before they are used.

The Māori Health Authority

51. The above interventions follow a relatively straightforward progression for most entities; however, two factors add complexity to interventions relating to the Māori Health Authority:

    a. The Authority operates as both a monitor and a commissioner, which could produce a conflict of interest where its advice on system performance for Māori may not fully reflect its performance in commissioning services for Māori.

    b. The Authority has accountabilities to both Ministers and Māori – meaning that some interventions may be perceived as pitting the Crown against the Authority's ability to act to deliver on Māori needs and aspirations (depending on the context).

52. We consider that the risk of a conflict of interest between the Authority's policy and commissioning functions to be relatively low, given both the presence of a co-commissioner in Health NZ, and of other strategy, policy and monitoring agencies in the Ministry of Health and Health Quality and Safety Commission.

53. Where the exercise of powers under the Pae Ora Bill is contemplated, the Minister must consult with the Hauora Māori Advisory Committee to ensure Māori voice is reflected in the decision. A response across Ministers in such circumstances, involving Associate Ministers of Health, the Minister for Māori-Crown Relations and / or the Minister for Māori Development, may be most appropriate to signal that due regard has been given to the Authority's unique role with respect to Māori.

How interventions might occur in practice

54. To provide greater understanding of how these powers may work in practice, we have identified and worked through several scenarios below. Expanded descriptions of these examples, how entities might work together, and the projected intervention pathway for each may be found in **Annex D**. These scenarios include:

    a. Service failure and lack of action to respond resulting in preventable morbidity and mortality.

    b. Continuing deterioration in financial performance, or inappropriate spending.

    c. Collective bargaining breaches set parameters (in excess of agreed budget or terms).

The first two years of the new system

Setting expectations early

55. During the first two years of the new system, it will be important to balance fostering ownership in new entities to realise the vision for the new system, with adequate Ministerial oversight and assurance of performance. We therefore recommend that you prioritise:

Proactively Released

a. using the interim Government Policy Statement and NZ Health Plan as the main vehicles to set and maintain direction – including setting high expectations for entities to evidence delivery against both artefacts, and to maintain a focus on achieving the aspirations and deliverables they outline; and

b. making use of non-statutory levers, rather than statutory levers, to shape system performance – including through regular conversations with boards and board chairs, and working closely with monitors to identify early areas of risk.

56. We recommend using the above in particular to articulate this expectation of transparency to agencies, with an emphasis that you expect over-sharing of issues and risks to monitors, rather than under-sharing. A culture of early escalation during the first few years of the reformed system will allow delivery and monitoring agencies to build clear standards, expectations and protocols for when escalation is needed, and clarify your expectations for when you expect to be informed. The Ministry will provide you with further advice on this at your Joint Ministers Health Check-Up meeting of 28 March.

57. Over at least the first six months of the reformed system, we recommend that you have more regular meetings with boards to provide opportunities to signal your priorities and expectations, as they build their view of how they govern their entities. These will provide opportunities for you to make clear where you want them to prioritise focus.

58. We note that during the period to Day 1, you will also have additional levers available to manage system performance:

a. The formal powers of interim boards are limited by their legal character as advisory boards to the Minister of Health; so, you can issue directions to chief executives of the interim departmental agencies if required (though this power should be used judiciously, if at all).

b. The appointment of interim boards offers the opportunity to appoint different members to the permanent boards if you so choose, without invoking the same level of public interest as is attached to the decision to remove a board member.

c. The 'go-no go' decision available to Cabinet in May 2022 can be used to amend or postpone reforms, if you have sufficiently serious concerns around system readiness or performance at that time.

Managing areas of existing underperformance from Day 1

59. System risks will not be mitigated overnight on Day 1, and the reformed system will inherit a number of known risks and issues from the current system. There will be a need to maintain oversight of these matters, and be ready to put in place interventions early to help ensure a smooth transition.

60. Managing inherited risks during the transition will require clear expectations to respective boards and the Ministry. While some of this direction setting will be achieved within the interim GPS and NZ Health Plan, this may also require Ministerial or Ministry direction for increased monitoring of known risks. This may include identifying behaviours or risks to be strict on when intervening (i.e., deficit management and control) with rapid escalation if issues arrive, to normalise the expected culture of moderate intervention in the new system.

Proactively Released

61. For example, there are already instances where Crown Monitors are in place to manage high-risk, low-performance areas of the system. In such cases, delivery agencies will need to work closely with Crown Monitors to ensure that these areas remain well-managed as responsibility transfers, which might involve some form of continued support to Health NZ or the Authority in the short-term, at the agreement of delivery and monitoring agencies. If you wish Crown Observers or Crown Monitors to be in place in a formal capacity from Day 1, you will need to make active decisions to do so under the new powers in the Pae Ora Bill.

62. The Ministry will provide you with further advice on anticipated system performance risks at Day 1, and options regarding interventions that may be put in place. We recommend that this is discussed explicitly at a forthcoming Health Check meeting between the Minister of Finance and Minster of Health.

Consultation

63. We have worked with the Treasury and the Public Service Commission to develop this advice.

Next steps

64. Subject to your comfort with the proposed intervention pathway, the Ministry and the Transition Unit will continue to work with Health NZ and the Māori Health Authority to ensure understanding of this framework as part of the broader monitoring and accountability of the future system.

65. We recommend providing this paper to the entity boards to inform discussion about your expectations for future system performance, and signal the culture shift that is expected within monitoring and delivery entities across the new system from Day 1. This will further support the interim entities to design their internal structures and processes in line with the principles set out.

66. As indicated, the Ministry will continue to provide advice to Ministers on current system performance and interventions; and in this context will provide specific advice on options regarding Day 1 for the reformed system and early intervention measures.

Proactively Released

Annex A: Roles of entities in health system intervention

Ministry of Health is the lead health system monitor. The Ministry will monitor system-level performance and outcomes, including performance of individual entities, and act as the Minister's agent in assuring functions and providing advice on the use of intervention powers. The Ministry may be directly involved in a cross-agency response to an issue, for instance by taking a brokering role or considering necessary policy or legislative changes. The Ministry will also act on behalf of the Minister in facilitating any statutory interventions.

Health New Zealand (Health NZ) will be governed by a board that is responsible for the performance improvement, monitoring and intervention of the health services which it manages and commissions. As such, it will direct HNZ to develop internal monitoring and reporting frameworks as part of its organisational performance management approach, to identify, escalate and respond appropriately to issues arising within health services. The Board will be expected to work with the HNZ executive team to track progress, risks and issues in a timely way, and – supported by the Ministry of Health – advise Ministers early if significant problems arise or seem likely to arise.

Māori Health Authority (MHA) will be governed by a board that is responsible for the dual functions of MHA's service delivery and commissioning, and monitoring. The Board will be responsible for the performance improvement of the services it commissions, and as such, will direct MHA to develop internal monitoring and reporting frameworks as part of its organisational performance management approach. With respect to its monitoring function, the MHA will monitor the delivery of hauora Māori priorities by Health New Zealand, and provide advice to the Minister as necessary; and will monitor the performance of the wider health system in relation to hauora Māori (in co-operation with the Ministry of Health and Te Puni Kōkiri).

Other agencies' roles in intervention:

Health Quality and Safety Commission (HQSC) will support Health NZ and the MHA to identify emerging issues for performance improvement or cross-agency responses. This includes monitoring and reporting on quality and safety, building sector capability for quality and safety improvement, and building consumer engagement and partnership – and reporting to the Minister of Health on these matters. HSQC will provide updates to the Ministry of Health on these matters, and provide input to analysis on improvement opportunities to support wider reporting and advice to the Minister of Health. HQSC will also facilitate cross-system mechanisms to support identification and diagnosis of systemic quality issues, and may provide direct support in response to some issues (e.g., guidance and evidence).

The Public Service Commission (PSC) will provide support and guidance to Health NZ and MHA in its management of employment relations; and work closely with the Ministry of Health to report and provide comprehensive advice to Ministers on key risks and challenges. PSC will also provide oversight and advice to Ministers on the design and implementation of the new structural arrangements for the health system. The Commissioner also has a statutory role to provide guidance and undertake investigations in matters of integrity and conduct across the Public Service and Crown entities.

The Treasury is the Government's lead economic and financial advisor and the steward of the public sector financial management and regulatory systems. The Treasury's role is to provide advice to agencies regarding any issues escalated with economic, fiscal and financial implications. This includes including performance reporting via appropriations. The Treasury will work closely with the Ministry of Health to report and provide comprehensive advice to Ministers on key risks and challenges.

Health and Disability Commissioner ensures that the rights of consumers are upheld and encourages service providers to improve performance. This includes making sure that consumer complaints are resolved in a fair, timely and effective way. The Commissioner also funds a national advocacy service to help with complaints.

Proactively Released

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

Annex B: Graduated intervention framework

Intervention type	Intervention response	Lead/roles	Triggers/Criteria (examples)	Reporting to Minister
Internal performance improvement Commissioning/ service delivery agencies identify and intervene in issues internally and escalate where necessary.	Internal escalation and targeted improvement	Commissioning and service delivery agencies (Health NZ or Māori Health Authority)	• Local issues with a single provider failing to deliver on contractual or community expectations • Data on patient outcomes for a particular service providing early signs of declining performance, or stalled inequities in care outcomes • Initial trends in uptake of a new service slightly exceed expectations, creating a risk of cost overrun.	• Reporting as usual • Potential 'no surprises' reporting depending on risk evaluation
Cross-agency response Monitors become actively involved in problem solving to bring appropriate powers to bear and ensure appropriate oversight. All issues requiring a cross-agency	**Non-statutory levers may include**: • Monitors working with agency to agree a cross agency response • Minister requests external parties work alongside response teams to support resolution	Commissioning and service agencies, with support from lead monitors as needed (e.g. Ministry of Health, Māori Health Authority). Other monitors, such as the HQSC, HDC; or agencies (such as Treasury, PSC)	• Issues are the right combination of serious and widespread • Problems are systematic and complex • When issues are formally escalated to Boards for consideration • Risk or issue could result in not delivering on an expectation set by the GPS or NZ Health Plan	• Required 'no surprises' reporting • Supporting information or papers as required by Ministers • Potential for Ministerial decision making depending on severity of issue and nature of response

Proactively Released

response should include regular reporting to Ministers to ensure visibility.		should be involved on an as-needed basis).		
	Statutory powers may include: • Director General or Minister requiring information to support monitoring and intervention response • Giving directions about the NZ Health Plan • Requiring a Performance Improvement Plan	Monitors; Minister(s)		
Statutory intervention Minister(s) deploys statutory powers to respond proportionately and appropriately to significant issues.	**Statutory powers include:** • Requiring a review of a Crown entity's performance • Appointing a Crown Observer to the board • Appointing a Crown Manager to the board • Appointment and removal of board members	Minister(s)	• Monitors or Ministers have lost confidence in the capability or transparency of agencies. • Very serious or immediate risk to the Crown (this might include a material fiscal risk or significant threat to public safety) • The risk or issue will be perceived as so serious or severe that independent action or inquiry is necessary.	• Minister-led, with regular reporting from monitors and discussions with monitors and agency boards about achieving necessary resolution

Proactively Released

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

Annex C: Graduated statutory intervention framework

As at 1 July 2022, assuming the Pae Ora (Healthy Futures) Bill passes into law with the changes recommended in the Departmental Report.

Power	Held by	Basis	Constraints and limitations
Levers designed to help Ministers address organisational performance issues:			
Require a Performance Improvement Plan	Minister of Health	Pae Ora Bill s.57	
Appoint a Crown Observer to the Board	Minister of Health	Pae Ora Bill s.55	
Appoint a Crown Manager to the Board	Minister of Health		(Proposed in Departmental Report)
Remove the Board and replace it with a Commissioner	Minister of Health	Pae Ora Bill s.56	For MHA, mutu have the consulted with the Hauora Māori advisory committee
Other levers that can be used for this purpose (alongside other purposes):			
Require information	Minister of Health	CEA s.133(1)	
	Director-General of Health	Pae Ora Bill s.93	"For the purpose of monitoring the performance of any health entity or the health system in general"
	Minister of Finance	Pae Ora Bill s.58	"provide economic or financial forecasts or other economic or financial information"
	Minister of Finance; Minister for the Public Service	CEA s.133(2-2B)	Can request information relating to their CEA responsibilities

Proactively Released

Appoint and remove Board members	Minister of Health	CEA s.36; POA s.23	For HNZ, no reason needed. For MHA, must consult with Hauora Māori Advisory Committee.
Issue a Ministerial Direction	Minister of Health	CEA s.103	
Give feedback on / direct changes to SOI or SPE	Minister of Health	CEA s.139A, s.145, s.147	
Give directions about NZHP	Minister of Health	Pae Ora Bill s.45(h), s.47	
Undertake a review of a Crown entity's operations and performance	Minister of Health	CEA s.132	The Minister must consult with the entity on the purpose and nature of the review, and consider any submissions made by the entity on the proposed review.

Appendix D withheld in full under section 9(2)(g)(i) of the Act

Proactively Released