Te Whatu Ora
Health New Zealand

Clinical Leadership Consultation: Final Decision Document

13 December 2024

Glossary

There may be some language or terms used in consultation and final decision documents that you may not be familiar with.
The below glossary (which is included in each document) provides an explanation of those terms.

Term	Explanation
Business Unit	The national team e.g. Planning, Funding & Outcomes, Finance.
Contestable Reconfirmation	Where there are more employees than positions available for reconfirmation, then a contestable process will be undertaken to select the employees whose positions will be reconfirmed. This process will be a closed process for only those employees employed in these positions. Where there are the same number of, or more, positions available for reconfirmation than employees then Health New Zealand |Te Whatu Ora may reconfirm affected employees in these positions without the need for a recruitment process, or the need for offer and acceptance.
Direct appointment	If there is only one candidate who has expressed interest in a position through the internal recruitment process, and they are assessed as suitable for that position, they may be directly appointed into the position and not need to undergo an interview process.
EOI Recruitment Process	The process by which employees whose position is disestablished can express an interest for new positions. Provided they have the skills, competencies and experience for the position (or could, with some training or upskilling), they will receive preference ahead of other employees whose positions are not disestablished, and external candidates. Internal Recruitment Process is summarised in the final decision document and a full guidance document will be provided to every employee whose position is disestablished.
Function	The name of a team within a business unit, e.g. Internal Communications, Health Analytics and Insights, Commissioning
Impacted/reconfirmed	A position is impacted where there is some changes to the current position, however the changes are not significant, and the position remains substantially the same. Examples of these types of changes may include a change in position title, reporting lines or transfer to a different business unit.
More to Less	Where there are more employees than positions available, within a particular job group, then a contestable process will be undertaken to select the employees who will be offered these positions as redeployment. This process will be a closed process for only those employees employed in these job groups.
No Impact	A position remains unchanged.

Glossary

Term	Explanation
Notice of disestablishment & termination	Where the Final Decision Document confirms that a position will be disestablished, the employee in that position will be given notice of termination due to redundancy as per their employment agreement, during which period Health NZ | Te Whatu Ora will engage with the employee to explore any alternatives to redundancy.
Pay in lieu of Notice	Where an employee is paid in lieu of working out their notice period.
Preference	During the EOI recruitment processes, an employee whose substantive position has been disestablished will be given preference over other applicants whose positions are not disestablished and external candidates for any vacant positions. This means that if they meet the selection criteria for the position, they will be interviewed and considered for the position before any other applicants. If a direct appointment situation applies, they may be directly appointed into the position and not need to undergo an interview process.
Reconsultation	An obligation to "reconsult" may arise where there are material changes to the original consultation proposal which substantially affect employees' positions. In this case affected employees should be given an opportunity to provide further feedback on the changed parts of the proposal.
Redeployed	An employee would be redeployed where their position has been disestablished, they have participated in the internal EOI recruitment process and they accept an offer to a new position in the structure. Additionally, where an employee whose position is disestablished applies for and is successful in their application for a current vacant position they will also be deemed to be redeployed.
Selection Criteria	The criteria against which candidates will be assessed in a selection process where there is potentially more than one suitable candidate for a position.
Selection Process	The process through which selection decisions will be made where there is more than one suitable candidate for a new or vacant position
Significantly Affected / Disestablished	A position is significantly affected where there is a significant change to the current position, including to its scope, location, terms and conditions or it does not exist in the new structure. A position is also significantly affected if there are fewer of the same, or substantially the same, positions in the new structure. These positions will be disestablished.

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SECTION 1 : Foreword

Kia ora koutou

We want to start by acknowledging your patience throughout this process, we know it has been long signalled and are extremely grateful for the significant feedback we received from across the motu.

We received 1236 comments and suggestions on 'What Say You', 24 individual submissions and had the opportunity to discuss the proposals at 10 in person events and additional online meetings.

The feedback we received has led us to rethink some aspects of the original proposal; we have listened and heard your views about what you think will and won't work, and have amended our structure in response, whilst continuing with a decision which will move us towards greater consistency in clinical leadership across the motu and strengthen the clinical leadership voice.

In our meetings during the process we had lots of discussion about the importance of the clinical voice in decision making, and as Deputy Chief Executives (DCEs), we want to ensure we have a partnership model with clinical leaders at the regional level, whilst maintaining GDO partnership with local clinical leaders. We set out our structure for clinical partnership with DCEs at the regional level, through portfolios which report to us, in this document. This also provides a link between local and regional clinical voice.

In this document we set out our decisions in more detail, and the high-level feedback we received, alongside our responses. We are also signalling in this document our intent to move forwards in establishing Regional Service Delivery Networks, and our intent to look at developing a rural clinical leadership model.

The way we work together is as important as the structural elements in making this change process successful. We have decided to continue with the proposed ways of working which includes clinical leaders working together in partnership with operational leaders, with a whole of system approach and utilising portfolios to ensure distributed clinical leadership. We want collaboration across districts and regions to be the norm, with a focus on patient outcomes, which will drive improvement across the healthcare system. We also want our clinical leaders to be working in an interdisciplinary way to harness the expertise and unique contributions of our workforces. Thank you for your commitment to making this work.

We want to thank you all for your ongoing mahi and leadership, in a challenging time for our organisation.

We look forward to continuing to work with you as we progress our clinical leadership model.

Richard Sullivan
Chief Clinical Officer

Mark Shepherd
Deputy Chief Executive Northern Region

Cath Cronin
Deputy Chief Executive Te Manawa Taki Region

Robyn Shearer
Deputy Chief Executive Central Region

Martin Keogh
Deputy Chief Executive Te Wai Pounamu Region

SECTION 2 : Decisions - Role of Clinical Leadership

The proposed role of clinical leadership was generally supported, and the four areas of leadership below form the basis of the PDs. We have developed profession specific PDs for CMOs, Chief Nurses and Chief Allied Health, Scientific and Technical (ASHT) based on feedback received through the consultation. PDs will be circulated to Chiefs in post for final feedback before being finalised in January.

- Quality improvement
- Strategic vision
- Driving change
- System connectivity
- Improving ways of working
- Delivering outcomes
- Clinical services planning

Clinical Leadership

- Support and mentoring
- Relationship with regulators
- Covers employment issues
- Ensuring workforce professional standards are maintained e.g. accreditations
- Ensuring training and service planning works in the local area

Professional Leadership

- Inter-disciplinary collaboration
- Defining who can do what at local level
- Local service delivery
- Implementing safe staffing
- Ensuring staff wellbeing
- Oversight and responsibility for FTE for the relevant profession

Operational Leadership

- Creates an environment where clinical excellence flourishes
- Ensures services are responsive to their communities
- Drives quality improvement, risk management and monitoring with whole of system focus
- Safe, skilled and compassionate

Clinical Governance

- Alongside core area of work
- Extend beyond main role and geographic area
- Focus on specific tasks or challenges
- Opportunities to contribute regionally/nationally and expand personal experience

Portfolio working

Ongoing clinical practice:

- Dependent on FTE requirements of the Chief role and personal preference of the individual they may continue in clinical practice

SECTION 2 : Decisions - Role of Clinical Leadership - Portfolios

The concept of portfolios was generally supported, with feedback on some of the roles that could be undertaken as a portfolio and that much work that could be described as 'portfolios' is already occurring. We have decided that portfolios will be formally enacted to provide distributed clinical leadership and partnership to key national and regional programmes of work.

Regional clinical partnership to us as DCEs will be provided through a portfolio model by District Chiefs for Medical, Nursing, Allied Health, Scientific and Technical (AHST), Midwifery and Mental Health and Addiction (MH&A) (please refer to slide 13 for more detail on the decisions about proposed regional roles for Midwifery and MH&A). These portfolios will be allocated through an EOI process led by DCEs, and Chiefs appointed to these roles will report to the DCE for the portfolio portion of the role. The Regional Chief portfolio will be for a fixed term to enable the portfolio to rotate between Chiefs across the region. This also provides a link between local and regional clinical leadership and gives a wider range of clinical leaders the opportunity to contribute, encouraging a pipeline of emerging leaders to develop. DCEs will determine other regional portfolios for our district Chiefs per the needs of our regions.

As proposed, there will be national portfolios for Chiefs which will be determined per the needs of the organisation.

FTE allocated to a portfolio will vary according to the requirements of the portfolio and agreed with the individual. An EOI process will be undertaken to allocate portfolios as they are developed.

To Confirm:

- Portfolios will be formally enacted.
- Regional partnership to DCEs will be provided through a portfolio model for Medical, Nursing, AHST, Midwifery and MH&A.
- The Regional Chief portfolio will report to the DCE and be for a fixed term.
- Other regional and national portfolios will be developed according to the needs of the organisation.
- FTE allocated to a portfolio will vary according to the requirements of the portfolio and be agreed with the individual.
- An EOI process will be undertaken to allocate portfolios as they are developed.

SECTION 2 : Decisions – Role of Clinical Leadership - Whole of System and Clinical/Operational Partnership

Whole of System

We received feedback that the concept of whole of system working for Chiefs was unclear, and concerns that the proposal did not adequately consider or include existing Clinical Leadership roles in other business units across Health NZ which work directly with Primary and Community providers such as roles in NPHS and Planning, Funding and Outcomes, and clinical leadership roles in other parts of our health system.

We acknowledge the important work being done by other teams, including those in Clinical Leadership roles, across our organisation and in other healthcare organisations in our communities. We know that a significant amount of healthcare is provided outside of hospitals, and that ensuring the most appropriate and efficient care pathways in the community is crucial to ensure the best patient experience, and sustainable health care; which is why we think it is crucial that our Chiefs within hospitals take a whole of system approach to system wide problems to improve integration between the different parts of our healthcare system. We also acknowledge that some areas are already working in a strongly integrated way across the whole system, however we want this to be the norm across the motu.

This does not mean that Chiefs will take on the current roles and responsibilities of Clinical Leaders in other parts of the organisation, or in other healthcare providers, but rather that there is an accountability for Chiefs to partner and collaborate with these other Clinical Leaders to ensure a wider than hospital view is taken when planning service provision or taking key decisions on healthcare delivery. Ensuring this wider perspective which takes a system wide view will lead to better integrated decision making, and ultimately and most importantly, better services for patients and whānau.

Clinical/Operational Partnership

There was general support for the importance of clinical/operational partnership to ensure decisions are taken with a clinical lens. There were queries about how this would work at a regional level with the mixed model of regional and district clinical leadership roles, and that it needs to be mirrored at all levels of the system.

As noted earlier, regional clinical partnership to DCEs will be provided through portfolios for Medical, Nursing, AHST, Midwifery and MH&A providing consistency across professions. These roles will report to DCEs for the portfolio portion of their role, to provide clinical partnership. The regional roles for QPS will also provide partnership for DCEs to ensure an oversight of quality matters across the region. With the reporting lines for Chiefs into the local GDOs, district clinical partnership is also maintained.

The next layers of leadership and partnership, and how this is further developed, will be considered by DCEs.

To Confirm:

- Clinical Chiefs and will be expected to work in a ‘whole of system’ way through partnership and collaboration with other leaders within and outside Health NZ.
- Clinical/Operational partnership will continue as a core part of how we work together.

SECTION 2 : Decisions – Role of Clinical Leadership - Te Tiriti Partnership and Rural Clinical Leadership

Hauora Māori Service structure

We received feedback on the importance of the partnership model with Hauora Māori colleagues and that this partnership should be modelled at all levels of clinical leadership. The Hauora Māori Service consultation sets out the proposed structure for the business unit, proposing clinical leadership positions at a national and regional level. These roles would partner with the clinical leadership roles in this structure and operational partners to ensure services meet the needs of Māori.

Equity remains a key priority for the organisation, and prioritising partnership and equity considerations is a core function of the clinical leadership roles in this document. The Hauora Māori Service proposed structure aligns with the direction of travel for the organisation towards devolved decision making, and our regional and district level Chiefs would partner with Hauora Māori colleagues to ensure collaborative decision making.

To Confirm:

- The Hauora Māori Service structure is being consulted and decided on separately.

Rural Clinical Leadership

We received feedback on the importance of rural clinical leadership, the different needs of and inequities that exist in rural communities, and the fact that a rural specific model was missing from the proposal with a perception that the proposal was metro-centric.

We acknowledge the importance of rural clinical leadership and heard well developed suggestions from colleagues about what a rural model might look like. We are committed to developing this thinking further and will work with individuals in rural leadership roles and with expertise in this area to develop a rural clinical leadership model which ensures a robust and consistent approach to rural clinical leadership.

To Confirm:

- We will work with colleagues to develop a rural clinical leadership model.

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SECTION 2 : Decisions - how we want to work

Whole of System

The outcomes we expect from 'whole of system' working include:

- Better integrated care for patients.
- New models of care which target prevention and disease progression earlier, in community settings.
- A system that prioritises seamless patient journeys and considers the whole person/ whānau in care.
- Improved outcomes for patients and whānau.
- More sustainable service models.
- Improved visibility of risk across the healthcare system enabling us to reduce risk.
- Shared innovation to tackle shared problems in our healthcare system.

Examples of this in action:

- virtual care which reaches across Aged Residential Care providers and is overseen by HSS specialists.
- moving radiology services into the community.
- effective population health action to best minimise ill health, through 'upstream' action on those risk factors that are common starting points for many illnesses and diseases seen in our hospital patients.

Partnership

The clinical leadership model is a partnership model between clinical leaders and organisational leaders and managers.

Local Clinical Chief roles will report to the Group Director of Operations (GDO), with a dotted line to the relevant national Chief.

Clinical Chief roles will work in partnership with operational leadership to implement models of care, develop service delivery improvements, ensure safety and quality of services and provide advice and direction including professional considerations for the clinical workforce group they represent.

These roles will ensure operational decision-making is influenced by clinical considerations. There will also be separate areas of accountability and responsibility for the clinical roles and the GDOs, but key decision making should be made in partnership.

We also want to work in an interdisciplinary way across clinical professions. Clinical leadership roles should be working together to ensure the contributions of each workforce are heard.

We also want to focus on engaging and supporting our clinical staff in the delivery of safe, effective and person-centred care; this begins and ends with positive practice environments. We need to work in a truly interdisciplinary way across clinical professions. Clinical leadership roles should be working together and supporting one another to ensure the contributions of each workforce are heard and recognised, utilising the talents of all clinical professions to enhance consumer and whānau experiences and deliver a step change in health inequities.

Clinical Chief roles will also work in partnership with colleagues in the Hauora Māori Service and Pacific Health teams to ensure equity is at the heart of everything we do.

Portfolios

Advantages of portfolios:

- A flexible approach to extending clinical leadership.
- Supports a more joined-up system building connections across the organisation to work on specific areas or challenges – ensuring clinical input and partnership across a range of work.
- Follows individuals' interests, strengths and skills.
- A route to expanding personal experiences and building skills, thus strengthening the senior leadership pipeline for the future.
- Supports integration activities at a regional and national level, and 'whole of system' working.
- Enables clinical expertise where required whilst avoiding FTE growth where this is unwarranted.

Examples of this in action:

- Regional Clinical Partnership to the DCEs.
- Lead for rural health regionally or nationally.
- Technical expert in Health Service Accreditation inspections.
- Co-lead for national or regional clinical services planning activities.
- Clinical leadership role to support Resident Doctors Support Service (RDSS)
- Leading the development of new pathways to support faster access to the right health professional such as the MSK pathway.
- Developing models of care such as Healthcare Assistants Earn and Learn Programme Level 3 Certificate/

SECTION 2 : Decisions – Local roles

Groupings

We received strong feedback on the proposed groupings with many concerns about the potential to lose local clinical voice and autonomy through the groupings, and the potential to destabilise leadership at an important time when districts are focusing on targets.

We have considered all of the feedback and have decided not to proceed with grouping any of the districts at this time. We may look to future groupings for these districts at the right time and if so, would undertake a further consultation process at that time.

To Confirm:

- We will not proceed with the proposed groupings at this time

Role content and titles

We received lots of feedback on the importance of local roles, the responsibilities and accountabilities these roles currently hold and what they should be doing going forward. This feedback has been reviewed, and draft PDs for each profession at a district level will be circulated to Chiefs in post for feedback prior to being finalised in January.

You also told us that the title 'Lead' in a grouped district did not reflect the seniority and mana of the role. These roles will no longer be featured in the structure, as we are not proceeding with grouping districts, however we will consider this feedback as the clinical leadership model continues to develop.

There was also feedback that the proposed Chief of Nursing role title should align to an internationally recognised title; this role title will be changed to Chief Nurse. Finally, if a district chooses to use its Chief FTE to employ two people rather than one, the second role will be called an 'Associate Chief'. An Associate role may also be used if a Chief takes up a significant portfolio and the district therefore requires more local leadership. This will be a case-by-case consideration.

To Confirm:

- Final PDs for Chief roles will be confirmed in January. These PDs will apply to all new and existing Chief roles across the motu.

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SECTION 2 : Decisions – Local roles

Reporting lines and FTE

In our proposal, we proposed that the Chief role for Medical, Nursing and AHST could be in either district, as could the Lead, e.g. the CMO could be in Wairarapa and the Lead could be in CCHV, or vice versa. As we have decided not to proceed with the groupings, local Chiefs will retain their reporting line to the local GDO.

We received feedback that 0.4FTE was not sufficient for the 'Lead' roles. As we are not progressing the groupings, these roles will not be established. We proposed Chief roles could be 0.6-1 FTE to allow for ongoing clinical practice. Where local Chiefs may have a lower FTE in their Chief role currently, we will not amend FTE. However, as roles become vacant over time we will look to implement the proposed 0.6-1 FTE in those districts too.

Joint professional roles

We proposed to disestablish joint professional roles (nursing and midwifery) and establish a Chief Nurse in their place at a district level. There was support for the uncoupling of these two professions, alongside concerns about a potential loss of local midwifery leadership.

Please refer to slide 13 for more detail on the decisions about Midwifery leadership. Where the midwifery leadership role for the district (i.e. an Associate Director of Midwifery role) reported into the joint Chief Nurse/Midwifery role, their reporting line will now change to the GDO on an interim basis, to mirror the other clinical leadership roles for Medical, Nursing and AHST. This interim arrangement will be in place whilst DCEs consider next steps for wider H&SS structures.

Multiple Chief roles

In Bay of Plenty there are currently two Chief Nurse roles: a Chief Nursing Officer and a Chief Nursing Officer – Toi Ora. These roles will be disestablished and replaced with one Chief Nurse role to align with other district clinical leadership structures.

EOI and recruitment process

The EOI process is outlined in section 4 of this document. For Bay of Plenty where we have a more to less situation, we will run a contestable EOI process to select the employee who will be offered the position as redeployment. This process will be a closed process only for the current Chief Nursing Officer and Chief Nursing Officer – Toi Ora in Bay of Plenty.

All roles which are currently filled in an interim capacity will be recruited through a competitive recruitment process.

To Confirm:

- Chiefs will continue to report into the local GDO.
- FTE for Chief roles will range from 0.6-1FTE (per the proposal).
- Joint professional leadership roles for joint nursing and midwifery roles will be split and replaced with a Chief Nurse.
- Where the midwifery leadership role for the district (i.e. an Associate Director of Midwifery (ADoM) role) reported into the joint Chief Nurse/Midwifery role, their reporting line will now change to the GDO on an interim basis, to mirror the other clinical leadership roles for Medical, Nursing and AHST.
- District Chief roles which are currently filled in an interim capacity will be recruited through a competitive selection process.
- Chief roles will be appointed by the relevant GDOs and National Chief.

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SECTION 2 : Decisions – Regional roles

Mental Health and Addiction

There was general support for the proposed Regional Chief Mental Health and Addiction to bring a regional focus to this important area. Feedback was received that the role should report into the DCE to ensure an operational focus and close partnership model.

We agree with the requirement for strong regional operational oversight of mental health and addiction services. This is different to the clinical leadership role we proposed and is an operational rather than professional leadership focused role which does not require a clinician to undertake the role. Therefore, DCEs are establishing interim regional operational MH&A leads, and professional regional leadership for MH&A will be provided through a portfolio model.

The portfolio Chief role will work closely with this operational role.

To Confirm:

- Regional clinical partnership to DCEs for MH&A will be provided through a portfolio. This portfolio will be appointed through an EOI process.
- These professional roles will work closely with the Regional Lead MH&A (operationally focused).

Midwifery

There was concern that the proposed Regional Chief Midwife role may disempower local midwifery leadership, and that district level midwifery leadership aligned to the other professions would be preferable. There was also feedback that regional representation could be achieved in other ways without the need for a regional level role. After considering the feedback, we have decided that regional Midwifery partnership will be provided through a portfolio.

To ensure appropriate local leadership is maintained, we will appoint interim, part time midwifery leadership roles to ensure clinical safety in districts which do not currently have adequate local midwifery leadership (Lakes, Wairarapa, South Canterbury). This interim arrangement will be in place whilst DCEs consider next steps for wider H&SS structures.

To Confirm:

- Regional partnership to DCEs for Midwifery will be provided through a portfolio. This portfolio will be appointed through an EOI process.
- Interim midwifery leadership roles will be appointed in districts which do not currently have an adequate midwifery leadership role..

SECTION 2 : Decisions – Regional roles

Regional Chiefs Kahu Taurima and Oranga Hinengaro Roles

Overall, there is general support for the intention of these roles which are population need focused and equity orientated. Feedback emphasised the importance of developing the operating model and ways of working that would ensure these roles enable system integration and collaboration. The presence of these roles should be informed by locally driven/IMPB community health plan priorities, and should not contribute to siloed ways of working, or duplication of any form across the system.

Although these roles were signalled in our consultation process, they sit within the Hauora Māori structure. The Hauora Māori Services consultation has been released and these roles will be consulted on, and a decision will be made on whether to proceed with these roles, through that process. The feedback received through this consultation process will be passed onto the Hauora Māori Service team for inclusion in that process.

The National Clinical Leadership Team are committed to our partnership with Hauora Māori Services. The inclusion of the Regional Chief MH&A and Midwifery portfolio roles, and the proposed inclusion of the Regional Chief Kahu Taurima and Oranga Hinengaro roles recognise the urgent need to reduce the inequities in health outcome, advance health gain and development for this proportion of our population. The roles would focus on high needs, vulnerable populations, leading and directing improvements regarding equity of access, quality and experience outcomes.

To Confirm:

- The Regional Chiefs Kahu Taurima and Oranga Hinengaro will be consulted and decided on through the Hauora Māori Service consultation process.

Quality and Patient Safety

We did not propose a structure for Quality and Patient Safety in our proposal but noted that discussions were ongoing between DCEs and the National Chief, Quality and Patient Safety regarding the regional level structure for these roles.

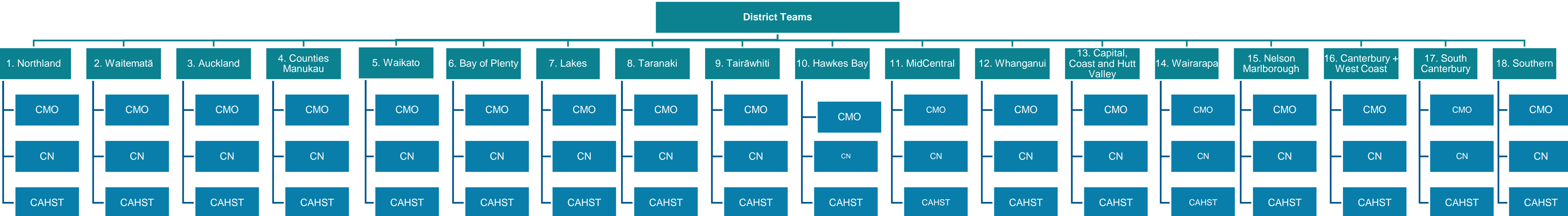
DCEs have decided to establish a Regional Quality and Patient Safety Lead in each region. These roles will be 1 FTE, with a direct reporting line to the DCEs, and a dotted reporting line to the National Chief, Quality and Patient Safety. These roles are being advertised.

The National Chief, Quality and Patient Safety is also working with colleagues across the motu on Clinical Governance arrangements for regions, to ensure a consistent and robust approach. Leadership in quality and clinical governance is one of the core functions of all Chief roles, and the QPS Lead will provide dedicated leadership and support across the region. Consistent frameworks and approaches will be developed at a national level.

To Confirm:

- Regional Quality and Patient Safety Lead roles will be established in each region.
- These roles will be 1 FTE, with a direct reporting line to the DCE and a dotted line to the National Chief, Quality and Patient Safety.

SECTION 2: Decisions– Full Local Clinical Leadership Structure



Key:

Key for Org Chart	
	Tier 4

CMO	Chief Medical Officer
CN	Chief Nurse
CAHST	Chief Allied Health Scientific & Technical

*All district level Chief roles will range from 0.6 – 1FTE to allow for continuing clinical practice.
*All Deputy Chief roles will range from 0.5-1FTE.

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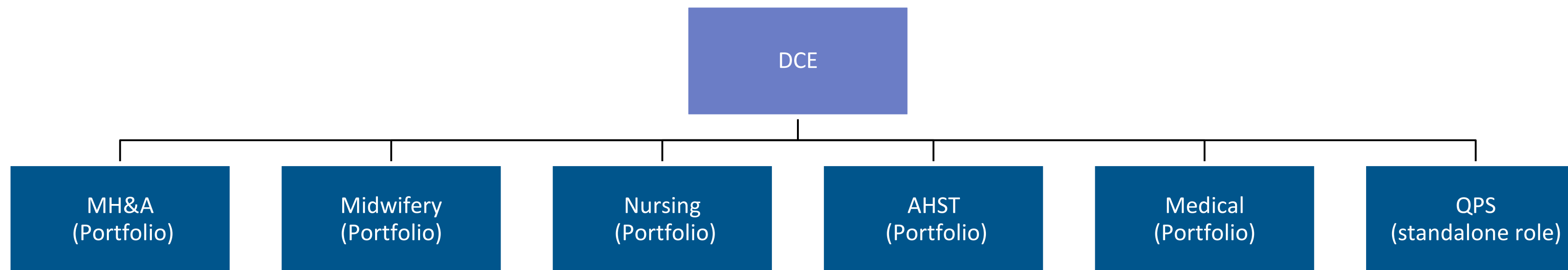
SECTION 2 : Decisions – Regional clinical leadership roles - structure



- These roles will have a dotted reporting line to the National Chief.

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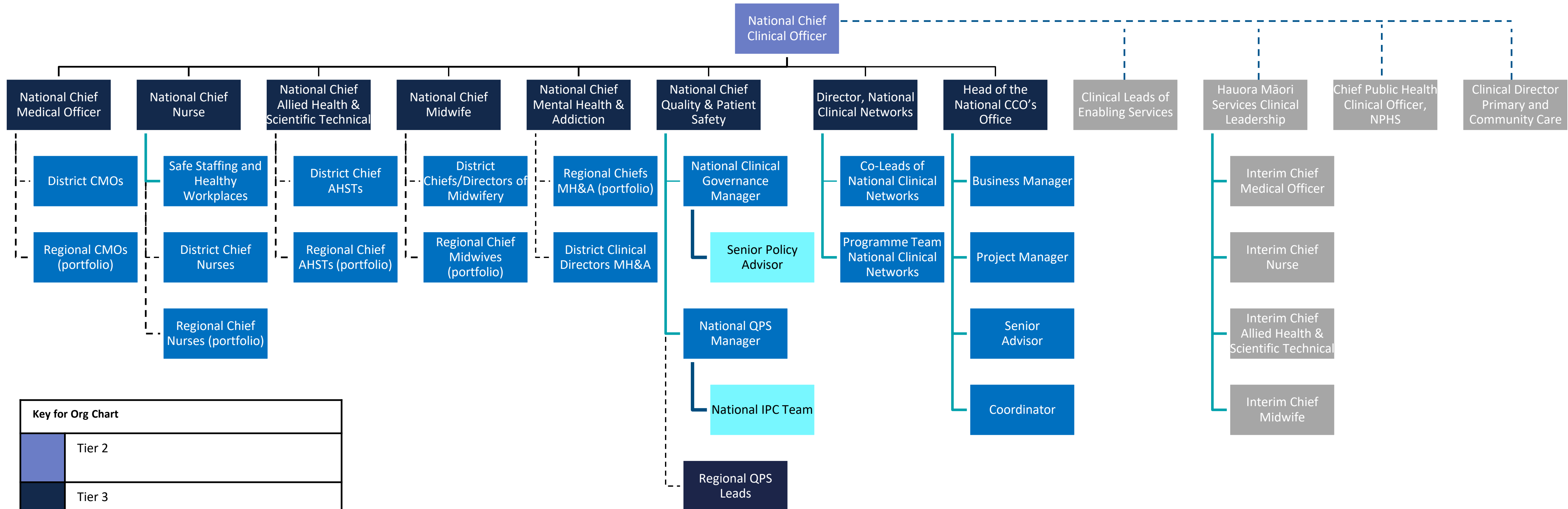
SECTION 2 : The wider national structure – National Clinical Leadership Team



- Grey boxes indicate the wider national clinical leadership team roles which report into other functions of Health NZ but work in partnership with the National Clinical Leadership Team.
- Hauora Māori Services Clinical Leadership will be consulted and decided on through their consultation process.

SECTION 2 : Next layers and Service Delivery Networks

Next Layers of the Clinical Leadership structure

We received feedback that it would be preferable to see the whole clinical leadership structure within Hospital and Specialist Services, with the number and format of supporting roles varying across the motu. The next layers of leadership and partnership, and how this is further developed, will be considered by DCEs.

Regional Service Delivery Networks

Some time ago, H&SS released a proposal which outlined the concept of Regional Service Delivery Networks. These networks were intended to operationalise national decisions and frameworks in key areas and improve consistency in clinical practice and access to services across a region. Networks will drive integration and improvement across the region in their specialist area.

We are signalling that we will begin to implement these networks, with Cancer and Radiology being the first of the networks to be established. The networks will have joint operational and clinical leadership. The clinical leadership of a network could be a portfolio for a Clinical Chief, dependent on the FTE requirements of the networks.

Regions will prioritise establishment of further networks dependent on the needs of the region.

How Service Delivery Networks will work

Service Delivery Networks are operational groupings of related services within a region that will provide a joined-up experience for patients regardless of where they are accessing the service within a region. Clinical leaders within Service Delivery Networks will provide a regional voice for issues within their particular services.

Regional Service Delivery Networks

- Drive the integration of care service delivery across a region
- Organise and manage care delivery across a region for the service, operationally
- Empowers local clinicians to deliver care more efficiently

National Clinical Networks

- Set national guidelines and models of care
- Design and propose national solutions for models of care
- Enables local clinicians to align to national models
- Set national standards and oversee clinical outcomes and data across the motu

Although we call both ‘networks’, the structures of Regional Service Delivery Networks and National Clinical Networks are very different. National Clinical Networks are standalone structures (distinct from service provision) that have been created to set national standards, provide national guidance and leadership, oversee national guidelines and models of care. On the other hand, Regional Service Delivery Networks represent groupings of existing services, with a small number of dedicated positions to help drive better integration of these services across the region.

SECTION 3 : Consultation Feedback

Altogether, we received 1236 comments and questions via 'What Say You', 24 submissions and held 14 feedback sessions (10 in person and 4 online) which were very well attended.

The following tables set out the themes heard in the feedback, and our responses. Please note this is not exhaustive but aims to cover off the key themes heard through the feedback.

Feedback	Responses
Whole of consultation	
Feedback that some groups disagreed with the whole concept of the consultation and that the consultation should not progress.	This consultation has already been delayed, and we heard lots of feedback that clinical leaders are seeking clarity and certainty about the future. We believe it is important to progress with the process and provide that certainty.
Rationale for change	
Some support for the aims of the proposal however feedback that the rationale for the proposal wasn't clear, nor were the current problems or intended benefits of the proposals	There were a number of current issues this proposal intended to address: • The need to define clinical leadership in the reformed Health New Zealand | Te Whatu Ora system, which had not yet been done for these roles; • Through doing so, gaining consistency in roles and responsibilities; • Aligning clinical leadership with the approach taken to Health New Zealand's structure, with one system but four regionally devolved service delivery models; • Strengthening whole of system leadership; and • Introducing portfolios to give clinical leadership and accountability from a national and regional perspective (as we retain local clinical leadership). The changes are intended to improve consistency, equity and outcomes through improved clinical/operational partnership, working across districts, regions and nationally and whole of system approaches to issues.

SECTION 3 : Consultation Feedback

Feedback	Responses
District Groupings	
General across all: Feedback that the proposed groupings were not supported for a number of reasons: • Lack of clarity on the rationale for the proposed grouping of some districts and not others • Loss of local voice and autonomy in smaller districts • Concerns rural requirements will be secondary if grouped with a larger/metro hospital, and that highest inequity is seen in rural settings • Concerns smaller well performing districts will become less efficient • Groupings not following patient flow • Potential to slow down decision making and adding additional layers • Loss of established local relationships e.g. with primary care, IMPBs and other local governance forums outside HSS • Anticipated reduction in local clinical leadership availability • Differences in population demographics and need between districts • Differences in culture, clinical structure and operational approach between districts • Enabling infrastructure not supporting shared leadership, especially D&D	• The proposed groupings were based on current district boundaries, existing relationships and ways of working. As the devolved system continues to evolve, we may consider other groupings. • Chief roles will continue to report to the local GDO which will support local autonomy. We also want to promote working across district boundaries and ways of working between districts will be crucial in this. • We are committed to working on a rural clinical leadership model to ensure a robust and consistent approach to rural clinical leadership. • As we are not progressing with groupings, local leadership is retained at the same level. • We do not believe this change will slow down decision making and believe it will lead to improved decision making through strong clinical/operational partnership. • One of the aims of proposing groupings was to improve equity for the populations of both districts. This does not mean that local solutions to local problems should stop, and local leadership is retained in this decision. • We acknowledge the need for culture shifts alongside structural shifts to improve working across districts and regions and to improve consistency. • We acknowledge the challenges of different systems across districts but do not believe this prohibits working across districts.

SECTION 3 : Consultation Feedback

Feedback	Responses
General across all: Feedback that working across districts is already happening in some areas and can be achieved without structural change.	We are supportive of this where it may already be working well, however it is clear that this is not happening consistently across the motu, and we are still seeing significant variation in care and equity outcomes. We want to encourage more working across districts and regions.
Geographic coverage: Feedback that travel time between the proposed grouped districts will make it difficult for Chiefs to spend time on site in locations outside their base location, and that groupings should consider iwi boundaries more closely.	In developing these proposals, we were working within current district and regional boundaries. As our system evolves in the future, we may look to alternative boundaries which take a fuller consideration of iwi boundaries, however this was not feasible for this proposal. As we are not going ahead with the groupings, Chiefs will not be working across districts however we still want to increase cross district and regional ways of working.
Hospital coverage: Feedback that individual hospital sites need local clinical leadership, noting some districts have more than one hospital site and the proposal was for one Chief and one Lead for medical, nursing and AHST in grouped districts.	We agree that local leadership is required, however this does not mean that every site needs to have a Chief on site. Chief roles are whole of system, strategic roles which, alongside providing local leadership, will hold a regional and national portfolio. On the ground local leadership may look different to this.
CCHV/Wairarapa: Feedback that Wairarapa has been merged before and perception this didn't work, has rural considerations which are different to a large hospital, concerns their voice will be lost, that a Lead won't be enough support and the current clinical leadership is not sufficient, CCHV already covers 3 hospitals and it is unmanageable to add another, Wairarapa has flow in many directions not just CCHV. **Midcentral/Whanganui:** Feedback that these districts have been merged before and perception this didn't work, concerns local voice will be lost, Whanganui is performing well already. **Lakes/BOP:** Feedback that Communities in each district are very different, concerns about losing local voice, community connections and innovation, Lakes is performing well already. Some comments that the grouping could work. Questions around whether the 2 Chief Nursing Officer roles in BOP will be maintained as there is currently a Chief Nursing Officer and Chief Nursing Officer Toi Ora and what alternative plans are to address the components of the Toi Ora role if it is disestablished.	Our strategic direction is to become more integrated, working across systems to reduce inequities, variation and support more sustainable services. For many areas e.g. clinical services planning, it makes sense to have a more collective approach. Grouping districts with shared leadership is one way to progress this. However, taking into account the feedback we have decided not to progress with the groupings at this time.

SECTION 3 : Consultation Feedback

Feedback	Responses
South Canterbury/Southern: Feedback that South Canterbury works independently but has more connections and patient flow links with Canterbury rather than Southern Feedback Sth Canterbury is performing well already and suggestions of alternatively growing South Canterbury as a district. Concerns that the Chief role was proposed to be in Southern and could not be situated in Sth Canterbury and HSS focused local leadership would be a backwards step for South Canterbury which does not have a PHO and so clinical leadership roles provide leadership across the system.	As above
West Coast: Feedback that West Coast current clinical leadership model is working well, and that West Coast has unique challenges as a rural district. Suggestions of alternative rural models of clinical leadership.	We agree that the current model for West Coast, which has a similar structure to our proposal for nursing and AHST, is working well and we think it could work for other districts too in future. However, taking into account the feedback we have decided not to progress with the groupings at this time. We will work with rural colleagues to develop a rural clinical leadership model.

SECTION 3 : Consultation Feedback

Feedback	Responses
Operational structures	
Alignment: Feedback that clinical and operational structures should be aligned to enable partnership, and any changes to clinical leadership structures should not be made in isolation to GDO structures.	We acknowledge this feedback and agree with the potential issues, however operational structures were not included as part of this proposal.
2 GDOs in grouped districts and reporting lines: Feedback that having 2 GDOs in the grouped sites will complicate communication, accountability and reporting processes. Questions raised around reporting lines for the clinical leadership roles in grouped districts which were not clear.	As we have decided not to group districts, local Chiefs will retain their reporting line to the local GDO.

SECTION 3 : Consultation Feedback

Feedback	Responses
Chief and Lead roles	
Feedback that 'Clinical Lead' is devaluing of the role. Also feedback that 'Chief of Nursing' is not supported and should be replaced with an internationally recognised title.	'Clinical Lead' roles will not be established as we have decided not to group districts. 'Chief of Nursing' will be replaced with 'Chief Nurse'.
FTE: Feedback that 0.4 is not sufficient for the responsibilities required of a lead role, concerns this will lead to challenges in availability, communication and recruitment. Feedback this will be a challenge for all professions and for both small and large districts for various reasons.	As we have decided not to group districts, Lead roles will not be established. Chief roles will range from 0.6-1FTE per the proposal.
Added layers: Concern that the lead role reporting into the Chief will create additional layers and delay decision making.	Grouping of districts were intended to improve clinical outcomes, reduce inequity and improve consistency. As we have decided not to group districts, Lead roles will not be established.
Chief roles: Feedback that a reduction in the number of Chief roles is not supported.	This is noted and as we have decided not to group districts, the number of Chief roles will not be reduced.
Next layers of leadership: Feedback that it is hard to comment on this proposal in isolation from the layers below, which are crucial support structures and vary between districts. Questions on the timing for consultation on the next layers. Questions on what happens to roles reporting into the ones being disestablished, including clinical and admin roles.	We agree that the next layers of leadership are crucial to get right; we want to stabilise this layer first and recruit to Chief roles permanently. The next layers of leadership and partnership, and how this is further developed, will be considered by DCEs. Where a current Chief role is disestablished, any roles reporting into that role will change reporting line to the new Chief role in the district. This will be communicated on an individual basis. The exception to this is where the midwifery leader for the district was reporting into the Chief Nursing and Midwifery, they will now report to the GDO.
Importance of local leadership: Feedback leadership should remain local to ensure effective decision making, relationship building and understanding local needs and communities, especially in smaller districts.	We agree local leadership is important and this decision retains local clinical leadership in districts. We have signalled we want to improve ways of working across districts and regions, portfolios are one way we intend to do this.
Uncoupling midwifery and nursing: In general this is supported but concerns around losing local midwifery leadership.	Local midwifery leadership is, in many districts, provided by joint operational and professional leadership roles which are not impacted by this consultation. To ensure appropriate local leadership is maintained, we will appoint to interim, part time midwifery leadership roles to ensure clinical safety in districts which do not currently have adequate local midwifery leadership.

Te Whatu Ora
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SECTION 3 : Consultation Feedback

Feedback	Responses
Role content	
General: There was feedback on role content across the proposed roles with requests for clarity and suggestions made for amendments.	Feedback received has been reviewed and profession specific position descriptions have been developed and are attached to this decision document.
Empowering clinical leadership: Feedback that the proposal limits clinical leadership's authority while holding them accountable for care delivery and that they should be empowered with decision making authority for resource allocation and funding.	A key driver of this change is to strengthen clinical/operational partnership. We want local clinical leaders to be working closely with GDOs in decision making for the local district, and with DCEs for the region.
Portfolios	
General support for portfolios with some suggestions on what might constitute a portfolio for a clinical leader.	We are glad portfolios are supported. Regional and National portfolios will be developed based on organisational need.
MH&A and Midwifery regional roles	
Regional roles: Concern regional roles add a layer of bureaucracy, will delay decision making and take it further away from the front line. Regional working can be done without the need for regional roles through networks, collaboration between districts, shared governance and decision making or portfolios. Conversely, some feedback that regional roles for all professions should be considered given the establishment of DCEs and developing regional approach. Some feedback that national or regional is helpful, but not both. Questions around the rationale for having some professions as regional roles and not others.	The purpose of proposing these roles was to stabilise and improve MH&A and Midwifery services across the region. Having considered the feedback, we have decided regional clinical partnership to DCEs for Medical, Nursing, AHST, Midwifery and MH&A will be provided through portfolios. This provides consistency of approach across the professions and provides a link between local and regional clinical leadership.
Reporting lines: Feedback that if regional roles are established, they should report to the DCEs aligning with district level Chiefs reporting to GDOs, questions around the mixed model.	All regional clinical leadership portfolio roles will report to the DCE for the portfolio part of their role.

SECTION 3 : Consultation Feedback

Feedback	Responses
MH&A: General support for a focus on mental health at a regional level. Concerns that the regional role overlaps with accountabilities of district Clinical Director roles, especially in large districts and questions whether local roles are better.	As outlined in this document, Regional Leads are being established for MH&A with an operational focus, and professional leadership will be provided through portfolios. Individuals in these regional leadership roles will be expected to work closely with local roles and ensure respective accountabilities are clear and understood.
Midwifery: Some support for a midwifery role at the regional level but concern a regional midwifery role may disempower local leadership and feedback that consistent and district level roles aligned to other professions would be preferable. Concerns local midwifery leadership is being removed. Feedback regional connection can be done in other ways. Some feedback the roles will help to stabilise the midwifery workforce and assist in consistency.	There is variation in local midwifery leadership with most district leadership roles currently joint operational and professional roles, we did not propose any change to these mixed operational and professional roles. Please refer to slide 13 for more detail on the decisions around midwifery.
Kahu Taurima: Feedback that this role should not be limited to midwifery. Suggestion this may be better served as a clinical network or with one national programme lead to avoid additional cost. Feedback that this piece of work already has clinical structures supporting it.	These roles will be consulted and decided on through the Hauora Māori Service consultation process. The feedback received about these roles will be passed onto the Hauora Māori Service Team for consideration.
2 regional Chiefs: Feedback that there does not need to be 2 regional Chiefs for midwifery and MH&A. This could lead to confusion and siloes or duplication.	As noted, the Kahu Taurima and Oranga Hinengaro roles sit within the Hauora Māori Service structure and they will be consulted and decided on through that process. However they were included in our proposal to show the regional partnership we believe is crucial to improve equity in these important areas. Both maternity/early years and mental health and addiction are areas within the health system where we need to target our services to the populations with the highest need. These roles would work with whānau, communities and service providers to provide integrated, tailored services and programmes for maternity, early years and mental health.

SECTION 3 : Consultation Feedback

Feedback	Responses
Whole of System	
Definition: Questions around what is meant by whole of system working, and how this is envisaged to work for the clinical leadership roles in the proposal which are HSS based.	Please refer to slide 8 where we set out more detail on what we mean by 'whole of system' working and the role of Clinical Chiefs in this.
Wider roles and functions: Feedback that some areas are doing this well and we should learn from those. Feedback that the proposal doesn't take into consideration other clinical leadership roles in primary and community, commissioning and public health and other areas which have their own clinical leadership structures which has led to siloes. Feedback that the clinical leadership model should be cohesive and include clinical leaders across areas to avoid duplication of efforts and confusion in leadership. Feedback these roles are diminished in the proposal. Concern HSS clinicians don't have the expertise to oversee whole of system care and that the role will be unmanageable.	Please refer to slide 8 where we set out more detail on what we mean by 'whole of system' working and the role of Clinical Chiefs in this. We believe the Chief roles can provide a solution to siloed working by working with clinical leaders from across other areas of our organisation with a whole of system approach.

SECTION 3 : Consultation Feedback

Feedback	Responses
AHST	
Multiple professions: Feedback that it is hard for one role to represent over 40 professions and suggestions of alternative ways to gain representation including regional representation of key professions or utilising national professional leadership groups.	In developing the proposal, we sought advice from the district Chiefs and Directors AHST on whether we should consider separating these roles into two: a Chief Allied Health and Chief Scientific and Technical. The advice received was not to do so given the small numbers in many of the professions and the risk that the roles become too watered down. AHST is an internationally used model for professional leadership. However, we agree it is a challenge to ensure the voices of the different professions within AHST is not lost.
Cost of additional FTE	
Concerns that the proposal is adding FTE and that this cost will be taken from elsewhere in the system.	We have taken a choice to invest in clinical leadership as this is crucial to achieve what we need to as a health system.
Quality and Patient Safety	
Feedback on the importance of quality and safety and that this forms an integral part of all clinical leadership roles and should take a whole of system approach.	We agree with this.
Regional roles: Feedback that QPS regional roles should be aligned with the clinical leadership structure and could consolidate existing other risk and quality roles across functions (risk, commissioning etc.).	Please refer to slide 14 where we provide more detail about the regional approach to QPS roles and functions.

SECTION 3 : Consultation Feedback

Feedback	Responses
Māori Clinical Leadership	
Feedback that Māori leadership and equity considerations should be embedded at all level of clinical leadership and that it would be helpful to understand the Hauora Māori Services structure alongside this one.	The Hauora Māori Service consultation outlines the proposal for their structure, including their proposed clinical leadership roles.
Rural Clinical Leadership	
Feedback that a rural clinical leadership model is missing from the proposal, that is is metro-centric and that rural communities have unique challenges and higher health inequity that requires a different approach.	We are committed to working on a rural clinical leadership model.
Women's Health Leadership	
Feedback that specific women's health clinical leadership should be considered beyond midwifery.	We acknowledge the importance of Women's Health and note that we have established a maternity clinical network which will look at consistency across standards and pathways across the motu. We will continue to consider how we can continue to improve women's health but are not considering any additional clinical leadership roles in this area currently.
Workforce Planning	
Feedback on the importance of clinical leadership in workforce planning and suggestion of the placement of this function in the clinical leadership structure.	We will provide this feedback to the People and Culture team, who are currently reviewing their structures.
Enabling Services	
Enabling services are key to supporting clinical leadership and structures across all functions of the organisation should be aligned	The enabling services will be releasing their own proposals for their structures aligning with the devolved direction of the organisation.

SECTION 3 : Consultation Feedback

Feedback	Responses
Process and risks of destabilisation	
Concern that the proposed changes miss good work already taking place, will destabilise services and compromise patient safety, outcomes, performance, and staff morale. Feedback that the model should be developed bottom up rather than top down.	We acknowledge this feedback but believe it is important to strengthen our clinical leadership structure now and appoint into these important roles permanently, to provide stable leadership in the important areas highlighted here. There is never a good time for change, however we are now 2.5 years into the reform and ensuring a clinical leadership structure which aligns to the reformed system is key to ensure appropriate clinical leadership in the system.

SECTION 4 : Impact of Decisions – Existing Positions

The decisions outlined in this document will impact a number of existing positions.

Please note that where there is no impact to an employee's position, they will not receive a confirmation letter.
When reviewing and undertaking an impact assessment we have considered the level of change to existing positions, their scope, function and deliverables, complexity, number of direct reports, budget etc.
Where applicable, direct feedback provided by individuals during the consultation process has also been considered.

The following definitions are used in Appendix 2 to describe the different scale of impacts:

Impact	Explanation
No impact	The position remains unchanged.
Impacted - Reconfirmed	A position is impacted where there are some changes to the current position as confirmed. However, the changes are not significant, and the position remains substantially the same. Examples of these types of changes include a change in position title, reporting lines or transfer to a different business unit. Individuals in these impacted positions are reconfirmed into the position, with any relevant changes, on their existing terms and conditions, including salary.
Significantly Affected - disestablished	A position is significantly affected where the current position incurs significant change to its scope, location, terms and conditions or would not exist in the new structure. A position is also be significantly affected if there are fewer of the same or, substantially the same, positions in the new structure. These roles will be disestablished.

SECTION 4 : Implementation Process – Reconfirmation and Disestablishment

This section should be read together with the FAQs. If you are a union member please read this in conjunction with the relevant Management of Change clause within your Collective Employment Agreement (CEA).

Reconfirmation

Employees who are reconfirmed into a position will receive a letter confirming this, including details of any minor changes/impacts to their role, which may include a title or reporting line change or transfer to a different business unit. Any individual reconfirmed will maintain their current terms and conditions, including salary (excluding those on district IEAs, see next point below).

Employees who are reconfirmed into a position are not eligible to take part in the EOI process, given that they have secured a position in the new structure. However, they may apply for any roles that are subsequently advertised internally and/or externally, in the normal manner.

Employees being Reconfirmed & No-Impact – Approach for those on District Individual IEAs

Where your role is reconfirmed or not impacted by this business function change, HNZ will offer you a new updated IEA agreement which will reflect the national HNZ terms. You are free to accept this new IEA or to remain on your current IEA terms.

This offer would be made on the following basis:

- That the employee is on a district aligned Individual Employment Agreement (IEA), not a national Health NZ IEA;
- The position is not covered by a Collective Employment Agreement (CEA);
- The positions sizing and
- That no terms and conditions of the employees previous employment agreement will be grand-parented
- Employee's would be given a reasonable opportunity to seek advice on the proposed IEA.

Disestablishment Notification

Where the Final Decision document confirms that a role will be disestablished, the employee in that position will receive a letter confirming this.

- Employees whose positions are confirmed as disestablished will be notified in line with their relevant contractual obligations
- We will work with all employees on an individual basis to explore all possible options including redeployment, reconfirmation, retraining etc
- If an individual whose role is significantly affected chooses not to engage in the EOI/change process (including the options and support provided for redeployment and/or retraining), and they would like to consider an early exit from Health New Zealand in line with their contractual entitlements, we will work with the individual on a case-by-case basis.
- If an individual's role is impacted or has no impacted and would also like to consider an early exit from Health New Zealand in line with their contractual entitlements, we will work with the individual on a case-by-case basis.

During this period Health NZ will engage with employees on an individual basis to work through any suitable alternative employment options. Redundancy is the last option, and we are committed to ensuring that employees have the best opportunity to remain in employment with Health NZ wherever possible. Options which may be considered in situations where there are more disestablished employees than new roles include redeployment, retraining, LWOP etc.

More detail on these options is included throughout this section. In addition during this period we will provide:

- Career Support - for those employees whose positions are disestablished, career support is available. Please email careertransition@tewhatuora.govt.nz who will be able to provide support and provide you with information in relation to additional individualised outplacement support
- EAP services who will be able to provide individualised support employees may need from a wellbeing perspective.
- Detailed guidance material on the expression of interest process (EOI).

SECTION 4 : Implementation Process – Disestablishment & EOI Process

Disestablishment Notification Cont.

We want to ensure that we are providing as much support to employees as possible during this time and we encourage you to access this support if you think it may be helpful. If you need additional support please reach out to your manager or local People lead who will be able to consider additional support.

We have been engaging with our union partners throughout these change processes and they have been formally notified of any of their members who are to be disestablished, prior to final decision documents being published. We will ensure that for those employees, we follow the relevant Management of Change provisions outlined in the applicable CEA (Collective agreement).

Your union is there to support you so please feel free to reach out to them.

EOI Recruitment and selection processes

The process for recruitment and selection into new positions is:

- Position descriptions will be available including salary level, to those whose roles are significantly impacted.
- Employees whose position is disestablished will be considered for new positions in the first instance with recruitment and selection processes to be undertaken.

In some cases, we have reduced the total number of similar positions, for example we may have had 10 of a specific position and we have reduced this number to five. We call this situation "more to less". In these circumstances we will undertake an assessment of an individual's EOI application against the position selection criteria. This process will be ringfenced to those holding a specific position to determine placement into the positions. After the ringfenced process if there are less appointees into these positions than positions remaining, we may open applications to a wider EOI process for staff whose positions are significantly affected by change.

- Disestablished employees will be able to express an interest for any suitable positions where they meet the requisite requirements and selection criteria.
- The-recruitment team will also make has an assessment of other current vacancies and consider whether any of those should be 'paused' to allow for employees whose positions have been disestablished to be considered for them. This assessment has been made on the basis of similarity of the vacancy to disestablished positions.
- Positions which have not been filled by employees whose positions are disestablished will be open to other internal candidates and external candidates following the EOI process.
- Reasonable time off (on pay) will be provided to significantly affected staff to attend career support sessions, retraining or interviews (including with external organisations), throughout the consultation process, during feedback review and after the final decision has been issued.

Terms and conditions of redeployment into new IEA positions

For employees whose positions are disestablished through this process and who are successfully redeployed to a new position with Health New Zealand | Te Whatu Ora in a position covered by an Individual Employment Agreement (i.e. a position not covered by a CEA), the following offer would apply:

- Appointments to new positions not covered by a CEA will be based on the current Health NZ IEA; and
- No terms and conditions of the employee's previous employment agreement will be grand-parented; and
- Salary equalisation will only be offered where it is a term of the individual's previous employment agreement.
- You would have a reasonable opportunity to seek advice on the proposed IEA.

Please note that as the employment relationship will be continuing, any accrued contractual leave will be carried over to the new position (not including sick leave, this will be carried over to a maximum accrual in accordance with the New IEA T's & C's)

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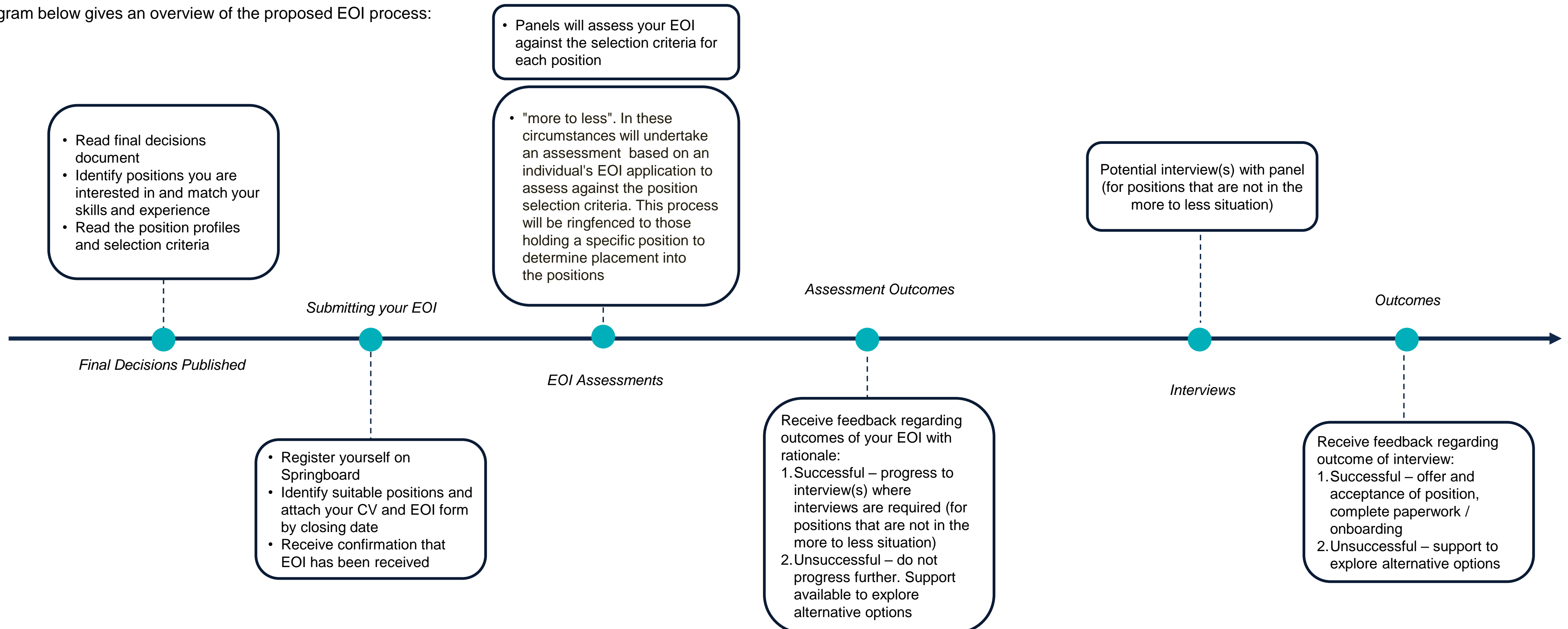
SECTION 4 : Implementation Process - EOI Process

Expression of Interest (EOI) process

The expression of interest process will be open to all employee whose positions have been disestablished and they will able to express an interest for any suitable positions where they meet the requisite requirements and selection criteria.

The diagram below gives an overview of the proposed EOI process:



SECTION 4 : Implementation Process - Assessment of EOIs

Assessment of EOIs

Every EOI submitted will be assessed against the selection criteria in the position profile by a panel. The panel of 2-3 people will be made up of individuals who are the relevant leaders of that function and other subject matter experts.

Types of EOI assessments:

- "more to less". In these circumstances we will undertake an assessment of an individual's EOI application against the position selection criteria and we are not proposing to interview. This process will be ringfenced to those holding a specific position to determine placement into the positions.
- For other new positions where an employee's skills, competencies and experience meet the selection criteria, they may be be interviewed by the panel with questions that relate to the selection criteria.
- If an employee's EOI does not meet the selection criteria they will be advised as soon as possible and provided with feedback.

At the conclusion of an interview process, the panel will assess the employee's suitability for the position and make a recommendation on whether to appoint. Being suitable means demonstrating they have the skills, competencies, experience, and attributes as outlined in the position profile and selection criteria to undertake the new position or that they could be upskilled to perform the position with reasonable retraining and within a reasonable of time.

If there is more than one employee who is assessed as being suitable, then the person assessed as being most suited will be offered the position.

Once the selection decision has been made, the successful employee(s) will be provided with an offer of employment for their consideration.

Ratings for Assessment of EOIs

The panel will collectively score the individuals EOI responses for each selection criteria against the ratings below:

SECTION 5 : Support and Wellbeing

As outlined in earlier sections, our environment has evolved, and as such we need to adapt to ensure our health care services are meeting our community and patients' needs now and into the future.

It is important to seek support and reach out if/when you need to. Make time to read the final decision document and the supporting information. Please ask for support at any time you need it and encourage your colleagues to do the same. Talk about how you are feeling. Talk to your manager, colleagues, your union representative or friends and family.

Sometimes a colleague may be more vulnerable to the impacts of change because of other things happening in their lives. If you have concerns about anyone's well-being, contact P&C for advice. If you are a manager or team leader and are concerned about one of your team members, please talk to them or seek advice from your People & Communications team.

Additionally, Employee Assistance Programme (EAP) confidential counselling services are also available to you for personal support in every district. Please reach out to your current provider to access this free service as they will be able to provide practical strategies and assistance in support of personal and workplace issues, workplace changes, life transition and career planning, and budgeting and financial advice.

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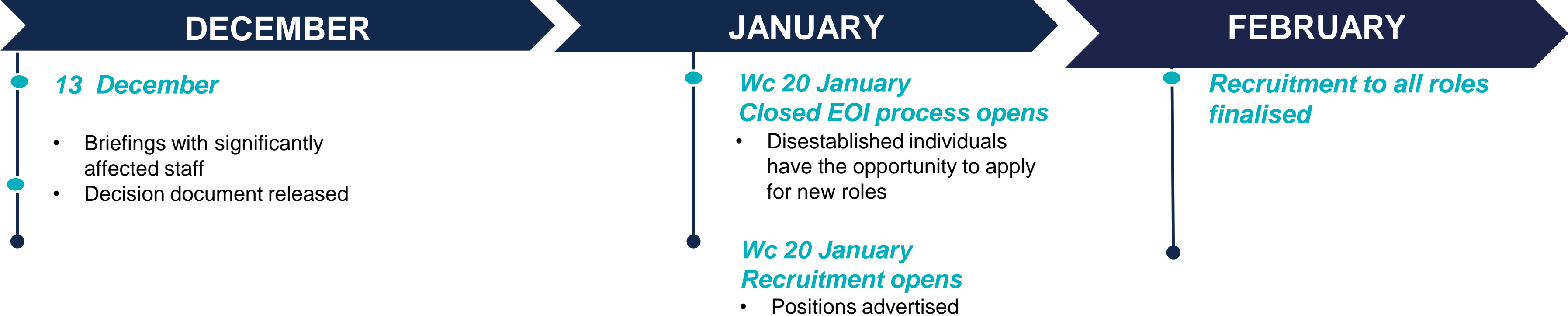
SECTION 6 : ImplementationTimeline



Positions for Advertising

Currently these positions may be filled on an interim or fixed term basis, we want to permanently recruit to all these clinical leadership positions and will advertise in January 2025. These positions will be open to candidates using our Health NZ recruitment process.

District	Position
Te Tai Tokerau	Chief Allied Health Scientific and Technical
Waitematā	Chief Nurse
Counties Manukau	Chief Medical Officer Chief Nurse
Waikato	Chief Nurse
Bay of Plenty	Chief Medical Officer
Lakes	Chief Nurse Chief Allied Health Scientific and Technical
Tairawhiti	Chief Medical Officer
Taranaki	Chief Nurse
MidCentral	Chief Medical Officer Chief Nurse
Whanganui	Chief Medical Officer Chief Allied Health Scientific and Technical

District	Position
Capital Coast/Hutt Valley	Chief Medical Officer Chief Nurse Chief Allied Health Scientific and Technical
Wairarapa	Chief Medical Officer
Nelson/Marlborough	Chief Nurse
Canterbury	Chief Medical Officer Chief Allied Health Scientific and Technical
West Coast	Chief Medical Officer
South Canterbury	Chief Medical Officer Chief Nurse Chief Allied Health Scientific and Technical

Positions Significantly Affected - Disestablished

The following existing positions will be significantly affected and due to the level of change are **disestablished.**

District	Position title	Rationale
Bay of Plenty	Chief Nursing Officer Chief Nursing Officer - Toi Ora	Reduce to one Chief Nurse role for Bay of Plenty

More to Less Contestable EOI Process

In the Bay of Plenty we currently have two Chief Nurse positions and in the confirmed structure we have one Chief Nurse Bay of Plenty available. We will undertake a contestable EOI process to select the employee who will be offered this position as redeployment. This process will be a closed process for only those employees employed in the current Chief Nurse positions in Bay of Plenty.

District	Position
Bay of Plenty	Chief Nurse

Positions Impacted - Reconfirmed

The following existing positions are impacted with changes in an updated position description and/or change in a change in title.

District	Position title	
Te Tai Tokerau	Chief Medical Officer	Updated position description
	Chief Nurse	Updated position description
Waitematā	Chief Medical Officer	Updated position description
	Chief Allied Health Scientific and Technical Professions Officer	Updated position description and change in title to Chief Allied Health Scientific and Technical
Te Toka Tumai	Chief Nursing Officer	Updated position description and change in title to Chief Nurse
	Chief Medical Officer	Updated position description
	Chief Health Professions	Updated position description and change in title to Chief Allied Health Scientific and Technical
Counties Manukau	Chief Allied Health Technical & Scientific Professions	Updated position description and change in title to Chief Allied Health Scientific and Technical
Waikato	Chief Medical Officer	Updated position description
	Chief Allied, Scientific & Technical Officer	Updated position description and change in title to Chief Allied Health Scientific and Technical
Tairāwhiti	Director of Nursing	Updated position description and change in title to Chief Nurse
	Director of Allied Health & Technical	Updated position description and change in title to Chief Allied Health Scientific and Technical
Bay of Plenty	Executive Director Allied Health, Scientific & Technical	Updated position description and change in title to Chief Allied Health Scientific and Technical
Lakes	Chief Medical Officer	Updated position description
Hawkes Bay	Chief Medical and Dental Officer	Updated position description and change in title to Chief Medical Officer
	Chief Nursing Officer	Updated position description and change in title to Chief Nurse
	Chief Allied Health Professions Officer	Updated position description and change in title to Chief Allied Health Scientific and Technical
Taranaki	Director Allied Health, Scientific & Technical	Updated position description and change in title to Chief Allied Health Scientific and Technical
	Chief Medical Advisor	Updated position description and change in title to Chief Medical Officer
Whanganui	Director of Nursing	Updated position description, change in title to Chief Nurse
MidCentral	Executive Director Allied Health	Updated position description, change in title to Chief Allied Health, Scientific and Technical

Positions Impacted - Reconfirmed

The following existing positions are impacted with changes in an updated position description and/or change in a change in title.

District	Position title	
Wairarapa	Director of Nursing	Updated position description and change in title to Chief Nurse
	Director Allied Health, Scientific & Technical	Updated position description and change in title to Chief Allied Health Scientific and Technical
Nelson/Marlborough	Chief Medical Officer	Updated position description
	Director Allied Health	Updated position description and change in title to Chief Allied Health Scientific and Technical
Canterbury	Executive Director Nursing	Updated position description and change in title to Chief Nurse
Southern	Chief Medical Officer	Updated position description
	Chief Allied Health, Scientific & Technical	Updated position description
	Chief Nursing & Midwifery Officer	Updated position description and change in title to Chief Nurse

Te Whatu Ora
Health New Zealand