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Clinical Leadership Consultation

Tēnā koē Richard,

Te Whare Piki Ora o Māhutonga – the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism, and surgical education in Aotearoa New Zealand and Australia. A strong focus on health advocacy is a central competency of a surgeon, and a core value of this College.

We are pleased to see Te Whatu Ora intends to correct the inadequate initial emphasis in its organisational design by retrofitting clinical governance and leadership into the operational management structure. Ensuring high quality – safe, timely, equitable, and patient centred – healthcare requires strong clinical engagement in governance and management, with clinicians and managers bringing their respective competence and accountabilities to work in partnership at each level of the organisation.

However, the proposals in the Clinical Leadership Consultation Document (the Document) are not sufficient to achieve effective clinical governance and leadership within the operating model for Te Whatu Ora and are likely to have significant unacknowledged adverse consequences.

RACS does not support the current proposal.

RACS recommends:

- You recognise the collective adverse impact of the shortcomings of your proposal, as outlined in this submission, and suspend the decision process until you develop a better case for change.
- Doctors need to be involved at all stages of designing a new clinical leadership structure as some critical decisions require medical expertise and professional attention that may not be apparent from an operational perspective.
- Explicit mandatory quality and safety standards and guardrails to ensure sustained quality of care, with patient safety considered at every step of the change management process.

Our key concerns are the following:

- There is no discussion of the impact of proposals on patient safety and patient outcomes.
- The proposal to group districts and to reduce the Chief Medical Officer (CMO) capacity does not provide any analysis or discussion of the geographic or community implications for the smaller rural localities and reverses the purported Te Whatu Ora impetus to localism.

- CMOs in larger districts have significant support in undertaking accreditation, credentialling, Quality and Risk, Quality Improvement, junior doctor education and wellbeing, and recruitment aspects of their roles. However recent and foreshadowed reductions in resources behind the front line are removing this support. The full CMO role in a large district cannot reasonably and safely be undertaken at the proposed 0.6-1 FTE with the imminent lower level of support behind the front line.
- CMOs in smaller rural hospitals already have a wide brief, wearing multiple hats and personally undertaking accreditation, credentialing, Quality and Risk, Quality Improvement, recruitment, and management of Resident Medical Officers. Fulfilling this role part-time is already challenging. The full CMO role in a smaller district cannot reasonably and safely be undertaken at the proposed 0.4 FTE particularly with the imminent lower level of support behind the front line. Most of our health inequity is in rural areas; we should be strengthening leadership in rural centres rather than making our leadership structure metrocentric.
- We note that the proposed grouped districts include significant third hospitals, such as Hutt and Rotorua, that will not have a CMO or Clinical Lead on the ground.
- In each of the smaller rural localities to be grouped, there are already significant differences in health status and needs for Māori and for rural populations. The reduced allocation of CMO capacity will exacerbate inequity of access to healthcare and inequitable health outcomes.
- The Document does not provide evidence the existing clinical leadership positions are a problem, or a clear linkage between the proposals and improving clinical leadership.
- The functions proposed for the clinical leadership roles exclude several current responsibilities of existing CMOs including patient advocacy, quality assurance, credentialing, role modelling, managing performance issues, and developing and enhancing relationships with the local community.
- The proposal has Chief Medical Officers (CMOs) reporting to the Group Director Operations with a dotted line relationship to the National Chief Medical Officer, giving primacy to the corporate relationship. A commitment to clinical governance and leadership would place the partnership at a higher level with CMOs reporting to the National Chief Medical Officer.
- The process does not pay sufficient attention to retention of individual incumbent medical practitioners, with consequential resignations, and redundancy and recruitment costs likely to negate any intended costs savings.
- Release of the Consultation Document, the nature of the proposals, and inadequate consultation time and process have added to the level of stress on the medical workforce. Te Whatu Ora must pay greater attention to protecting the health and wellbeing of the medical, nursing, and wider clinical workforce during any change process.

Grouping districts

We understand your intention to create consistency in clinical leadership roles at regional and district level by moving clinical leadership from the inherited 18 districts each with a CMO to a 14-district model. CMO capacity in the newly grouped districts will be reduced from 2 FTE to 0.6-1 FTE in the larger district and 0.4 in the smaller district.

The Consultation Document should set out the evidence or rationale for the groups chosen and for 14 districts. Why was 14 CMOs a better option than 12, 20 or 24 from a clinical leadership perspective? Rather than just a reduction from the current state, we expected to see criteria for a district being designated as stand-alone with a CMO. For example:

- seeking local voice and the impetus to localism
- the number of hospitals, geographic or community implications, rural and remote areas
- significantly inequitable relative health status within the district, including for Māori and rural populations, often with high health needs and low socioeconomic status.

We consider any intended cost savings from the proposed removal of four CMO roles and replacement by four Medical Leads are likely to be negated by:

- changes in CMO role, functions and reduced support as described above, and recognising these in position descriptions, appointment, recruitment, job-sizing, and remuneration
- current CMO roles being disestablished, with incumbents required to apply for a new CMO role or a Medical Leader role, creating the possibility that some current CMOs will not apply for the less senior role.

RACS represents more than 7000 surgeons and 1300 surgical Trainees and International Medical Graduates across Aotearoa New Zealand and Australia. RACS is the accredited training provider in nine surgical specialties. Surgeons in these specialties are also required by RACS and Te Kaunihera Rata o Aotearoa Medical Council of Aotearoa to continue with surgical education and review of their practice throughout their surgical careers.

Nāku noa, nā

Ros Pochin
Chair, Aotearoa New Zealand National Committee