Dear Prof Duckett,

Following the Department of Health and Human Services (DHHS) workshop on 18th March 2016 I would like to make the following submission to the Review of Hospital Safety and Quality Assurance in Victoria. The views are mine, although I note I have the support of my CEO in providing this submission and on that basis provide this submission in my capacity as Director Medical Services at Northeast Health Wangaratta, a position I have held for 13 years. My submission naturally focuses on the role of the Director of Medical Services (DMS) in providing, enhancing and assuring clinical governance in Victorian health services. For additional perspective I have attached a paper that I recently wrote considering the role of the DMS in rural health services (especially small rural health services (SRHS)) in Victoria. It expands on a number of the points I shall make here and provides some logistic perspectives for the role. Perhaps the key component of the paper for the purposes of your review however is the first two pages which describe the pivotal roles of a DMS in clinical governance.

At the start I should note the relevance of recent consideration by the Royal Australasian College of Medical Administrators of changing its name to that of the (Royal) Australasian College of Medical Leaders. Whilst traditionally referred to as a Medical Administrator, the reality is that a key role of a DMS is to be a Medical Leader and to lead the medical profession and other clinicians in the pursuit and delivery of high quality and safe services to patients. Despite the importance of this the role of DMS has not been nurtured in Victoria for many years, and it has been shown little appreciation of value by the DHHS, in contrast to the position in some other states (eg Queensland). From many perspectives the role of a DMS can be regarded a relatively thankless task, with few 'friends'. The lack of value of the role by the DHHS, as evidenced (amongst other things) by the exclusion of Directors of Medical Services from award conditions granted to all other salaried medical specialists, has contributed to a progressive workforce shortage that was predicted by the author ten years ago. This is not an issue caused by a model of devolved governance and it should not be suggested that it is an issue solely for health service boards and CEOs to resolve. It is clearly a systemic issue and requires ownership and resolution by the Victorian DHHS.

Part of the reason that the DMS is a key component of clinical governance is that the devolved model of health service governance in Victoria leads in rural health services to the paradoxical situation of a complex adaptive system being governed in large part by unremunerated volunteers generally with no health background and therefore little understanding of the core business of the organisation. I note this with no disrespect intended to any health service board member past or present who give generously of their time for no financial reward. I am fortunate to work for a very good board of management and so my comments are from a whole-of-system point of view rather than any one health service. The reality is however that a system which depends on people volunteering their time and varying levels of expertise in order to sit on a board giving direction to an organisation that directly affects the health outcomes of thousands of people inherently adopts a significant level of risk that those responsible for governing the health service will be in the unenviable position of ‘not knowing what they don't know'.

One thing that many boards don't know they don't know is what a DMS should be doing in terms of leading clinical governance, and consequently what they should be expecting a DMS to do for their health service. As my paper describes, and as you will be well aware,

there are many models of how a DMS might provide services to a rural health service. I believe a significant number of rural health services in Victoria receive significantly less DMS input than they truly require and, with no disrespect to any rural DMS, the reality is that increasing the level of input required of them will inevitably put pressure on their time commitments to the point for many of unsustainability.

It is my view that when, some ten years ago, the Victorian DHHS mandated that every health service should have a medical practitioner leading their credentialing and appointment processes many small rural health services bought precisely that - enough DMS time to supervise credentialing and appointments but little else. These health services however may think that they now have a DMS so all must be well. The reality is that true leadership of clinical governance, and assurance of safety and quality is not achieved in a day a month, or two days a month. Whilst the time required to guide clinical governance is undeniably proportional to the size and complexity of the services provided, the reality is that most Victorian rural health services are woefully undersupplied with DMS time, or more accurately with medical leadership.

It is easy in the present context of workforce undersupply to argue that there is no point wishing for more medical leadership when 'the people [DMSs] just aren't there'. This position is disingenuous and avoids taking a responsibility for clinical governance that boards and the DHHS must assume and maintain. Once again the paucity of experienced clinical leadership on rural health service boards does not make the necessary change easy.

Whilst there are a number of models under which medical leadership can be supplied to rural health services there are a few key aspects that must be incorporated into any model for it to succeed.

Firstly, it must be acknowledged that in the rural health service environment relationships between SRHS and their subregional/regional centres are key, including in medical leadership. A full-time specialist DMS in a subregional/regional health service can provide professional support and expert advice to a part-time (and usually non-specialist) DMS in a SRHS, and support the board and CEO of the SRHS during times of SRHS DMS leave.

Secondly, the clinical governance structure at a SRHS must support a part-time DMS to function. Whilst there are some SRHS DMSs that espouse the view that they can provide appropriate guidance to the SRHS CEO and board in a day or two a month provided that there is a competent Quality Manager to feed them data I believe that this provides only a fraction of what is actually required. For the DMS to function efficiently they must be able to lead and contribute to a integrated committee structure that gives them clear visibility of key metrics and current and evolving issues. For the DMS to be fully effective however I believe that they must have sufficient on-site time for them to develop and maintain relationships with 'coal-face' clinical staff that will enable the DMS to feel the pulse of the organisation and which will engender the trust that facilitates clinical staff 'dropping in' to the DMS's office to voice concerns or provide valuable perspectives and suggestions.

Thirdly, the 'pedigree' of the DMS is of great importance to the ability of the incumbent to establish relationships with key medical staff. In SRHS in particular the medical staff usually comprises a significant number of highly experienced General Practitioners and specialists who are unlikely to take kindly to either direction or suggestions from a DMS that they

perceive to be less experienced (and particularly less clinically experienced) than they are. As a result an ideal DMS for a SRHS may therefore be an experienced clinician who is interested in a part-time DMS role, perhaps as a staged retirement from clinical medicine. Such appropriate doctors should be encouraged to assume a leadership role, and supported to do so, albeit not in their home health service. The recent announcement by the DHHS (Workshop: Director of Medical Services Rural Regional Models, 23 March 2016) that it is working with RACMA to devise a practical pathway for rural GPs to gain experience and qualifications in medical administration (leadership), probably through a modified Associate Fellowship pathway, is welcomed. From a perspective of addressing workforce shortage, 'the sooner the better' is an applicable maxim.

Additionally, it is the author's opinion that a model such as the NHW-auspiced Central Hume Subregional Director of Clinical Governance in such areas as Obstetrics and Anaesthetics, in which a respected specialist based in the subregional centre provides clinical governance leadership to relevant SRHS, is a model which can be readily translated to other subregions, and which can provide significant support to part-time SRHS DMS models.

Finally, to revisit the issue of boards not knowing what they don't know, the reality is that a key input to ensuring that boards know what questions to ask, and to ensuring that they get the answers they need, is the attendance of an independent medical leader/DMS at board meetings. This function cannot be provided by a doctor with a clinical appointment at, or financial relationship with, the health service. Instead it should be regarded as an irreducible function of the DMS role at a health service of any size and complexity.

This and the other issues raised above mean that in general Victorian rural health services are not getting enough DMS/medical leadership input. The consequence is that in order to be assured of safety and quality in service delivery these health services need to contract for more medical leadership. They need to do this starting not from the perspective of 'what do we currently have?' or even 'what can we afford?' but from the perspective of 'what do we truly need?'. In addition they need to do this regardless of whether they think that the workforce is there to provide what they need. When they have individually and severally worked out what they need then these rural health services must consider what model(s) will work best for them to obtain the required level of medical leadership, and the DHHS must take a lead in addressing the issue of workforce shortage to ensure that we are not looking at the same landscape in another ten years' time.

Many thanks for your consideration

Yours sincerely

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