ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Richard

ASMS feedback on the Clinical leadership proposal

Toi Mata Hauora (the Association of Salaried Medical Specialists) is the union for salaried senior doctors and dentists in Aotearoa New Zealand. Toi Mata Hauora represents over 6,000 members. We promote, protect and support the interests of our members in all aspects of their working lives. Under our constitution, we also strive for an equitable, accessible health care system that meets the needs of all New Zealanders. We have significant interest in the clinical leadership change proposal from both these perspectives.

Toi Mata Hauora has serious concerns about the consultation, and firmly rejects the proposal to reduce the number of Chief Medical Officers from eighteen to fourteen. Medical leadership in the health system must be strengthened, and this proposal fails to do that. In the context of the entire health budget, investment in local Chief Medical Officer roles across the country is a small investment with a large return.

The consultation document asserts that unions were consulted during development of the proposal. This is incorrect. Unions were informed of the consultation, but no process occurred whereby views were sought and taken into account, prior to release of the proposal. The perceived urgency and short timeframe for feedback does not provide Toi Mata Hauora with confidence that the proposals have been developed with the appropriate evidence, rigour, or collaboration required to achieve success.

Healthcare is a complex, high-risk, high-hazard industry that deals with human lives. Any changes to organisational systems and practices must be evidence-based, and approached with rigour, caution, and a firm understanding of the implications for frontline staff and the communities they serve. It is our expectation that prior to the next round of formal consultation, Te Whatu Ora will collaborate with unions, and with its own clinical staff, to develop a fit-for-purpose, evidence-based, and well-informed proposal for clinical governance and leadership.

We have rapidly sought feedback from members in the short timeframe the consultation has been open and our preliminary feedback is outlined below. However, far more collaboration and

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consultation will be needed to create a successful clinical governance and leadership model for Te Whatu Ora.

We look forward to discussing this with you at our meeting on 18th November 2024.

Nāku noa, nā

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Toi Mata Hauora submission on the Clinical Leadership Consultation Document

Executive summary

Effective clinical leadership is critical for achieving best-practice health care and a well-functioning health system and urgently needs to become firmly established at every level of service delivery throughout Aotearoa New Zealand. We are a long way from that goal. However, Te Whatu Ora's proposals are fundamentally flawed and likely to do more harm than good. We call on these proposals to be halted. Toi Mata Hauora ASMS would be more than willing to assist in a rewrite.

Our reasoning, in summary:

- For the health reforms to succeed, clinical and corporate governance and leadership need to be integrated and aligned towards the same goal of safe high-quality delivery of healthcare. Strong clinical engagement in governance and management is necessary to ensure a clear line of sight from the bedside to the boardroom.
- Medical involvement in leadership is associated with safer staffing; more pragmatic clinical decision-making; lower morbidity rates; and a better quality rating for service providers (Clay-Willaims, Ludlow, Testa, Li, & Braithwaite, 2017)
- Medical practitioners are accountable for the clinical services delivered, and therefore need to be able to make decisions about how these services are delivered, including resources, people, and direction.
- There is a substantial evidence base for achieving good clinical leadership, which has been largely ignored in this proposal, which has evidently been developed in haste, with scant evidence, rigour, and the collaboration required to achieve its goals. The proposal carries a high risk of creating wider division between management and clinical leaders and staff, and poor decision-making, leading to poorer health care and inefficiencies.
- Members provided feedback that structural changes and change programmes have significantly stripped substantive Chief Medical Officer (CMO) roles of decision-making authority and accountability, at the same time as stripping enabling functions such as IT and administrative staff.
- Marginalising clinical leadership creates significant risk for Te Whatu Ora. Any structure that requires clinical leaders to convince operational leaders to take an issue seriously will not succeed.
- Medical practitioners are responsible for admitting patients, ordering tests, providing treatment orders, and discharging patients, which generates most of the cost of providing healthcare. Medical practitioners must be involved at management and governance levels to ensure the best clinical outcomes within the available resource.
- The consequences of inadequate clinical governance or leadership are catastrophic, as seen with the critical failings in patient care at the Mid Staffordshire NHS Foundation Trust in the United Kingdom.

- Harms that result from poorly conceived and implemented changes can have profound impacts that cannot be remedied for those who were impacted.
- The proposals lack clarity and use terms that are not clearly defined.
- Our members expressed frustration with the short notice for local meetings that limited the ability to meaningfully engage and did not account for clinical schedules. Members also expressed frustration with the top-down approach used in developing the proposal.
- The proposal focuses on how the geographical model looks rather than in-depth understanding and consideration of how it would work in practice.
- The proposal does not adequately consider or strengthen rural and remote clinical leadership and appears to be attempting to save money by reducing clinical leadership in high needs, rural and remote communities.
- For all of the proposed groupings, there are significant clinical, geographical, cultural, and community-based reasons why merging these regions is not compatible.
- The draft "Clinical Chief" position profile does not resemble the work undertaken by CMOs and is lacking substantial elements of the role.
- The generic draft position profile does not differentiate between medical, nursing and allied health Clinical Chief positions, demonstrating a lack of understanding that these roles are distinctly different from one another, but complementary. These roles fulfil different functions, serve distinct professional and occupational groups, and require different job descriptions, skills and qualifications.
- The proposal to reduce the number of CMO positions from eighteen to fourteen appears to be based on cost savings. Despite this, the reductions would have a modest impact on budget, but a potentially major negative impact on system safety and performance.
- Each hospital and its associated district (regardless of size or population served) is an intact ecosystem. Attempting to merge these districts will disrupt these ecosystems for little gain.

Recommendations

Toi Mata Hauora recommends:

- Te Whatu Ora must revise its top-down approach to developing a clinical leadership structure. New proposals will need to be developed from the ground up, in partnership with clinicians across the country. Models need to be determined locally, by those who understand the unique pressures each hospital and community faces.
- Proposals for clinical leadership structures must be developed in concert with corporate leadership models and consider all layers of the system. This is necessary to ensure models are based on effective, genuine partnership between clinical and corporate leaders, at every level.
- Proposals should be based on distributive leadership, where responsibility, power, authority and decision-making is distributed within and throughout the organisation to those with expertise, capability and motivation, rather than concentrated at the top of a hierarchy.

- Proposals must be firmly grounded in evidence. Evidence-based health policy requires an assessment of:
    - The evidence that existing arrangements constitute a problem.
    - The evidence supporting the assumed causes of the identified problems
    - The evidence that the preferred strategy is the optimal strategy. (Lin & Gibson, 2003)
- Proposals developed must embody the principles of clinical governance established in the *In Good Hands* report. (Ministerial Task Group on Clinical Leadership, 2009)
- Clinical leadership serving rural and remote communities must be strengthened rather than diminished, as part of the strategy to eliminate inequitable health outcomes.
- All CMO roles must be retained, with further roles developed. The roles must be attractive, with authority, resources, and decision-making abilities, alongside accountability.

Further detail is provided below. As the union for senior doctors, our preliminary feedback focuses on medical leadership, but we note that strong, well-functioning nursing, allied health, and corporate leadership structures working in a team arrangement at all levels of the system is required for safe, high-quality patient care.

Success of the health reforms depends on clinical governance and leadership

The purpose of the Pae Ora (Healthy Futures) Act 2022, is to protect, promote, and improve the health of all New Zealanders; achieve equity by reducing health disparities among New Zealand's population groups (in particular for Māori) and build towards pae ora (healthy futures) for all New Zealanders. Te Whatu Ora was established under the Act, with objectives to achieve the purpose of the Act; achieve the best possible health outcomes for all New Zealanders; and respond to the aspirations and needs of the population. Its establishment aimed to reduce geographic variation in service provision and achieve equitable health outcomes.

Previous health reforms have failed to adequately address inequalities or create an integrated system (Stolarek, et al., 2022). Disengagement between clinicians and managers has been a problem in the health sector previously and is growing. Feedback from Toi Mata Hauora members is that since Te Whatu Ora was established, clinicians are increasingly unable to influence the system while still being held to account for it. The 2009 report, "In Good Hands -Transforming Clinical Governance in New Zealand" remains highly relevant, and outlines principles and structures to underpin effective clinical governance and leadership at all levels of the health system. (Ministerial Task Group on Clinical Leadership, 2009).

For the recent reforms to succeed, clinical and corporate governance and leadership structures need to be integrated and aligned towards the same goal, with quality and safety the goal of every clinical and administrative initiative (Ministerial Task Group on Clinical Leadership, 2009). Separating clinical and corporate governance results in cost containment becoming the privileged goal of a system facing resource constraint. However, financial decisions impact all domains of the system (including safety and quality) and clinical decisions impact the financial position of the organisation. Governance structures must enable effective partnership of clinical and corporate management working towards the same goal. This includes mechanisms for clinical review of administrative decisions, support for the practical enactment of those decisions, and close engagement with

clinicians to assess the impact. Strong clinical engagement in governance and management is necessary to ensure a clear line of sight from the bedside to the boardroom (Waikato District Health Board, 2020).

Toi Mata Hauora considers that the current change proposal for clinical governance and leadership falls well short of meeting the principles outlined in *In Good Hands*. In turn, it also falls short on building towards pae ora; achieving the best possible health outcomes for New Zealanders; responding to the aspirations and needs of the population; eliminating inequity and reducing geographic variation in care. The proposal does not articulate what is being governed or present a structure for integrated clinical-corporate leadership. Drawing from past attempts, it will likely exacerbate the clinical and corporate divide and lead to a siloed approach.

> *"Healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical."* (Ministerial Task Group on Clinical Leadership, 2009)

> *"If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people."* (Darzi, 2008)

The value of medical leadership

Internationally, it is well accepted that the involvement of medical professionals in senior leadership and management roles within health systems contribute to better performance, particularly for quality and safety metrics such as hospital infection rates and patient experience (Kirkpatrick, Altanlar, & Veronesi, 2024). Medical involvement in leadership is also associated with safer staffing; more pragmatic clinical decision-making; lower morbidity rates; and a better quality rating for service providers (Clay-Willaims, Ludlow, Testa, Li, & Braithwaite, 2017). Clinically trained leaders and managers are also associated with stronger management performance, and improved organisational efficiency ((Jones, Home, & Jones, 2024).

Clinicians bring a number of strengths to leadership and management roles within health systems, including a detailed, hands-on understanding of service provision; the ability to make strategic decisions through a quality and safety lens; the ability to assess clinical risk; credibility with clinical peers; and a strong understanding of how the health outcomes and experiences of patients' will be impacted by poor service delivery (Jones, Home, & Jones, 2024). This also means they are best placed to recognise substandard patient care, and understand what changes are needed to improve systems (Gauld, 2017). Medical clinical leaders often retain a component of clinical practice, which is important for understanding the working environment, concerns of frontline staff, opportunities for

improvement, and clinical impacts of organisational decisions. Having medical leadership that is both empowered and accountable at all levels of an organisation is critical for ensuring that the safety and quality of patient care is central to operational decisions (Australian Commission on Quality and Safety in Healthcare, 2017).

The consequences of inadequate clinical governance or leadership are catastrophic, as seen with the critical failings in patient care at the Mid Staffordshire NHS Foundation Trust in the UK. The subsequent inquiry identified a number of factors that contributed to the failures, including a culture of prioritising finances and targets over patient outcomes; defensiveness and denial when patient safety concerns were raised; inadequate clinical governance meaning the leadership of the Trust was blind to the issues; a culture of self-promotion rather than critical analysis and openness, insufficient attention to risks in service delivery; imposed cost-savings that had a profound impact on the organisation's ability to deliver safe and effective services; little attention paid to the impact of proposed savings on quality and safety; and officials too remote from the realities of service provision to understand the impact. Also cited was the constant reorganisation of the NHS, leading to loss of corporate memory and poor communication and information flow (Francis, 2013).

Given that the New Zealand health sector is currently being required to operate under a model of significant fiscal austerity, coupled with a time of significant change, it is critical to get clinical leadership and governance structures right, to prevent similar failings as occurred in Mid Staffordshire. Harms that result from poorly conceived and implemented changes can have profound impacts that cannot be remedied for those who were impacted.

None of this is suggesting that the current model is ideal. Toi Mata Hauora has heard concerns from senior doctors across various specialties that since Health New Zealand was established, clinical voices have been marginalised and lost in the centralisation, with variability in whether concerns raised to operational management will be heard, acknowledged and addressed. Austere funding constraints have further created a dominating, top-down leadership approach that devalues clinical input, and sets aside the lived realities of clinicians in favour of public relations management in the media. This has led to a lack of trust, disempowerment, and reduced engagement from capable leaders within the system.

Further marginalising clinical leadership creates significant risk for Health New Zealand. Any structure that requires clinical leaders to convince operational managers to take an issue seriously will not succeed. The absence of effective clinical and corporate partnerships is visible in a number of ways, including:

- Communication from Te Whatu Ora leaders that there was no hiring freeze earlier in the year, which did not match the experiences of clinicians attempting to recruit staff.
- The appointment of Deputy Chief Executives to the four regions, with no clinical counterparts appointed at the same level to bring clinical quality and safety into decision-making. These appointments appeared to be made without the usual due process.
- The ad hoc establishment of 'Clinical Forums' to provide clinical advice, indicating that clinical leadership is not appropriately heard or embedded in the structure of the system, requiring workarounds to be developed.
- Media reports that Te Whatu Ora managers brain-stormed potential service cuts in the event of not receiving funding for health cost pressures (including dialysis, child development

services, clot retrieval, cardiac care, IVF, respiratory medicine) without clinical staff in the room. Although it was a hypothetical scenario being discussed, it is inappropriate for such planning to take place without clinical input from a safety and quality lens to understand the implications for patients, and the costs and impacts such measures would have generated elsewhere in the health sector.

- The removal of enabling functions (IT, finance, HR) with little regard to the flow-on effects for clinicians delivering services.
- The proliferation of generic, national HR policies that neither tailored to nor informed by the different workforces within the system.

It is imperative that Te Whatu Ora re-engages with clinicians and develops a structure with effective clinical and operational partnerships at all levels of the system. Significant work is required to regain the trust of clinicians.

"Governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation." (Australian Commission on Quality and Safety in Healthcare, 2017)

"The most effective use of resources occurs when clinical leadership is embedded at every level of the system." (Ministerial Task Group on Clinical Leadership, 2009)

The Consultation process

Toi Mata Hauora is disappointed with both the consultation process and the proposal itself. We raised with Te Whatu Ora immediately that three and a half weeks to provide feedback is totally inappropriate for a consultation with such significant implications. We received feedback from many members who were frustrated with the short notice for local meetings that limited the ability to meaningfully engage and did not take account of clinical schedules. We also heard concerns that the short period for feedback suggested a disingenuous approach to consultation.

In-depth consultation should have occurred across the country involving clinical staff in co-designing an evidence-based, fit-for-purpose model from the ground up that would then be consulted on formally. It has been over two years since Te Whatu Ora was established, and a co-design process could have taken place in this timeframe. Instead, the proposal provided is top-down and has not been informed by the needs of those working in the system, or the communities they serve.

The proposal itself lacks rigour. It does not appear to draw on the wealth of evidence available on clinical leadership models and the multiple benefits for health services and the patients they serve. Nor does it investigate the efficacy of clinical leadership models used internationally, to inform development of a model for Aotearoa New Zealand under the new centralised structure. It is unclear what the proposed model is trying to achieve, or how it relates to the goals stated in the document. At roadshow meetings, members of Te Whatu Ora's national clinical leadership team were unable to

articulate what wasn't working with the current model and what problems the proposed model would fix. It was also suggested at meetings that a leadership model itself would not improve patient care – reflecting a lack of understanding of the evidence that suggests clinical leadership can indeed improve quality, safety and patient experiences, as well as management performance and efficiency.

The proposal only deals with change for one to two layers of clinical leadership and does not outline a proposal for roles above and below this. It does not propose a structure for operational roles at all. This suggests an arbitrary split between clinical leaders and operational leaders – as though clinical leaders manage service provision and operational leaders manage the budget in isolation from one another. However, both clinical and operational leaders must be united in governing health services with the same goal of pae ora and achieving the best possible health outcomes for New Zealanders.

Any leadership proposal should encompass both clinical and operational leadership, with significant thought applied to how these roles will interact, and the importance of clinical assessment of operational decisions. Similarly, so that different layers of leadership within the system can understand how they relate to and work with one another, the leadership proposal should include multiple layers. It is difficult to comment on a change proposal for one or two layers of clinical leadership in isolation from leadership throughout the system.

Toi Mata Hauora received feedback from members that the proposal document lacked clarity, was bureaucratic, and utilised terms that are not clearly defined and are open to interpretation (such as 'partnership'). There was concern that the proposal was more focused on how a national, regional, local model would 'look' on the page rather than in-depth understanding and consideration of how it would work in practice.

Overall, it is difficult to see how the proposal as framed is based on anything other than reducing the FTE of CMOs from 18 to 14 for cost savings purposes.

Industrial implications

The industrial implications of the proposal do not appear to have been considered or understood and will impact all ASMS members employed as CMOs. The proposal includes a revised position description for CMOs. However, Clause 48 of the ASMS SECA states: "*all employees are entitled to mutually agreed job descriptions*." This requires Te Whatu Ora to consult with all CMOs who are ASMS members to mutually agree a revised job description. This has not been recognised within the proposal.

Clause 43 of the SECA also requires employers to consult with employees and invite them to participate at the earliest practical opportunity, when an employer proposes any review that might result in significant changes to either the structure, staffing or work practices affecting employees. However, consultation with employees prior to the current review has not occurred.

The purposes of the requirement to consult under the SECA are to contribute to:

a) *improved decision-making*

b) *greater co-operation between employees and the employer*

c) *a more harmonious, effective, efficient, safe and productive workplace.*

The failure to consult early is evident in the job description for the Draft Clinical Chief Position Profile provided with the consultation. Members have indicated that the draft position profile does not

resemble the work undertaken by CMOs and is lacking substantial elements of the role. The generic draft does not differentiate between medical, nursing and allied health Clinical Chief positions, demonstrating a lack of understanding that these roles are distinctly different from one another, but complementary.

Much more relevant and accurate position descriptions could have been developed by engaging with senior medical officers, and nursing and allied health leaders who hold these roles across the country, to develop an in-depth understanding of what the roles entail, and what experience and qualifications are required.

Clause 52 of the ASMS SECA is also relevant to this proposal, and outlines requirements and processes for making appointments of SMOs (including for leadership positions) in an impartial, fair and transparent manner. Clause 52 requires that:

> *"Before reaching a decision to engage the services of a senior medical or dental officer the employer shall consult other affected employees, (i.e. those in the same service or on the same roster) as to the need for such an engagement; the nature of the role; the level of skills, qualities and experience appropriate for the role or appointment. Following this consultation, a new or revised job description, if required, shall be prepared."*

This clause applies to any appointments made to clinical leadership roles.

The Chief Medical Officer role

Members provided feedback that structural changes and change programmes have significantly stripped substantive CMO roles of decision-making authority and accountability, at the same time as stripping enabling functions such as IT and administrative staff. These changes have negatively impacted CMO roles and contributed to low morale and engagement from medical staff across the sector. To enable the system to benefit from strong clinical leadership, CMO roles need to be empowered and accountable, working in a team with nursing, allied health and operational leadership, and supported adequately by enabling functions such as IT, HR and administration.

Members have also identified notable omissions from the draft CMO position description that are indicative of the lack of rigour applied to the process. These include (but are not limited to):

- Oversight of research and innovation. Research governance must sit at the CMO level close to where research activity takes place and where the quality and safety of programmes can be assessed by someone clinically trained.
- Critical appraisal and evaluation of the cost effectiveness of new treatments proposed.
- Maintaining relationships with universities and medical colleges and providing oversight for the safety and clinical training of medical students and junior doctors. In some CMO roles this includes oversight of simulation centres.
- Supporting post-graduate research and education.
- Liaising with and developing strong relationships with the Medical Council of New Zealand, the Health and Disability Commissioner, the Accident Compensation Corporation, and the Coroner.
- Crisis management and responding to major issues such as cyber-attacks, pandemics, and mass casualty incidents.

- In-depth understanding of the health needs of the local communities they serve.
- Interface and relationship development with primary and community care.
- Supporting SMOs, RMOs and junior doctors, maintaining morale and engagement, safe staffing, and overseeing recruitment and retention.

In terms of the position description, some members recommended CMOs should have substantial leadership experience, as well as training and qualifications in medical management (such as Fellowship of the Royal Australasian College of Medical Administrators (FRACMA), or qualifications in Public Management or Public Health, and professional development in project management, finance, governance, audit and quality improvement, and health systems law), in addition to registration in a vocational scope. Qualifications are required for CMO roles in Australia, and academic literature and professional standards reiterate the importance of identifying and fostering the development of clinical leaders at all levels. (Ministerial Task Group on Clinical Leadership, 2009) (Jones, Home, & Jones, 2024)

Workforce planning needs to take leadership development into account, and support pathways for clinical leaders to gain the skills, experience and qualifications required. Maintaining clinical practice is also important for CMOs to retain clinical skills; an understanding of current workplace challenges and the impact of organisational decision on patients; and credibility with peers.

Member feedback

"Weakening the CMO role poses a significant risk to patient safety and the hospital's capacity to address clinical challenges effectively."

The relationship between clinical leaders and operational leaders

We heard concerns that since the establishment of Te Whatu Ora, a complex managerial model that subsumes clinical agency has developed. The consultation document refers to the importance of clinical leadership and the need for clinical and operational leaders to work in partnership, which are principles Toi Mata Hauora supports. However, members noted that the proposed structure does not demonstrate true clinical and operational partnership and reduces the genuine decision-making ability of CMOs. For example:

- Chief Medical Officers report to Group Directors of Operations (GDOs). Some members raised that GDO roles are not as senior as the previous DHB Chief Executive roles were and are more akin to the previous Chief Operating Officer roles, who CMOs worked in partnership with.
- Deputy Chief Executive Officers have been introduced for each of the four regions. However, there is no CMO counterpart for these roles. CMOs at hospitals report to GDOs locally, and to the National CMO, bypassing all contact with regional Deputy Chief Executives. This both disempowers local CMOs and leaves the Deputy Chief Executives with inadequate clinical support to succeed in their roles, and reduced ability to influence the clinicians who deliver healthcare.
- The proposal does not look at clinical and operational leadership simultaneously, risking that ongoing iterative change proposals will drive the "partnership" further out of step.

- The proposal has not been informed by consultation with clinicians across the country, to understand the needs of local services and how the CMO role supports those needs. This gives the impression that the clinical leadership model, has predominantly been designed by corporate management.

Rural and remote clinical leadership

The proposal does not adequately consider or strengthen rural and remote clinical leadership and appears to be attempting to save money by reducing clinical leadership in high needs, rural and remote communities. This is evident from the demotion and reduction of FTE at sites which serve rural and remote communities, such as Whanganui and the West Coast. Members raised concerns that reducing clinical leadership at smaller sites would result in the needs of these sites being subsumed by the larger sites.

Proposals to restructure clinical leadership should embrace the opportunity to strengthen rural and remote clinical leadership. This is particularly important in light of rural communities facing significant challenges with fragile after-hours primary care; poorer health outcomes than their urban counterparts; and higher levels of socioeconomic deprivation.

The concept of either a National Rural Health CMO, or a Rural Health CMO for both Te Ika a Maui and Te Waipounamu was suggested by members, to support strong rural input into nationwide development of policy, strategy and planning, and strengthen rural health care across the country. It was noted that strong working relationships would need to remain between CMOs at rural hospitals, with CMOs at their nearest tertiary hospital, and a new model would need to support this.

The proposed clinical leadership groupings

The proposal suggests that the number of CMO positions across the country be reduced from eighteen to fourteen, by grouping:

- South Canterbury and Southern;
- Capital, Coast and Hutt Valley and the Wairarapa;
- Bay of Plenty and Lakes;
- Midcentral and Whanganui.

There would be one CMO for each of these groupings, with a medical lead situated at sites where there was no CMO. Hutt Hospital appears to be an exception with no CMO or medical lead situated at the site, despite serving a population of 150,000 people.

Members provided strong feedback highlighting a number of concerns about the impact of these proposed groupings. These concerns are outlined below.

The loss of local clinical leadership

Members provided feedback that CMO roles are relationship based and require frequent face-to-face interaction locally. There was widespread concern that CMO roles covering multiple sites will result in diminished local leadership, and reduced visibility of critical clinical and staffing issues at sites where the CMO is not based.

Some members had prior experience of sites where the CMO was not based locally but shared across multiple sites. They reflected that this led to a limited relationship with the CMO; inappropriate

decision-making for local needs; reduced understanding of issues facing clinicians locally; inadequate support for local departments; and CMOs stretched too thin across multiple sites. Members emphasised the importance of having an accessible CMO, who knows and understands local challenges and can quickly make informed decisions based on a firm understanding of local context.

Members at sites proposed to be merged expressed concern that the significant value their local CMO had contributed would be lost.

Member feedback

"Having the ability to find an SMO CMO from your own hospital shouldn't be underestimated."

"I have always known the CMO and [they have] attended our department meetings when requested. This would be difficult if the CMO was based in another region."

"If we move forward with having a single CMO … I am concerned this will further dilute our voice and representation, ultimately impacting our capacity to manage our departments and hospital effectively."

"I am deeply concerned about the prospect of losing our CMO…[who] has provided essential clinical leadership within our management team…[implemented] quality improvement projects… enhancing our SMO recruitment strategy… making [the hospital] a more attractive place for medical professionals to work. I fear that a merger with [region] will undermine these important initiatives."

"Suggesting the removal of CMO[s] from some hospitals fails to acknowledge the important role of doctors in our health system. "

"I support integrating the health system to make it function better for patients, communities and those of us who work in it. Leadership needs to be present, decentralised and empowered - this change accomplishes none of these."

The impact on service provision to patients

Members raised concerns that the proposed groupings would negatively impact service provision to local communities where the CMO was not located in that community, and that this would disproportionately impact smaller hospitals and those that serve rural and remote communities.

Feedback included that local CMOs are needed who understand the unique geographic, demographic, culture and health characteristics of their region, as well as how the hospital functions. This view is supported by standards from RACMA which support the concept of a locally resident medical workforce in rural areas, and highlights the value that clinical leaders bring to health service delivery in rural and remote areas, including workforce planning to meet local need, supporting integration across primary, secondary and tertiary care, and being highly involved in and accountable to the communities they serve, including indigenous communities (Royal Australasian College of Medical Administrators, 2022).

Members expressed that clinical leadership needs to be supported and strengthened in these areas rather than diminished. For example, Whanganui serves a population with a higher proportion of Māori, higher rates of unemployment, and higher socioeconomic deprivation than the New Zealand population in general. Whanganui Hospital is located in in an urban area (U2 based on the geographic classification for health) but also serves rural and remote communities with classifications ranging

from R1-R3 (University of Otago, 2024). Rural and remote areas in New Zealand experience higher preventable mortality rates than the rest of the population, lower screening and immunisation rates, poorer mental health outcomes, poorer oral health, and higher rates of workplace injuries (Ministry of Health, 2023). These inequities are exacerbated for Māori. However, the proposal would likely see Whanganui lose its locally based CMO position. Losing the locally based CMO position, and a clinical leader who lives and works in the community, is a risk to local service provision and may exacerbate inequities.

Member feedback

"The unique needs of our community will not receive the same attention, being lost in the demands of the greater size and noise of our neighbours."

"Regions differ in their local problems and need more localised CMOs."

"Being independent is better so we can utilise the services we need from both regions if needed and can serve our region people better depending on their needs."

"It places patients at risk from managers who simply fail to understand the impact on our patients of their business rather than patient focused solutions."

"A key concept of rural health delivery is understanding the specific context in which we work. This changes from location to location, and is best understood by those situated in the area, not those remote from it. I fear this action by the government will contribute to further inequities in health for rural people."

References

Australian Commission on Quality and Safety in Healthcare. (2017). *National Model Clinical Governance Framework.* Sydney: Australian Commission on Quality and Safety in Healthcare.

Clay-Willaims, R., Ludlow, K., Testa, L., Li, Z., & Braithwaite, J. (2017). Medical leadership, a systematic narrative review: do hospirals and healthcare organisations perform better when led by doctors? *BMJ Open*.

Darzi, L. A. (2008). *High Quality Care for All: NHS Next Stage Review Final Report.* London: The Crown.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary.* London: The Stationery Office.

Gauld, R. (2017). Clinical leadeship: what is it and how do we facilitate it? *J Prim Health Care*, 5-8.

Jones, B., Home, J., & Jones, D. (2024). *Strengthening clinical leadership and management.* London: Health Foundation.

Kirkpatrick, I., Altanlar, A., & Veronesi, G. (2024). Doctors in leadership roles: consequences for quality and safety. *Public Money & Management*, 515-522.

Lin, V., & Gibson, B. (2003). *Evidence based health policy: problems and possibilities.* Melbourne: Oxford University Press.

Ministerial Task Group on Clinical Leadership. (2009). *In Good Hands - Transforming clinical governance in New Zealand.* Wellington.

Ministry of Health. (2023). *Rural Health Strategy 2023.* Retrieved from Ministry of Health: https://www.health.govt.nz/strategies-initiatives/health-strategies/rural-health-strategy

Royal Australasian College of Medical Administrators. (2022). *Position Statement on Remote, Rural and Regional Medical Leadership by Medical Administrators.* Retrieved from RACMA: https://racma.edu.au/advocacy/position-statements/2022-position-statements/position-statement-on-remote-rural-and-regional-medical-leadership-by-medical-administrators/

Stolarek, I., McHardy, K., McCann, L., Simpson, A., Howard, G., & Robson, J. (2022). Leadership and governance-what is needed to deliver Aotearoa New Zealand Health reforms. *NZMJ*.

University of Otago. (2024). *Rural Health Research Network.* Retrieved from The Geographic Classification for Health: https://rhrn.nz/gch/analysis-by-the-gch

Waikato District Health Board. (2020, September 23). Quality Assurance framework (Clinical). Hamilton.