



# Review of the BreastScreen Aotearoa Program

## People and Culture in the National Screening Unit: Moving Forward

August 2011

## Report of the Review of the BreastScreen Aotearoa Program

### Executive Summary

Since the inception of National Screening Unit (NSU) in 2001, there had been great continuity in key people working in the BreastScreen Aotearoa (BSA) Program including the Clinical Directors, many of the Lead Provider Managers and many of the members of the BSA Advisory Group (BSAAG). This had been mirrored by continuity in the key people working in the BSA Program at NSU until 2008/2009.

The resignation of a number of key NSU staff since 2009 who had significant population cancer screening experience is concerning. Three of the nine positions mentioned in the letter from the Clinical Directors' Unidisciplinary Group (UDG) have been removed due to Ministry of Health (MOH) headcount reductions. The delays in recruiting replacements to the remaining six roles can be described as having internal and external drivers.

These recruitments were occurring in a timeframe of recruitment freezes and headcount reduction directed from MOH. Remuneration issues played a role in the recruitment of a new BSA Clinical Adviser and NSU Quality and Equity Manager. Also there were attraction issues for the role of BSA Clinical Adviser.

The NSU Senior Management Team (SMT) has described the limited recruitment pool for people with expertise and experience in population screening programs in New Zealand, and described the way those skills and experience were usually developed while working in the NSU. It is extremely important that those skills and experience are optimised across the population screening programs in New Zealand.

The replacements to most of these roles have not brought with them equivalent population screening experience and expertise. This is understandable due to the longevity of many of the prior incumbents in their roles and NSU; they had developed experience and expertise not easily found elsewhere in New Zealand. The impact of this turnover and reduction on headcount on key deliverables for breast screening Programs (digital mammography, PACS and a central register), has been discussed in the accompanying report.

There is a great need for the NSU of the future to re-develop and recruit these capabilities back into the unit, particularly into key positions for the BSA program.

There is a great passion for improving the health of New Zealand women through breast screening expressed by all parties interviewed, but a concern expressed by the Lead Providers, the BSAAG, and most of the prior and current NSU staff interviewed that the continued improvement of the BSA program is impacted by the lack of capacity and experience in population screening in key positions in NSU. The relationships between

NSU and the Lead Providers and BSAAG have become fractured, but there is a great desire expressed to repair those relationships looking forward to the future.

The number of structural changes that NSU has been subject to in such a short succession of time cannot have assisted with relationships with Lead Providers; interviews with NSU leadership describe the need to implement changes in focus and multiple restructures leading them to become inward looking to the changes NSU was experiencing, and not allowing them to focus on relationships with Lead Providers.

However there is overwhelming feedback that the change in focus of the NSU from the time it was restructured into the Health and Disability National Services Directorate has been a key feature in the loss of population screening capacity and expertise in the NSU. This has occurred through the resignation of key people concerned about the change of focus, the inability to recruit people with population screening expertise and experience into the NSU, and a number of new people being recruited into the NSU with a contract management focus.

This is contrasted with the view of the NSU SMT who believes they have worked hard to achieve a balance between clinical governance and oversight, contract management, provider program performance, quality and equity.

The accompanying report “Future Directions for the National Screening Unit” makes recommendations to align the NSU more closely with the Cancer Control team, in particular so that the strategic directions and priorities of the cancer screening programs are better identified in the National Cancer Program Work Plan, as part of the Government’s priorities for cancer. The report recommends the consideration of incorporating the National Bowel Cancer Screening Pilot into NSU. This would also mean the consideration of aligning the Newborn and Ante-natal screening programs with the relevant Child and Maternal Health area in the MOH.

It is also recommended that the cancer screening teams in the NSU be strengthened through realigning the Quality and Equity teams into the screening program teams, and establishing a position of Program Director (Manager) for the breast cancer screening program, reporting directly to the Group Manager NSU, and holding a position on the SMT.

Also it has been recommended that NSU appoint a part time radiologist Clinical Leader for the BSA Program to work with the BSA Program Director (Manager) employed by a Lead Provider to ensure maintenance of their clinical entitlements.

The culture of NSU can be described as a group proud of the work of the NSU and the MOH, and proud of the NSU screening programs. Most people enjoy working inside their teams. Some concerns have been expressed about co-operation across teams in

the NSU. Most people are happy with the support and management skills of their manager.

Surveys results of all NSU staff indicate an improved internal organisational culture across NSU since early 2009, over a period of internal and external restructure, headcount reduction and recruitment freezes

There is a concern about job security in the NSU, most likely due to the restructuring of roles into other parts of the MOH and the reduction in headcount directed by MOH in recent years.

There are conflicting views about the population screening expertise and experience within the NSU. The Lead Providers and Clinical Directors for the BSA Program, many of the recently resigned or retired staff from NSU cancer screening roles, and many of the current NSU staff interviewed expressed concerns about the population screening expertise and experience of key positions in and supporting the BSA Program in the NSU. This is contrasted with other current staff interviewed working in the cancer screening roles who spoke about the performance and contract management focus of their roles, and the NSU SMT who have expressed a view that currently the NSU has as much population and public health expertise as there has ever been in the NSU.

The consultants recognise the wariness of the NSU staff towards a perceived further realignment, but the overwhelming feedback about the changes needed to advance the BSA Program point towards these recommendations. It will be important to recognise the sensitivity to these further changes to NSU for the current NSU staff.

The report has also recommended that an independent advisory team assist in a three year action plan in consultation with the NSU and BSA Lead Providers to implement MOH endorsed recommendations. A key function for this advisory team will be to support the staff of NSU through the changes implemented through MOH endorsed recommendations.

## Introduction

This report accompanies the report “Future Directions for the National Screening Unit”. This report has a particular area of focus around the people and culture of the NSU, and its impact on key stakeholders of the BreastScreen Aotearoa Program.

This report makes reference to a number of recommendations from “Future Directions for the National Screening Unit”, as they are relevant to the review in its entirety. This report makes some recommendations that are unique to the issues discussed, and important to the future of the BreastScreen Aotearoa Program.

The BreastScreen Aotearoa (BSA) Clinical Directors’ Unidisciplinary Group (UDG) sent a letter of concern about the central administration of the National BreastScreen Program and the National Screening Unit (NSU) in New Zealand. This letter was sent by Chair, Dr. Sally Urry, on 28 January 2011 to Hon. Tony Ryall, Minister of Health.

The letter expressed concern about resignations from key positions within NSU since October 2009, and in particular expressed concern about the recruitment of a Clinical Leader to the BSA Program.

The letter expressed an opinion from the group that a significant level of knowledge and skill has been lost from the NSU, which puts BSA at risk, particularly in terms of clinical safety.

The key issue to be addressed is in the last sentence of the letter, “The question has to be asked why so many have resigned and indeed not been replaced.”

This letter, and the concerns it raised, became part of the overall terms of reference for a wider review of the BSA Program. This report will address the issues of turnover in NSU, particularly in cancer screening, and the current culture within NSU.

## Methodology

This review was undertaken using the following methodology:

- 50 interview sessions with individuals or groups undertaken in Wellington, Auckland and Christchurch over the period 16 May until 27 May 2011. The list of groups and individuals included in the interviews is provided in Appendix 3.
- Subsequently six telephone or Skype interviews were undertaken with people identified as important to this review, and further email clarification sought from two other people.
- All current NSU staff (including some long term contractors) were surveyed seeking responses to how they felt about working in NSU, working in their team, working with their immediate manager, what currently supports them in their role, and what would support them in their role in the future.
- Relevant documents provided by NSU were reviewed. Those documents are listed at Appendix 4
- Drawing on the expertise and knowledge of the reviewers in population cancer screening and leadership, human resource management and organisational change.

This review report contains sections that are grouped around the theses of:

- Turnover of particular individuals and roles
- Concerns of Lead Provider Managers, Clinical Directors and the BSA Advisory Group
- Changes in Focus of NSU since 2007
- Restructures in NSU
- Effects of MOH Headcount Changes on NSU
- Effects of MOH HR Policies and Practices on Recruitment
- The Culture at NSU

## Recommendations

1. It is recommended that future recruitment in to the NSU has a focus on those skills important to population screening, particularly skills in public health, epidemiology/biostatistics, quality assurance, community engagement and communication.
2. It is recommended that the relevant positions in the NSU management team (SMT), dedicated to leading the population screening programs, have their position descriptions reviewed to ensure a rebalancing of skills, capacity and experience in the key requirements of population screening, sector relationships and contract management for these important roles.
3. It is recommended that the focus of the NSU shifts away from compliance and contract management towards coordination and collaboration with the Lead Providers to deliver a quality program.
4. It is recommended that the National Screening Unit (NSU) and the BreastScreen Aotearoa (BSA) strengthen its collaborative links and alignment with the Cancer Control team given that cancer screening programs are a key part of the cancer control continuum including the following considerations:
  - i. That the strategic directions and priorities of the cancer screening programs be better identified in the National Cancer Program Workplan, as part of the Government's priorities for cancer and the New Zealand Cancer Control Strategy and that relevant Program and Clinical Leaders have membership on the Steering Group.
  - ii. That the cancer screening programs strengthen their collaborative alignment and the linkage with the regional cancer networks and the development of clinical pathways for breast, bowel and cervical cancers.
  - iii. That the NSU be renamed National Coordination Unit (NCU) for Cancer Screening to assist in communicating the change in focus to Lead Providers, stakeholders and the community.

- iv. That consideration be given to moving the Antenatal and Newborn screening programs out of the NSU to be aligned with the relevant Maternal and Child Health area in the Ministry of Health to increase the focus and alignment of the cancer screening programs in the NSU.
5. It is recommended that the NSU realign quality and equity functions into the program teams to ensure the most efficient use of resources and to promote national program leadership and strategic direction for BSA including the following:
  - i. Establish a position of Program Director (Manager), that would report directly to the Group Manager (NSU) and remove the current Manager Cancer Screening position. The key role and responsibility of this position would be to provide leadership and strategic direction for the BSA Program and to lead a program team that undertakes national coordination functions and strategic management for BSA.
  - ii. Rebuild the BSA program team by integrating relevant positions from the Quality and Equity team with the current program positions to undertake the key functions of national coordination, strategic and capacity planning, BSA service development and support, community engagement and communication, policy and standards, quality assurance and monitoring including coordination of BSA Service Audits and reporting.
  - iii. Ensure the retention of existing staff in the NSU that have significant BSA program knowledge and experience and recruit, to current vacant positions, personnel with the appropriate skills in public health, epidemiology or biostatistics, quality assurance, community engagement and communication.
  - iv. Maintain cross program knowledge, skills and resource sharing, particularly in the disciplines of epidemiology/biostatistics and community engagement and communication, through a matrix structural alignment and formalised processes.
  - v. Ensure that communication and collaboration with the Maori and Pacific Advisory Groups is coordinated as appropriate across the BSA and National Cervical Screening Programs to maintain and continue joint strategies through the Independent Service Providers (ISPs) and Lead Providers to improve participation for these priority groups.



6. It is recommended that consideration be given to incorporating the National Bowel Cancer Screening Pilot Project into the NSU to maximise the efficient use of resources in population screening knowledge and skills across the cancer screening programs, in particular the following:
  - i. The establishment of the national register for bowel cancer screening on the same system platform as the National Cervical Screening Program (NCSP) and BSA to share functionality, system management costs and population register linkage and reference tables.
  - ii. The quality assurance and monitoring processes could be incorporated into the quality management system and structure recommended for the BSA Program and the NSU quality management framework.
  - iii. Specialist staff resources, in particular biostatisticians/epidemiologists that are critical for monitoring cancer screening programs could potentially work across the programs and provide professional support for other key staff involved in monitoring quality and performance.
  - iv. Relationships with Lead Providers can be coordinated across the three cancer screening programs in negotiating agreements and monitoring outcomes.
  - v. The existing Advisory Groups for Maori and Pacific communities could be broadened to encompass bowel cancer screening or if not culturally appropriate used as a model for engagement with these priority groups.
  - vi. The recommended systems development for the cancer screening programs be aligned across the cancer continuum to ensure data consistency including electronic use of structured reporting and electronic linkage with national cancer and regional systems.
7. It is recommended that the Ministry explores opportunities to provide ongoing professional development in population health screening for current NSU employees.
8. It is recommended that further work be done to address issues of relationships between teams in NSU. Interviews suggest there are concerns with role clarity between teams, and issues with co-operation between teams. This can be addressed through the engagement of an external facilitator with organisational design and dispute resolution expertise to work with the teams in question and their managers.

9. It is recommended that all planned MOH approved recommendations are communicated to NSU staff with an implementation plan so that NSU staff can have some expectations about changes in their workplace over the medium term.
10. It is recommended that an independent advisory team assist in the development of a three year implementation plan in consultation with the NSU and the BSA Lead Providers to implement MOH endorsed recommendations. It is further suggested that:
  - i. This advisory team be comprised of individuals independent of the NSU that have expertise in the following: population screening, organisational change, human resource management, clinical governance and leadership, strategic planning, clinical information systems and public health program development and implementation.
  - ii. The advisory team would assist the NSU to transition and provide oversight of the implementation plan, in particular the consultation and communication with the BSA Lead Providers.
  - iii. Mentoring support be provided to the NSU leadership, in particular the BSA Program Director through the transition process.
  - iv. The advisory team provide regular reports to the MOH executive and Minister as required.

## **Resignations from NSU mentioned in letter from Clinical Directors' UDG, BSA**

The letter from the Clinical Directors' UDG mentioned the resignations of nine people from NSU with significant cancer screening experience. Seven of the nine people mentioned were interviewed in person, or via telephone, email or Skype. Details of each person's resignation/retirement will be outlined below.

There were two people mentioned in the letter who worked primarily on the BSA Program, the BSA Clinical Leader and the NSU Quality Information Manager.

The BSA Clinical Leader had worked in the NSU on the BSA Program from 2002 until 2009, and was highly regarded as a Clinical Leader by the Clinical Directors. The process of recruiting a replacement for this role is discussed later in this report.

The NSU Quality Information Manager had worked in the BSA Program in the NSU and its predecessor from 1999-2010, and his resignation was seen as a significant loss of organisational knowledge by the Clinical Directors and Lead Providers. This role was filled in January 2011.

Three other people mentioned in the letter from the Clinical Directors worked in the Quality and Equity Team in NSU.

The Quality and Equity Manager worked at NSU from 2007 until early 2010 when she retired. There was a MOH recruitment freeze in 2010 which impacted on the recruitment process for this role. In the interim the NSU Information Manager and later another MOH Manager covered the role, until the present incumbent was recruited in September 2010.

The role of Epidemiologist was held on a 0.5 FTE basis for three years until November 2010 when the incumbent resigned. This role primarily worked on the NCSP, and has not been replaced as the role was removed from the NSU structure due to a MOH FTE cap.

The role of Senior Adviser Maori sat in the Quality and Equity Team, and the incumbent mentioned had worked in the NSU for two years before resigning in September 2010. A role of Manager Sector Relationships, which sat on the SMT, was developed after the departure of the Senior Adviser Maori following a review of the role. However soon after the development of the role of Manager Sector Relationships the role was disestablished as part of the MOH restructure.

Also mentioned in the letter were two people who worked in the National Cervical Screening Program (NCSP).

The NCSP Manager mentioned had worked in that role from 2007 until August 2010, when she commenced a role in the Ante-Natal and Newborn Screening Programs, still part of the NSU. That person was well known to Lead Providers and Clinical Directors through work on the cancer screening programs since 2002. This role was filled in August 2010.

The Service Development Analyst mentioned worked in this role from 2009 until her resignation in November 2010, primarily for NCSP. They were well known to the Clinical Directors and Lead Providers having been Health Promotion Co-ordinator across both breast and cervical programs from 2002-2009. There have been two attempts at recruiting for this role. The first attempt was caught in a MOH recruitment freeze, and then failed to secure an appropriate candidate. The second wave of recruitment was underway at the time of review.

Another person mentioned had the role of Senior Adviser Communications. This role was restructured to another group in the MOH in July 2010, and the incumbent resigned in October 2010. That position has since been removed as part of an FTE cap in MOH.

The role of Chief Adviser Screening was also mentioned in the letter from the Clinical Directors' UDG. This role commenced in April 2010 across all the screening programs in NSU with the incumbent seconded from a DHB role. That secondment finished in December 2010. This role was removed as part of MOH restructuring, but there has been recent agreement to reinstate the role as National Clinical Director Screening, which sits alongside the Group Manager NSU.

## Interviews with key stakeholders of the BSA Program

### Dr Sally Urry

The consultants met with Dr Urry, as Chair of the Clinical Directors' UDG and author of the letter sent to the Minister of Health, on 18 May 2011.

Dr Urry described the letter being written on behalf of all the clinical directors due to a sincere concern about turnover in the NSU, particularly related to BSA. The letter mentions some NSU staff members who had primarily worked for NCSP, but were included in the letter as part of their concern for the staff changes affecting the whole of NSU, and the loss of the experience that both cancer screening Programs had in the whole concept, needs and delivery of a screening Program.

## Clinical Directors and Lead Provider Managers

The consultants met with the all BSA Clinical Directors and all but one BSA Lead Provider Manager. One Lead Provider Manager was absent but submitted their views to the meeting. These interviews took place over three meetings held in Christchurch and Auckland.

From these meetings a number of themes about areas of concern were developed. The group believes there had been a serious loss of population screening expertise and capability in the NSU since late 2009, particularly with the resignation of the BSA Clinical Leader and the subsequent absence of someone in that role for the large part of 2010. They also saw people with significant other population cancer screening experience and capability resigning from the NSU. From the point of view of the meeting, many of the replacements for those roles did not display the capacity in population screening and interpersonal skills with the Lead Providers that they had experienced in the past. There was a concern that there was a cultural issue within NSU driving the resignations of these valuable staff.

The meetings were aware there had been restructures to the NSU, both internally and driven from the MOH, but were unsure what part those restructures played on the changes in NSU personnel. The groups felt that these changes, and their impacts, had not been well communicated to the Lead Providers. In particular, the meeting described a long period where they had six monthly visits from the Clinical Director, the Data Manager and at times the Program Leader, which were very useful to discuss clinical progress; now there are three monthly visits from Performance Management Analysts which are seen as micromanaging the Lead Providers but neglecting clinical components.

There were concerns expressed about the most recent round of audits of Lead Providers, where NSU did not have a clinical presence in the auditing process, resulting in a number of issues to be resolved around those audits.

The Lead Providers also expressed concerns that clinical progress in the BSA Program was being hampered by the lack of Clinical Leadership at NSU, citing the interval cancer review process as an example. The Lead Providers believe that in the past NSU consulted with them about the strategic direction, the work plan, and ways of working forward, and did not feel that this level of consultation was being achieved at present.

The meetings expressed a view that the relationship between senior managers at the NSU and the Lead Providers had fractured over the last three years, but particularly since late 2009 with the resignation of the BSA Clinical Leader. The meeting highlighted that fact that interactions between the Lead Providers and senior managers at NSU had often been robust in the past, but were based on a quality improvement, monitoring,

partnering basis, with great respect for the population screening capacity of the NSU management.

When the groups were interviewed there was heightened emotion about the recent Workforce Development Forum held in March 2011. The Lead Providers believed this event could have been a golden opportunity to celebrate successes, with recent data showing significant improvements in coverage for all women, Maori women and Pacific women. However the Lead Providers described a poorly designed event which fuelled confusion between Lead Providers, ISPs and NSU. There was particular concern about assumptions made about development of work plans with Maori and Pacific communities, and the ways in which those expectations were communicated at the Forum.

The Lead Providers and Clinical Directors all expressed a passion for the BSA Program and a strong desire to have a successful working partnership with NSU. Their hope is that the relationship can be one of partnership, quality improvement, monitoring and trust.

## **BSA Advisory Group**

The consultants met with the BSA Advisory Group on 23 May 2011.

This group consists of representatives of key stakeholders in the BSA Program, including consumer and Maori and Pacific representatives. This group is a passionate advocate for the health of New Zealand women.

This group expressed similar concerns to those expressed by the Clinical Directors and Lead Provider Managers regarding turnover of key NSU staff to the BSA Program, and the lack of population screening capacity and experience in the replacements of those people who had resigned.

As an advisory group, there were also themes of decreased engagement of the BSA Advisory Group with NSU, with a decreased involvement in strategic planning, work plans and key decision making for BSA. The group felt that in the past they had been consulted more about key BSA initiatives.

The BSAAG also felt that their relationships with NSU management had fractured over time.

The Advisory Group described the role of the NSU as one of co-ordination, strategic direction, evaluation, development of standards and quality improvement. However they felt there had been a much greater emphasis put on business process and contract management.

The BSAAG seeks an improved partnering relationship with the NSU in the future.

## Interviews with current NSU staff

The consultants met with all current NSU staff involved working in the BSA Program, or supporting BSA. This included the BSA Program team, the Quality and Equity Team and the Information Team. The consultants also met with all members of the NSU Senior Management Team (SMT). Some current NCSP staff were also interviewed about particular aspects of this review. Interviews were not conducted with current members of the Ante-Natal and Newborn team or the Business Performance team, except for the SMT members, and a prior NCSP team member.

Current staff all expressed a similar passion for the health of the women of New Zealand to all individuals and groups interviewed. There was strong recognition and pride in the increase in breast screening coverage of women in New Zealand.

There was a variation in views expressed by current NSU staff interviewed. One group interviewed expressed concerns about the change in focus in the NSU, particularly since the restructure of the NSU from the Public Health Directorate into the Health and Disability National Services Directorate. Many people spoke of the significant loss to the BSA program of the prior Clinical Leader, and expressed enthusiasm at the recent appointment of a BSA Clinical Adviser at the time of review. There was concern expressed by people interviewed that there had been a loss in population screening capacity and experience across the NSU in recent years. This was contrasted with other current staff who expressed a need for improvement in the contracting and business processes of the NSU; most of the staff expressing this view had a contract management background in prior roles. Current senior NSU managers described a change in focus for NSU once it was restructured into the Health and Disability National Services Directorate in 2007. From that time there was a clear strategic change from the Directorate leadership to improve contract management of Lead Providers, and to align NSU with the contracting practices of other areas of MOH. The model used by the Directorate required a stronger focus on systems and outcomes in the way constituent groups of the Directorate were required to manage relationships with providers. The intention was to continue a leadership, quality improvement and monitoring function within NSU. The NSU SMT describes the drivers for change across Government focusing on improving the efficiency and effectiveness of delivery whilst ensuring value for money for government spend.

Senior NSU staff also described the difficulty in attracting people with population screening experience to roles within NSU. There is not a large applicant pool in New Zealand of people with the skills and expertise required in population screening; most staff within NSU gain this experience and expertise on the job.

Upon interview, many of the staff recruited into cancer screening roles in NSU since 2009 have had contract management and public health experience in their past roles; however there are very few people recruited into NSU cancer screening roles since 2009 with experience, qualifications and capacity in population screening.

## Interviews with prior NSU staff

While wanting to preserve confidentiality, many of the prior NSU staff that were interviewed by the consultants were able to share some areas of concern about NSU. These concerns were not necessarily described as the key reasons for resignation, but were expressed across the group. There was an ongoing theme expressed that since 2007, when the NSU was restructured into the Health and Disability Services Directorate, there had been a change in focus from a clinical screening Program to a focus in contract management. There was a strong feeling that people recruited into key positions in the cancer screening Programs did not have population screening capacity or expertise, and that this had affected the performance of the BSA Program. There were suggestions made that the focus on contract management and business process had detracted from the important program improvements like national digital mammography, PACS and a centralised data register.

Some of the prior incumbents had concerns about the behaviours of particular people at NSU; however there was no pattern of concern about any current NSU staff.

## Summary

Since the commencement of NSU in 2001, the BreastScreen Aotearoa Program had seen a great deal of continuity in key NSU staff until 2008/2009. Alongside this has been long term involvement by the Clinical Directors and many of the Lead Provider Managers in the BSA Program.

There have also been a number of long serving representatives on the BSA Advisory Group.

The letter from the Clinical Directors' UDG mentioned a number of key staff resigning from NSU since 2009. It is also worth mentioning other significant turnover in NSU Cancer Screening leadership.

The prior Group Manager NSU worked in NSU from 2002-2008. Also the SMT role of Marketing and Communications Manager, held by the prior incumbent from 2005-2010 was restructured to another part of the MOH.



Therefore, the face of NSU, from the point of view of Lead Providers, Clinical Directors and the BSA Advisory Group, had been very consistent until 2008. These are listed below

- Group Manager, NSU, same incumbent 2002-2008
- Clinical Leader BSA, same incumbent 2002-2009
- Quality Information Manager, same incumbent 1999-2010
- BSA Program Leader, still at NSU after commencing in BSA program in 2003 in varying roles

Therefore there has been significant recent turnover in the eyes of Lead Providers and the BSAAG in many of the key BSA roles. While current incumbents to these roles brought a vast array of talents and capabilities to their roles, they have not brought with them the experience in population screening held by the previous incumbents.

While seven of the nine people mentioned in the letter from the Clinical Directors' UDG did not work directly for the BSA Program, they all had significant experience and expertise in cancer screening programs.

The two roles directly working for the BSA Program have been filled, but three of the remaining seven roles have been removed from MOH headcount as part of a headcount reduction.

Simultaneous to this turnover in key roles pertinent to the BSA Program was the perceived change in emphasis of the role of Performance Management Analysts in the 2009 restructure. Prior to that there had been a role for a BSA Performance Manager since 2007, with a succession of short term incumbents. The Performance Manager role (and similar roles before that) was seen as a relationship management role by Lead Providers, involving quality improvement, and a Program development relationship. Lead Providers now see the role of Performance Management Analysts as being contract management focused, with the incumbents having little Program knowledge. This view was also expressed by the BSA Advisory Group.

The NSU SMT summarise the key responsibilities of the role of Performance Management Analyst (now called Portfolio Manager) as relationship building and networking, team membership, operational activities and procedures, continuous improvement and performance management. The SMT believes that these roles continue to meet the needs of the program from a quality, equity and performance perspective and satisfy the requirements of the MOH and the Government.

## Discussion

Since the inception of NSU in 2001, there had been great continuity in key people working in the BSA Program in the NSU, the Clinical Directors, many of the Lead Provider Managers and many of the members of the BSAAG.

The resignation of a number of key NSU staff since 2009 who had significant population cancer screening experience is concerning. Three of the nine positions mentioned in the letter from the Clinical Directors' UDG have been removed due to MOH headcount reductions.

There was difficulty in recruiting to replace a number of the six remaining positions, which will be discussed later in this report. The replacements to most of these roles have not brought with them equivalent population screening experience and expertise. This is understandable due to the longevity of many of the prior incumbents in their roles; they had developed experience and expertise not easily found elsewhere in New Zealand. The impact of this turnover and reduction on headcount on key deliverables for breast screening Programs (digital mammography, PACS and a central register), have been discussed in the accompanying report.

There is a great need for the NSU of the future to re-develop and recruit these capabilities back into the unit, particularly into key positions for the BSA program.

There is a great passion for improving the health of New Zealand women through breast screening expressed by all parties interviewed, but a concern expressed by the Lead Providers, the BSAAG, and most of the prior and current NSU staff interviewed that the continued improvement of the BSA program is impacted by the lack of capacity and experience in population screening in key positions in NSU. The relationships between NSU and the Lead Providers and BSAAG have become fractured, but there is a great desire expressed to repair those relationships looking forward to the future.

## Recommendations

1. It is recommended that future recruitment in to the NSU has a focus on those skills important to population screening, particularly skills in public health, epidemiology/biostatistics, quality assurance, community engagement and communication.
2. It is recommended that the relevant positions in the NSU management team (SMT), dedicated to leading the population screening programs, have their position descriptions reviewed to ensure a rebalancing of skills, capacity and experience in the key requirements of population screening, sector relationships and contract management for these important roles.

## **NSU Structural Changes and Focus Changes; 2007-present**

In 2007 the NSU was restructured to respond to significant changes in the role of NSU and to external organisational requirements. This restructure was known as Strengthening Foundations. In practice this meant that the Newborn and Ante-natal screening Programs were brought into NSU, there was the creation of a role, Manager Cancer Screening with responsibility for both Breast and Cervical cancer screening Programs and there was the development of a Quality Team. At this time Clinical Leaders of both BSA and NCSP were removed from the management team (SMT), and became part of the leadership team (SLT). In practice the existence of both these teams became problematic, and the SLT was dissolved in 2009.

Also in July 2007, a MOH restructure resulted in NSU moving from the Public Health Directorate to the Health and Disability National Services Directorate. At this time, the Health and Disability National Services Directorate saw itself as having expertise for social service purchasing, and there was a very deliberate strategy to align purchasing and contracting practices in NSU with practices across MOH. There was also recognition that compliance, quality and safety of the current screening Programs needed to be continued.

Then in 2009 a MOH decision was made to reduce FTE headcount. The impact of that reduction in staffing numbers for NSU was to plan the outsourcing of the cervical screening register, and move the strategy roles into MOH. The cervical screening register was eventually outsourced on 1 July 2010.

In 2008 the long term NSU Group Manager resigned, and the present NSU Group Manager was appointed as interim Group Manager in 2008 and was appointed into the role in late 2009. The Group NSU Manager was tasked with a core responsibility for compliance, quality and safety of current Programs, and to align business and contracting processes in NSU with the rest of MOH. Also, there had been conflict within the SMT, and the NSU Group Manager was tasked with improving the performance of that team.

In response to these requirements, a further restructure of NSU occurred in late 2009. Overall, this restructure recognised the movement of marketing and communication, and policy roles into other parts of MOH, and introduced the Performance Management Analysts role into the screening Programs, with a focus on contract management. While some of the incumbents recruited since 2009 into the Performance Management Analyst role have public health backgrounds, there has been a stronger focus on contract management expertise in the backgrounds of recent appointees.

Also, in 2009 a number of roles which had reported directly to the Group Manager, (namely Clinical Directors and Maori and Pacific advisers) were aligned into other teams. This meant that the Clinical Leaders for the both Cancer Screening Programs were now

reporting into the Manager, Cancer Screening and the Maori and Pacific Advisers reported into the Quality and Equity Team.

During this period the Group Manager NSU also worked with external consultants and the SMT to improve working relationships within the SMT.

Concurrent to the restructure of NSU in 2009 has been ongoing pressure on headcount for MOH. As positions have become vacant there have been recruitment freezes for some positions, or positions have been removed from NSU FTE. This has been ongoing and continues to date.

In 2010 creation of the National Health Board meant further changes to the NSU reporting relationships, with the all units in the Health and Disability National Services Directorate now reporting through the National Services Purchasing Group into the National Health Board. With this change the roles of Clinical Leader was also changed to Clinical Adviser.

## Summary

The NSU has undergone internal restructuring in 2007 and 2009, and then changed its reporting relationships within MOH in 2007 and 2010. Since 2009 there has been ongoing reduction in NSU headcount as part of overall reduction in MOH headcount.

Many of the staff, past and present, interviewed described ongoing restructures with little opportunity to bed any changes down before the next significant change in structure, roles and headcount. This has contributed to an environment of uncertainty for NSU staff, which has been reflected in a survey undertaken by the consultants and discussed further later in this report.

Most significantly for this review was the restructure of the NSU into the Health and Disability National Services Directorate, which brought with it a change in focus for the NSU. From the point of view of Lead Providers and the BSAAG this meant that the NSU shifted its focus to compliance and contract management away from coordination and collaboration with the Lead Providers to deliver a quality program. Senior managers at NSU believe they have worked hard since that time to achieve a balance between clinical governance and oversight, contract management, provider program performance, quality and equity

There has also been significant criticism from Lead Providers, the BSAAG, and past and present NSU staff that the change in focus to compliance and contract management, and subsequent changes in staffing levels and skills and expertise, has impacted development of important initiatives of a breast screening Program (like digital mammography, PACS, and a centralised data register).

## Discussion

The number of structural changes that NSU has been subject to in such a short succession of time cannot have assisted with relationships with Lead Providers; interviews with NSU leadership describe the need to implement changes in focus and multiple restructures leading them to become inward looking to the changes NSU was experiencing, and not allowing them to focus on relationships with Lead Providers.

However there is overwhelming feedback that the change in focus of the NSU from the time it was restructured into the Health and Disability National Services Directorate has been a key feature in the loss of population screening capacity and expertise in the NSU. This has occurred through the resignation of key people concerned about the change of focus, the inability to recruit people with population screening expertise and experience into the NSU, and a number of new people being recruited into the NSU with a contract management focus.

This is contrasted with the view of the SMT Senior Management Team who believes they have worked hard to achieve a balance between clinical governance and oversight, contract management, provider program performance, quality and equity.

The accompanying report “Future Directions for the National Screening Unit” makes recommendations to align the NSU more closely with the Cancer Control team, in particular so that the strategic directions and priorities of the cancer screening programs are better identified in the National Cancer Program Work Plan, as part of the Government’s priorities for cancer.

## Recommendations

3. It is recommended that the focus of the NSU shifts away from compliance and contract management towards coordination and collaboration with the Lead Providers to deliver a quality program.
4. It is recommended that the National Screening Unit (NSU) and the BreastScreen Aotearoa (BSA) strengthen its collaborative links and alignment with the Cancer Control team given that cancer screening programs are a key part of the cancer control continuum including the following considerations:
  - i. That the strategic directions and priorities of the cancer screening programs be better identified in the National Cancer Program Workplan, as part of the Government’s priorities for cancer and the New Zealand Cancer Control Strategy and that relevant Program and Clinical Leaders have membership on the Steering Group.

- ii. That the cancer screening programs strengthen their collaborative alignment and the linkage with the regional cancer networks and the development of clinical pathways for breast, bowel and cervical cancers.
- iii. That the NSU be renamed National Coordination Unit (NCU) for Cancer Screening to assist in communicating the change in focus to Lead Providers, stakeholders and the community.
- iv. That consideration be given to moving the Antenatal and Newborn screening programs out of the NSU to be aligned with the relevant Maternal and Child Health area in the Ministry of Health to increase the focus and alignment of the cancer screening programs in the NSU.

## **Ministry of Health HR Policies and Processes-Impact for NSU**

The letter from the Clinical Directors' UDG mentions the resignations/retirements from key roles for the cancer screening programs, and concerns about the apparent difficulties in replacing these roles. The NSU has experienced some challenges in recruiting replacements for those people. These are discussed below.

### **The Recruitment of a Clinical Adviser**

The NSU was able to provide details of recruitment activity for a Clinical Adviser in the time since the BSA Clinical Leader resigned in October 2009. A recruitment agency was contracted immediately and advertised both nationally and internationally, but to no avail. The role was covered by a Clinical Director from a Lead Provider on a fixed term contract from November 2009 until March 2010 on a 0.4 FTE basis, but declined to continue in the role.

The NSU then requested support and assistance from the Clinical Directors' UDG. Two candidates were suggested. Both candidates did not pursue the opportunity after meeting with NSU.

The NSU cites reasons given to them for not pursuing the opportunity were the insecurity of working for MOH due to constant restructuring, lack of medical development opportunities and remuneration levels.

In discussions with the consultants potential candidates also described concerns about the lack of cancer screening expertise and experience in key positions in the NSU, and concerns with their ability to progress key initiatives like digital mammography, PACS and a centralised data register in the current MOH and NSU environment.

There was also a significant attraction issue with this role, as the remuneration package available was significantly lower than that available to radiologists working in the DHB environment.

Later the Group Manager NSU spoke with the Clinical Directors' UDG and discussed the potential of having a Clinical Leader who was not a radiologist. Another candidate was suggested as a candidate for the role, who is a Breast Physician. There is still variable support for this role being filled by a person who is not a radiologist amongst Lead Providers and Clinical Directors; however the Clinical Directors' UDG supported the appointment. The current incumbent commenced on a 0.4 FTE basis in April 2011, after participating in an open recruitment process, on a fixed term contract until September 2011. These contractual terms were sought by the incumbent.

The selection panel for this recruitment included a representative from the Clinical Directors' UDG, who is also a member of the BSA Advisory Group, and the Chair of the NSU Clinical Governance Group

## Recruitment of Other Key Positions in BSA and Quality and Equity

There were difficulties in attraction for the Quality and Equity Manager role, with the remuneration package offered by NSU not able to match similar positions in the MOH and DHB environment. Ultimately there was a six month period between the resignation of the former Quality and Equity Manager and the appointment of the current incumbent, with temporary placements in the role in-between. This recruitment process was impacted by a recruitment freeze during this time. The salary issue for the role has been resolved, and a permanent recruitment has commenced.

In previous areas of this report, mention was made of the fact that a number of the people's roles mentioned in the letter from the Clinical Directors' UDG had been removed from NSU as part of an MOH headcount cap.

In fact, three of the nine roles mentioned in the letter have since been removed from NSU headcount. They are:

- Epidemiologist/Biostatistician in the Quality and Equity Team
- Senior Advisor Maori/Manager Sector Relationships
- Senior Adviser Communications

The consultants were also provided information about delays in recruiting to a number of other roles in NSU imposed by MOH recruitment freezes.

## Summary

Alongside a significant number of resignations from the NSU by people with roles important to the BSA Program, has been an ongoing issue in the ability of the NSU to attract and recruit people into NSU.

The reasons for this can be described as:

- Difficulty in attraction to the role of Clinical Adviser BSA due to remuneration issues, lack of medical development opportunities, concerns about the cancer screening experience and capacity within key positions in the NSU,



and concerns about progressing key development initiatives for BSA in the current MOH and NSU environment.

- Difficulty in attraction to the role of Quality and Equity Manager due to remuneration issues, and delays in the process due to a recruitment freeze
- Pressure on headcount, which has meant a number of positions have been lost to NSU
- Recruitment freezes, which have delayed the replacement of people who have resigned in NSU.

## Discussion

The delays in recruiting replacements to the nine roles described in the letter from the Clinical Directors' UDG can be described as having internal and external drivers.

These recruitments were occurring in a timeframe of recruitment freezes and headcount reduction directed from MOH. Remuneration issues played a role in the recruitment of a new BSA Clinical Adviser and Quality and Equity Manager. Also there were attraction issues for the role of BSA Clinical Adviser.

The NSU SMT has described the limited recruitment pool for people with expertise and experience in population screening programs in New Zealand, and described the way those skills and experience were usually developed while working in the NSU. It is extremely important that those skills and experience are optimised across the population screening programs in New Zealand.

The accompanying report "Future Directions for the National Screening Unit" has recommended a realignment of the Quality and Equity functions into the program teams, as well as establishes a position of Program Director (Manager) for BSA, reporting directly to the Group Manager NSU, and holding a position on the SMT.

There is also an opportunity for consideration to be given to incorporating the National Bowel Cancer Screening Pilot into the NSU to maximize the efficient use of resources in population screening knowledge and skills across the cancer screening programs.

Also it has been recommended that NSU appoint a part time radiologist Clinical Leader for the BSA Program to work with the BSA Program Director (Manager) employed by a Lead Provider to ensure maintenance of their clinical entitlements. This recommendation should ameliorate attraction issues around remuneration for this role. Currently, the previous Clinical Adviser has been contracted back by the NSU to carry out the interval cancer analysis and provide independent clinical advice for the BSA IT centralisation project.

## Recommendations

5. It is recommended that the NSU realign quality and equity functions into the program teams to ensure the most efficient use of resources and to promote national program leadership and strategic direction for BSA including the following:
  - i. Establish a position of Program Director (Manager), that would report directly to the Group Manager (NSU) and remove the current Manager Cancer Screening position. The key role and responsibility of this position would be to provide leadership and strategic direction for the BSA Program and to lead a program team that undertakes national coordination functions and strategic management for BSA.
  - ii. Rebuild the BSA program team by integrating relevant positions from the Quality and Equity team with the current program positions to undertake the key functions of national coordination, strategic and capacity planning, BSA service development and support, community engagement and communication, policy and standards, quality assurance and monitoring including coordination of BSA Service Audits and reporting.
  - iii. Ensure the retention of existing staff in the NSU that have significant BSA program knowledge and experience and recruit, to current vacant positions, personnel with the appropriate skills in public health, epidemiology or biostatistics, quality assurance, community engagement and communication.
  - iv. Maintain cross program knowledge, skills and resource sharing, particularly in the disciplines of epidemiology/biostatistics and community engagement and communication, through a matrix structural alignment and formalised processes.
  - v. Ensure that communication and collaboration with the Maori and Pacific Advisory Groups is coordinated as appropriate across the BSA and National Cervical Screening Programs to maintain and continue joint strategies through the Independent Service Providers (ISPs) and Lead Providers to improve participation for these priority groups

6. It is recommended that consideration be given to incorporating the National Bowel Cancer Screening Pilot Project into the NSU to maximise the efficient use of resources in population screening knowledge and skills across the cancer screening programs, in particular the following:
  - i. The establishment of the national register for bowel cancer screening on the same system platform as the National Cervical Screening Program (NCSP) and BSA to share functionality, system management costs and population register linkage and reference tables.
  - ii. The quality assurance and monitoring processes could be incorporated into the quality management system and structure recommended for the BSA Program and the NSU quality management framework.
  - iii. Specialist staff resources, in particular biostatisticians/epidemiologists that are critical for monitoring cancer screening programs could potentially work across the programs and provide professional support for other key staff involved in monitoring quality and performance.
  - iv. Relationships with Lead Providers can be coordinated across the three cancer screening programs in negotiating agreements and monitoring outcomes.
  - v. The existing Advisory Groups for Maori and Pacific communities could be broadened to encompass bowel cancer screening or if not culturally appropriate used as a model for engagement with these priority groups.
  
7. It is recommended that the Ministry explores opportunities to provide on-going professional development in population health screening for current NSU employees.

## NSU Culture-How do people feel inside the National Screening Unit

A survey was undertaken which focused on the way staff were feeling inside NSU as part of this review.

Results of the Gallup Employee Engagement Survey run across MOH in early 2009 had indicated some issues with levels of staff satisfaction. In the twelve areas surveyed at that time NSU's scores were lower than the MOH mean score in all but three areas (having a best friend at work; having fellow employees committed to doing quality work; and the mission purpose of my organisation making me feel my job is important)

It was agreed to conduct a further survey, as there had been so many changes in NSU staff since the Gallup survey, and there had been both the NCSP parliamentary review and this BSA review undertaken in the meantime. Also NSU Senior Managers believed there had been a significant improvement in culture in NSU since the Gallup Survey had been undertaken.

There were 45 respondents out of a total pool of 53 people. However, the respondents were spread evenly across teams within NSU, with responses from most people from all NSU teams. The summary results of the survey indicate a workforce proud to work for NSU and MOH, but with little job certainty for the future. Only 24.4% agreed with the statement "I feel secure about my continued employment with NSU". A vast majority of respondents agreed with the statements "I am proud to be part of NSU", "I am proud to be part of MOH", and "I am committed to seeing NSU succeed".

There are a number of questions about relationships inside teams within NSU and between teams in NSU in the survey. Most responses indicated good relationships inside teams.

In response to the questions about the relationships between teams there was only 42.2% of respondents who responded positively to the statement "People co-operate across teams in NSU", and 60% of respondents responded positively to the statement, "I get the co-operation I need from those outside my team, in NSU". Significantly, only 35.6% of respondents responded positively to the statement "There is a high degree of co-operation between NSU and other parts of MOH".

There are a number of questions in the survey about people's perception of their manager's performance. Across the whole of NSU the vast majority of respondents answered positively to the questions about their manager's support and management skills.

This review has been asked to consider in particular turnover in the Quality and Equity Team, so it is worth reviewing their results. On almost all measures the Q&E team

results suggest a team working well internally, with some concerns about co-operation with other teams expressed. The Quality team was formulated in 2007, and then the Quality and Equity team was formulated in 2009. This is an extremely new team. Four out of ten survey respondents have been in NSU less than two years. Nine out of ten survey respondents have been in their current role for less than two years; in fact four out of ten have been in their current role for less than one year. However, as a team only two out of ten respondents felt secure about their continued employment in NSU.

### **What do staff feel supports them in their role**

There were open ended qualitative questions about what staff feel currently supports them in their role. Responses could be grouped into areas of:

- Supportive manager
- Relationships with colleagues and team members
- Feedback opportunities (two-way)
- Experience of long serving NSU staff
- A clinical Leader
- Physical requirements (desk, PC)
- Tools of work
- Professional development

Similarly there were other open ended questions asking staff what would support them in their role in the future. Responses can be grouped into areas of:

- Improved job security
- Stability in headcount
- Better role clarity between teams
- Improved communication from SMT
- Better co-operation across teams
- Improved technology (work tools)
- More expertise –epidemiology, clinical leaders in ante-natal and newborn, public health physicians
- Improvement in NSU culture
- Improved information flow through NSU from MOH and SMT
- Improved management skills

## Feedback from interviews

When interviewed current NSU staff expressed a great pride in the work of NSU. They were particularly proud in the achievements of the different screening programs in the NSU, and its impact on the health of New Zealand people. Some people were concerned about behaviours of a small group of people in NSU; however there wasn't uniform concern about the same people.

While the people mentioned in the letter from the Clinical Directors' UDG left NSU for a variety of reasons, when interviewed there was concern about behaviours modelled by some NSU staff, although for many this was not the reason for resignation. The concerns were expressed about the behaviours of a small number of different people; there was not a pattern of concern.

Also current staff and managers who were interviewed displayed signs of "review weariness". Many staff described the stress of undertaking three sets of interviews over 5 months; firstly as part of focus groups as part of an internal conflict resolution process in December 2010, then as part of the NCSP Parliamentary review Committee in March 2011, and then this BSA review in May 2011.

Staff expressed doubts that despite sharing their concerns in the focus groups in December 2010, their experience was that they had not experienced significant improvement in the behaviours of people of concern to them. The Group Manager NSU was able to share some attempts at dispute resolution between some parties over this period.

When interviewed, a common theme from staff that had left NSU was a concern about the decline in population screening expertise in the NSU. This view was also expressed by a number of current, long serving staff. However there was another group of current NSU staff whose language was focused on contract management. This group was relatively new to the NSU, and expressing to the consultants the focus that had been directed since the move of NSU into the Health and Disability National Services Directorate; a number of these staff interviewed had experience in contract management.

Also when we look at the wider NSU group who replied to the survey, 26.7% of respondents had been at NSU less than one year, and 42.3% of respondents had worked at NSU for less than two years. Only 31.1% of respondents had been at NSU for 5 years or longer. As the move into the Health and Disability National Services Directorate occurred in 2007, there is a high chance that a significant percentage of NSU staff has experienced working at the NSU with a different focus to those people working in the NSU prior to that time.

These survey figures reflect turnover figures in the NSU. The NSU has had staff turnover in the last three years consistent with turnover in the MOH.<sup>1</sup>

## Summary

Through interview with current staff working in and on the BSA Program, and through survey of the whole of NSU staff, NSU consists of a group of people proud to be part of the NSU and the MOH, and proud of the achievements of the NSU screening programs.

However there is wariness to perceived constant restructuring and headcount reduction, and a lack of confidence in job security at NSU. It is likely that this concern with job security is due to ongoing headcount reductions directed by MOH in the last two years.

Most people are happy with the relationships inside their teams. However there seems to be a problem for some staff in co-operation between teams in NSU.

Most people are happy with the support, and management and leadership skills provided by their manager. There is a conflicting concern about the population screening capacity and experience in current NSU staff. All Lead Providers, the BSAAG, and most recently resigned staff interviewed were particularly concerned about this issue regarding key staff working in and supporting the BSA Program. Many current NSU staff interviewed are concerned about the decline in population screening experience and capacity, and believe it impacts the ability of NSU to lead the BSA Program. This is contrasted with other staff in NSU that have a strong focus on the performance and contract management responsibilities of NSU.

This view is not shared by the SMT of the NSU. The SMT believes there has never been a time in the history of the NSU where there has been as much population and public health expertise as there is now, despite staff turnover, recruitment freezes and loss of FTE.

When current NSU staff were asked through survey what supports them now in their current role most responses referred to a supportive manager, relationships with colleagues and team members, two way feedback opportunities, experience of long serving NSU staff, a clinical leader, physical requirements (desk, PC), tools of work, professional development.

When current NSU staff were asked through survey what would support them in their role in the future most responses referred to job security, increased population screening and management capacity, role clarity, improved relationships between teams, improved information flow from MOH and SMT through to NSU, and improved NSU culture.

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<sup>1</sup> Turnover figures provided by NSU Senior Management Team, 10 August 2011

## Discussion

The culture of NSU can be described as a group proud of the work of the NSU and the MOH, and proud of the NSU screening programs. Most people enjoy working inside their teams. Some concerns have been expressed about co-operation across teams in the NSU. Most people are happy with the support and management skills of their manager.

Whilst not comparing “like for like” survey questions between the Gallup Employee Engagement Survey in early 2009 and the survey carried out by the consultants in this review, the responses indicate an improved internal organisational culture across NSU, over a period of internal and external restructure, headcount reduction and recruitment freezes

There is a concern about job security in the NSU, most likely due to the restructuring of roles into other parts of the MOH and the reduction in headcount directed by MOH in recent years.

There are conflicting views about the population screening expertise and experience within the NSU. The Lead Providers and Clinical Directors for the BSA Program, many of the recently resigned or retired staff from NSU cancer screening roles, and many of the current NSU staff interviewed expressed concerns about the population screening expertise and experience of key positions in and supporting the BSA Program in the NSU. This is contrasted with other current staff interviewed working in the cancer screening roles who spoke about the performance and contract management focus of their roles, and the NSU SMT who have expressed a view that currently the NSU has as much population and public health expertise as there has ever been in the NSU.

In the accompanying report “Future Directions of the National Screening Unit” it has been recommended that the Cancer Screening Programs currently inside NSU be closely linked and aligned with the Cancer Control team, and also incorporate the National Bowel Cancer Screening Pilot into NSU. This would also mean the consideration of aligning the Newborn and Ante-natal screening programs with the relevant Child and Maternal Health area in the MOH.

Further recommendations involve the alignment of the Quality and Equity Team functions into the Program areas, and the development of a role of BSA Program Director (Manager), a member of the SMT.

The consultants recognise the wariness of the NSU staff towards a perceived further realignment, but the overwhelming feedback about the changes needed to advance the BSA Program point towards these recommendations. It will be important to recognise the sensitivity to these further changes to NSU for the current NSU staff.



The “Future Directions for the National Screening Unit” report has also recommended that an independent advisory team assist in a three year action plan in consultation with the NSU and BSA Lead Providers to implement MOH endorsed recommendations. A key function for this advisory team will be to support the staff of NSU through the changes implemented through MOH endorsed recommendations.

## Recommendations

8. It is recommended that further work be done to address issues of relationships between teams in NSU. Interviews suggest there are concerns with role clarity between teams, and issues with co-operation between teams. This can be addressed through the engagement of an external facilitator with organisational design and dispute resolution expertise to work with the teams in question and their managers.
9. It is recommended that all planned MOH approved recommendations are communicated to NSU staff with an implementation plan so that NSU staff can have some expectations about changes in their workplace over the medium term.
10. It is recommended that an independent advisory team assist in the development of a three year implementation plan in consultation with the NSU and the BSA Lead Providers to implement MOH endorsed recommendations. It is further suggested that:
  - i. This advisory team be comprised of individuals independent of the NSU that have expertise in the following: population screening, organisational change, human resource management, clinical governance and leadership, strategic planning, clinical information systems and public health program development and implementation.
  - ii. The advisory team would assist the NSU to transition and provide oversight of the implementation plan, in particular the consultation and communication with the BSA Lead Providers.
  - iii. Mentoring support be provided to the NSU leadership, in particular the BSA Program Director through the transition process.
  - iv. The advisory team provide regular reports to the MOH executive and Minister as required.

## Appendix 1



28 January 2011

Hon. Tony Ryall, Minister of Health

By Email: [tony.ryall@parliament.govt.nz](mailto:tony.ryall@parliament.govt.nz)

Dear Mr Ryall,

Concern was expressed at a recent meeting of the Clinical Directors of the Lead Providers of BreastScreen Aotearoa (BSA), regarding the central administration of The National BreastScreen Programme and the National Screening Unit (NSU) in New Zealand.

The Clinical Directors are all senior radiologists from around New Zealand, working in BSA for many years, some since its inception.

Of particular concern, is the number of resignations from key positions since October 2009, as follows:

- Dr Madeleine Wall, Clinical Leader, not fully replaced.
- Mr Andrew Palmer, Quality Information Manager, National Data Manager.
- Dr Nina Scott, Public Health Physician, Main strategic advisor, not replaced.
- Jude Cooney, Communication Advisor, not replaced.
- Victoria Scott, Senior Policy Analyst, not replaced.
- Eileen Hewer, Manager Quality and Equity.
- Jill Coulson, Biostatistician.

Also:

- Dianne Casey, National Cervical Screening Programme Manager.
- Dr Julia Peters, Chief Advisor Screening and Clinical Governance Group of NSU.

The pivotal role of Clinical Leader, originally held by Dr Wall, was filled temporarily, on a part-time basis, by Dr Jenny Walker (Clinical Director, BreastScreen Waitemata Northland) who declined to carry on in the role. There has been great difficulty recruiting for this role. We understand an appointment has recently been made. This is part time and a short term contract only.

With the resignation of the above group has gone a large amount of knowledge and skill. Many have not been replaced. This puts BSA at significant risk in a number of ways, particularly clinical safety.

The question has to be asked why so many have resigned and indeed not replaced.

Yours sincerely,

Dr Sally Urry

Chair, Clinical Directors' Unidisciplinary Group

BreastScreen Aotearoa

cc: Hon. Tariana Turia, Associate Minister of Health, [t.turia@ministers.govt.nz](mailto:t.turia@ministers.govt.nz)

Mr Chai Chuah, National Director, National Health Board Business Unit,

[chai\\_chuah@moh.govt.nz](mailto:chai_chuah@moh.govt.nz)

## Appendix 2

### **Investigation into concerns raised by BreastScreen Aotearoa (BSA)**

#### **Clinical Directors**

#### **Terms of Reference**

#### **Purpose of the review**

The purpose of the review is to investigate the concerns raised by Dr Sally Urry (on behalf of the BSA Clinical Directors) in her 28 January 2011 letter to the Minister of Health, Tony Ryall (with copies to the Associate Minister, Tariana Turia, and the National Director of the National Health Board Business Unit, Chai Chuah), and subsequent telephone conversation with the Director General of Health, Kevin Woods.

#### **Approach**

The review will be led by an appropriately qualified individual external to, and independent of, the National Screening Unit (NSU) who will report to the Acting Director, National Services Purchasing. The individual will be tasked with compiling a report that will address the key questions identified in this terms of reference and make recommendations for action as appropriate.

The review will not include other screening programmes managed by the NSU beyond the BSA programme.

#### **Concerns Raised**

The concerns raised by Dr Urry include:

- The number of resignations of staff in key positions since 2009, and the risk to BSA
- The length of time taken to recruit a new BSA Clinical Leader, and that the new appointee will be part time and on a short term contract only.
- Clinical developments within BSA have been on hold while the BSA Clinical Leader role was vacant

- The directive management culture within the NSU and lack of support for clinicians
- The use of the job title 'Performance Management Analyst' and reports from some Lead Provider Managers that they feel micro-managed
- The timeframes and process for the implementation of a centralised Picture Archiving Communication System (PACS) and single version of Concerto BreastScreen (cBS) software

## **Context**

The NSU was established in 2001 to deliver safe, effective and equitable breast and cervical cancer screening programmes. The NSU now manages five national screening programmes, including BSA, and one quality improvement initiative. BSA provides free biennial mammography and any necessary follow-up tests, up to the point of breast cancer diagnosis, to eligible women aged 45 to 69 years. The BSA programme was established nationally in December 1998 and originally covered women aged between 50 and 64 years. Expansion to the current age range occurred in July 2004.

The NSU and wider Ministry have undergone significant change management processes since 2007. In 2009 the NSU underwent an internal restructure which sought to ensure that there was clarity regarding accountabilities, and that the NSU was equipped to deliver on its objectives and wider Ministry requirements. As a result of this restructure the Quality & Equity team was established to focus on monitoring and evaluation, and a Clinical Governance Group was established to focus on clinical governance.

## **Proposed scope for the review**

It is proposed that the scope of the review will include the two-year period to December 2010 and will have six main areas of focus as listed below.

- 1) the concerns raised by Dr Urry as above;
- 2) the changes that have occurred in the Ministry of Health and the National Screening Unit (NSU) since 2008, the impact of these changes, the mitigation actions undertaken by the NSU, and whether there are any outstanding issues resulting from these changes;
- 3) the processes and procedures in place for ensuring the clinical safety and quality of the BSA Programme, including the project to implement a centralised PACS; and
- 4) the relationships and processes in place for engagement between the NSU and the BSA Lead Providers and Clinical Directors.
- 5) overview of progress made on the BSA programme since 2009
- 6) The level of clinical support required at NSU senior management level

## **Key questions the review will address**

### *BSA resourcing*

- What process is used in the development of the BSA workplan?
- Does the BSA team have sufficient resources to deliver on its work programme and its wider leadership and co-ordination functions?
- Is the NSU, as a part of the Ministry, well placed to meet current and future challenges?
- Has the programme been able to meet the workplan deliverables?

### *Staff retention and HR policies and practices*

- Has there been an issue with staff retention and recruitment in the BSA and Quality & Equity teams? If so, why?
- Do the Ministry HR policies and processes impact on staff retention and recruitment?
- What HR impacts have there been in the last two years that were caused by Ministry of Health restructuring, recruitment freezes, and NSU restructuring?
- What process was followed to recruit a new BSA Clinical Leader (including timeframes, people involved in selection, and conditions of employment)?
- What do staff feel supports them in their roles? What other supports would staff welcome?

### *Implementation of a Centralised PACS and one consistent version of BSA software across all providers*

- What processes were followed to facilitate engagement in the project to implement a centralised PACS and a single version of Concerto BreastScreen software?
- What activities have been undertaken to progress a centralised PACS?

### *BSA Quality Frameworks*

- What policies and processes (including monitoring, audit and clinical governance, clinical expertise and input), are in place to manage clinical quality and safety across the BSA programme?
- Are clinical risks appropriately identified, monitored and addressed?
- With the challenges of securing clinical leadership within the NSU, what strategies have been put in place to address this?

### *BSA sector relationships*

- What processes and procedures are in place to manage relationships between the NSU and BSA Lead Provider Managers and Clinical Directors?
- What structural changes have occurred and how have they impacted the NSU's ability to establish wider engagement and increase capacity and capability as part of ensuring the progress of the BSA programme?

## **Out of Scope**

The review is primarily focused on the BSA and Quality & Equity teams and will not include a detailed review of the other screening programmes managed by the NSU beyond the BSA Programme.

## **Deliverable**

The reviewer will produce a report that addresses the key questions listed above. In the report the reviewer will provide an objective view on these questions and will make recommendations for actions to address any concerns.

In completing the report the reviewer will:

- Undertake interviews with the NSU Group Manager, members of the National Services Purchasing Group Leadership Team, the Chair of NSU Clinical Governance Group, members of the NSU Senior Management Team, the former Director National Services Purchasing (Geraldine Woods), the Personal Assistant to the Group Manager NSU (Anne Batten-Thomas), relevant staff in the BSA and Quality & Equity teams, and other staff in the NSU as appropriate
- Undertake interviews with relevant clinical and management staff from BSA Lead Providers, including Clinical Directors and Lead Provider Managers
- Review relevant NSU and BSA documentation including policies and procedures
- Make comparisons with other comparable national screening programmes, specifically BreastScreen Australia

### Timeframes

The review will be completed within 7 weeks of agreeing a start date with the selected reviewer as shown in the table below.

<b>Milestone</b>	<b>Timeframe</b> (shown in weeks from start date)
Individual selected to complete review	0
Draft report will be provided to the Acting Director National Services Purchasing	5 weeks
Feedback provided by the Acting Director National Services Purchasing to the reviewer	6 weeks
Final report submitted to the Acting Director National Services Purchasing	7 weeks

## Appendix 3

### List of people and groups contacted as part of BSA Review

BreastScreen Aotearoa Program team members  
National Screening Unit Senior Management Team  
Lead Provider Managers BreastScreen Aotearoa Program  
Clinical Directors BreastScreen Aotearoa Program  
BreastScreen Aotearoa Advisory Group  
National Screening Unit Clinical Governance Group  
National Cervical Screening Program team members  
Quality and Equity team members, National Screening Unit  
Information Services team members, National Screening Unit  
Former staff members (resigned and retired), MOH  
GSL Network  
Former organisational consultant to National Screening Unit  
National Health Board Business Unit  
Eru Pomare Centre, University of Otago, Wellington  
Professor of Public and International Health, University of New South Wales  
BreastScreen South Limited team members  
Chair Surgeons Unidisciplinary Group, BreastScreen Aotearoa Program  
Acting Chief Medical Officer  
Sector Capability and Implementation, Cancer Control Program  
Radiologists



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