Clinical leadership response College of Nurses Aotearoa October 2024

> *"Clinical leadership is a crucial component of driving change in the health system. We know that to ensure positive change at all levels of the health system we need to strengthen the partnership between clinical leadership and our operational/managerial leadership so that all significant decisions have a clinical frame of reference. We also want to have clinical leadership working in partnership with clinical colleagues in other disciplines, within different business units of our organisation, and across the wider healthcare system."*

Richard Sullivan

Background

The College of Nurses Aotearoa (NZ) Inc. The College is a leading national professional nursing organisation. We are bicultural organisation committed to te Tiriti o Waitangi. We are a leading voice for support, advancement, and valuing of the nursing profession. Our organisation's membership includes nurse leaders affected by this proposal. It is therefore, disappointing that our group, despite requests, have not been included in the consultation process. The protracted process leading up to the release of this document has been poor and caused significant and unnecessary distress for our members.

Nursing is the largest workforce in healthcare. To ensure safe high quality care and in order to achieve Pae ora, effective and visible nursing leadership is essential. Historically in periods of health reform, there has been a demonstrable negative affect on patient outcomes (Diers, Carryer et al 2010) when there has been significant reduction in leadership and financially based health reform. In Aotearoa, healthcare delivery, in particular Health NZ Te Whatu Ora, is in a period of fiscal scrutiny and austerity, where nursing is being expected to save money through budget cuts, delays to recruitment and significant reduction of leadership roles. Anecdotal evidence suggests a rise in hospital acquired infections, patient falls, and an increasing length of stay is already occurring due to the tightening of budgets for clinical staff, despite assurances that front line staff will not be affected. However, our members have reported to us that this is not the case and indeed the current wave of reform is negatively affecting patient outcomes. These are failure markers that weigh heavily on nurses who are unable to deliver high standard care in a system increasingly designed not to value or support it. The Francis Report into the systemic failings of Mid Staffordshire NHS Trust, highlighted stark findings – where a focus on fiscal imperatives and lack of nursing leadership had serious and often fatal consequences for patient care (Francis, 2013).

Establishing a supportive and consistent foundation of clinical leadership across our national system, to work alongside other parts of the organisation, is vital for driving change. It is unclear what the restructures are trying to achieve and the body of the document does not support the stated acknowledgment of how critical clinical leadership is. The drivers for change seem to be fiscally motivated as there is not credible rationale. The proposed restructure flies in the face of the rhetoric which is all about investing in the 'front line' clinical leadership – which is more vital than ever before with the workforce issues pressing. These are the leaders who are identifying,

managing and mitigating clinical risk every day as well as supporting recruitment, retention, a positive workplace culture and inspiring nurses to provide high quality care. Clinical leadership is critical for effective clinical governance.

Feedback

It is unclear what 'refocusing chief roles to be whole of system' means. There needs to be recognition in the document of existing clinical leadership structures that exist outside of Health New Zealand and the implications of placing new leadership over roles and structures that Health New Zealand has no mandate over. There is no evidence that this has been discussed with those groups e.g. GPNZ, Chief Clinical Officers in Aged Care, and what their thoughts are regarding this.

The proposal makes no reference whatsoever about the need to consider and factor in Māori Nursing leadership opportunities. Partnership in this regard and commitment of senior nurse leadership to Te Tiriti o Waitangi is critical for addressing issues of access and equity for Māori. Pae ora will not be achieved without this. Māori health models are based on a holistic view of wellness. They show the importance of taha Wairua, the spiritual dimension, in health services for Māori. Without a well-resourced and strong structure of Māori nursing leadership, responding to the outcomes of the Wai 2575 Tribunal report and Māori Health Action Plan priority actions will not be fully achieved. Whakamaua: Māori Health Action Plan 2020–25.

This proposal focuses on regional and district-level clinical leadership roles like Chief Medical Officers (CMOs), Directors of Nursing (DoNs), and Directors of Allied Health (DAHs). The proposed title Chief Of Nursing (CON) is not supported – we propose the title Chief Nursing Officer as this does not have the same unfortunate and potentially derogatory abbreviation of "CON". It is also better aligned with the other proposed leadership titles of other disciplines and the title used in other jurisdictions.

The document outlines a series of objectives including creating national consistency. It is agreed that within nursing in particular there has been an evolution of multiple titles for the leadership roles, but to disestablish these roles is an unnecessarily complex process. Roles and position descriptions could have been standardized through a far less destructive process .

The proposal outlines a complex restructuring to reduce clinical leadership FTE. The proposal has a number of omissions and inconsistencies that need to be addressed to ensure any future change does not result in unintended consequences. The loss of significant clinical leadership FTE, in particular for nursing, does not seem to have any relationship to the population size or need in the regions.

The proposal to incorporate and downsize clinical leadership roles in some districts is concerning. Current roles already have sufficient work for full time clinical leadership positions, and many are already working across the system in a way that will be unable to be achieved with

a significantly smaller FTE (0.4). This is not good for the professions or the district governance with siloed decisions. If nurses are not at the table, we are on the menu (Kitson et al., 2022).

Local leadership is essential for ensuring safe clinical practice, supporting workforce development, having visible career paths that will support clinicians to remain in regional and rural areas, and supporting cross sector 'whole of system' working. The proposed reduction of current clinical leadership roles to 0.4FTE by combining districts will leave these smaller districts struggling to maintain local clinical governance, safety and quality. In addition, 0.4FTE is also insufficient for these roles to pick up portfolio expectations, subsequently reducing the overall capacity of clinical chiefs to achieve the intended outcomes of the proposal.

The proposal to reduce local leadership in some districts to 0.4FTE clinical leadership shows a significant lack of understanding of the complexities of regional and rural health care provision where recruitment and retention are challenging, patient complexity is compounded by the rurality, ethnicity and socio-economic status found in rural areas, and the value of strong clinical leadership across the system that works to mitigate these issues. South Canterbury is an excellent example of where a whole of system approach works well. As there is no PHO, the Director of Nursing works effectively across the primary, community and hospital system. This is not recognised in the proposal.

By removing 0.6FTE in 4 districts and creating a nurse lead, this devalues the leadership contribution and leadership requirements of the district by removing the most senior nurse in the district from the district's highest governing decision-making and strategic planning body.

All districts have strategic nursing leaders but it's the next layer down that has significant variation. It's this variation that creates unequal demands on senior clinical leaders in some districts while other districts have spare capacity. Spare capacity enables significantly greater representation at regional and national level that has unintended consequences of giving greater voice to urban need and thus perpetuating inequality and rural disadvantage (because capacity exists primarily in metropolitan districts where even when accounting for higher populations, is disproportionate). If nothing else, New Zealanders are egalitarian and want things to be seen to be fair as we work towards addressing postcode healthcare.

There are specific nuances related to the operational leadership of districts, education, and professional standards which if not specified may not be understood of be a core component of the Chief Nurse role.

- Lead oversight of the quality of pre-registration and post registration education including participation in TEP programme reviews, annual programme governance and quality of new graduates.
- Provides professional advice and direction into HR, ER and IR activities as they relate to the profession ensuring professional and patient safety standards are met
- Oversee strategic insights and learning from complaints and serious adverse event responses, in particular in relation to the nursing profession and patient safety more generally advocating

for rigour, learning and actions are implemented.

In addition, there are multiple other facets to the Chief Nurse's role which have not been articulated or recognised in the proposal.

- Participation as part of the GLT in leading and managing the organisation's strategy and allocation of resources to ensure the organisation's goals and objectives are met or exceeded.
- Leading by example and promote the vision and values across all staff.
- Working as part of the GLT to ensure overall achievement of annual business plans.
- As a member of the Group Leadership Team identify and promote sustainable outcomes as a key requirement in all strategies and organisational goals.
- Demonstrate the model of partnership with clinicians and managers for the benefit of patients, staff, and services.
- In leading as a Clinical Leader, put people first, because it's people who do the work and who care for patients
- Apply a process that ensures nursing staff are listened to across the district, regionally and nationally.
- Practice management by walking around to ensure you are visible and easy to communicate with, e.g. visit team members and staff in the wards.
- Ensure nursing staff (and employees generally) are recognised and appreciated for their contributions.
- Provide system leadership and direction to leverage nursing workforce and systems capability by optimising opportunities to improve patient experience and professional standards and safety across the whole continuum of care.

This proposal states that it does not address roles below this leadership level, which will likely be the focus of lower level leadership reform. One of the key problems with this approach is the complex structures that sit below and report to the disestablished roles, particularly in nursing. The recommendations are in isolation from any of the structures locally that report to clinical roles. There is no reference to the current structure of regional and national portfolios.

In respect of nursing leadership roles in particular, the document fails to support clinical leadership as a crucial component driving change. Acknowledgment of the crucial role of clinical leadership is at odds with the significant reduction in nursing leadership FTE nationally.

Clinical leadership teams across the country have been set up to share responsibility and workload, operating within a team construct. This is particularly evident within smaller districts already operating with very limited FTE. Failing to understand this or addressing roles below local CMO/CNO or DON/DAHST within this change consultation introduces significant organisational and clinical risk into the process. It also fails to give due consideration to the level of support that will remain within districts for the newly established roles – thereby enhancing the risk of any new roles being 'set up to fail' – particularly in geographically isolated small districts with new roles reporting to a Chief role and a GDO positioned a long way away.

There are a large number of roles which report directly to the current CNOs and DONs. These people work within a range of key functional areas such as Practice Development Units (nurse educators, coordinators and coaches). CNO and DON roles also hold the responsibility for the delivery of all undergraduate student placements and student experience in collaboration with the local TEP; governance, funding and delivery of new graduate programmes; governance and funding of post graduate education and expert nurse pathways; governance and administration of both the CCDM programme and TrendCare system. Under the proposed construct, all of these people, systems and processes will experience a change in reporting lines, governance and administration as a first order impact of the CNO and DON positions being disestablished and the new Nurse Lead roles within the smaller districts reporting to new Chief roles in larger centres.

Therefore, these people and their roles are directly impacted by this change proposal – regardless of whether the time has been taken to pay due diligence to the broader impacts or not. This is a situation which will require immediate interim plans to be enacted as soon as those CNO and DON roles are disestablished.

The Pae Ora Act and strategic guidance has been clear in articulating the need to address health service access issues for people living in vulnerable communities within peripheral districts – i.e.: the districts which this proposal is combining with larger districts while significantly reducing local clinical leadership within those districts. Implementing enhanced regional service models designed to address service access within small peripheral districts will be absolutely reliant on strong local clinical leadership and (from a nursing perspective) a significant number of new expert nurse roles working within flexible and agile multi-disciplinary constructs based within it.

The proposal also appears to have been developed with no adjustment to aligning with the altered executive leadership structure for health service delivery. The establishment of the four new DCEs with responsibility for both HSS and Commissioning very much aligns to a regional model of health service delivery. Clinical leadership and operational management structures should be set up to support the regional approach. Therefore, in the context of this proposal, establishing regional clinical leads for all the professional disciplines would appear to be the most important first step in establishing effective and efficient regional structures.

There is some dissatisfaction amongst midwives with the proposal to add midwifery leadership roles at a regional level with most midwifery leaders at district level feeling that it would be better to invest the resources into more midwifery clinical and operational leadership at district level, rather than creating new regional roles. Most of the Directors of Midwifery are working strongly together at a regional level already and are sharing the responsibilities for representation and strategic work, collaborating and communicating well with each other. Refer the New Zealand College of Midwives response). The College of Nurses Aotearoa supports the NZCOM submission in regard to midwifery leadership issues.

There is support in particular from midwifery for de-coupling midwifery from nursing leadership. However, if the proposed disestablishment of the remaining Directors of Nursing and Midwifery goes ahead, there must be sufficient nursing and midwifery leadership capacity within each district setting for the strategic and professional oversight.

Recommendations

1. It is **strongly recommended** that the proposal is reviewed to ensure Māori Leadership is considered at all levels of clinical leadership at both district and regional levels as well as at national level.
2. That the recommendations out lined in the proposed title Chief Of Nursing (CON) **is not supported** – the title Chief Nursing Officer or similar is recommended and better aligns with the titles of the other professional clinical Leads
3. The significant reduction of clinical leadership to 0.4 FTE at a local district level and 0.6FTE at a regional level **is not supported.** This is insufficient resource to deliver on patient safety and clinical quality or operational decision making, the partnership leadership must enable this.
4. The scope of this review is narrow and fails to consider the level of staff, who through a complex network report to clinical roles – in particular within the nursing workforce clinical teams reporting to Chief Officers of Nursing. We **strongly recommend** that these changes are not made in isolation and that the review is broadened to capture the impact of removing or significantly depleting these roles will have on the system as a whole.

If you wish to discuss any aspect of this feedback further, please contact Kate Weston, executivedirector@nurse.org.nz or on 027 225 8287

Nga mihi nui

Executive Director

College of Nurses Aotearoa

References

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