

The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

Striving for paradigm shift in DHBs

The ASMS is striving to achieve a paradigm shift in DHBs that requires a transformation in their decision-making through significantly enhancing the role of senior doctors and dentists, along with other clinical staff. This began with our work in, gradually over the years, extending the coverage of our collective agreements in DHBs and their predecessors to include various professional rights.

The MECA on professional rights and engagement

The first national DHB multi-employer collective agreement (MECA) covering ASMS members (2003-06) brought this to a new national level with a series of provisions, (carried over into the current MECA) such as:

- DHBs recognising that they benefit from their senior medical staff "having significant influence in their internal decision-making" (Preamble).
- DHBs and ASMS committing to working together to establish and strengthen the engagement with and empowerment of senior medical staff (Preamble).
- Senior medical staff engagement and empowerment should be "integral to the internal culture of each DHB" (Preamble).
- DHBs and ASMS will "actively encourage collective negotiations and responses to workplace challenges and issues" (Clause 1.1).
- DHBs and ASMS recognised the "primacy of the personal responsibility" of senior medical staff to their patients and to their role as a patient advocate along with their responsibilities to the Medical (or Dental) Council and to the ethical codes and standards of relevant colleges and professional associations (Clause 39).
- Requiring DHBs to invite affected ASMS members to participate in reviews at the earliest practical opportunity (Clause 43.2).
- Requiring DHBs to consult and seek the endorsement of the ASMS before undertaking any review "which might impact on the delivery or quality of clinical services" (Clause 43.2).

- DHBs and ASMS reaching agreement over a process for resolution of "any serious professional or clinical concerns" arising out of the recommendations of any concluded review (Clause 43.4).
- DHBs and ASMS reaching agreement over a process to resolve serious actual or potential patient safety concerns (Clause 41).

And then came 'Time for Quality'

The next significant development along the transformation towards clinical leadership was the *Time for Quality* Agreement signed in August 2008 by ASMS and the 21 DHBs (discussed in detail previously in *The Specialist*, September 2008, on the ASMS website www.asms.org.nz). *Time for Quality* is, in effect, incorporated into the MECA through the direct inclusion of its engagement principles (Clause 57 of MECA).

"managers will 'support' senior medical staff 'to provide leadership in service design, configuration and best practice service delivery.' "

Time for Quality recognises that DHBs need to be driven by quality which needs health professionals (not just senior medical staff) in leadership who, in turn, require time to provide this leadership. Underpinning this keynote agreement is the theme of partnership between clinicians and managers based on teamwork and respect. This includes an emphasis on lead roles for clinicians in certain circumstances and, where appropriate, devolved decision-making. Central to *Time for Quality* is the objective of enshrining this partnership as simply being the normal way of doing things in DHBs.

The second engagement principle (also in the MECA) is central to transformation. It states that managers will "support" senior medical staff "to provide leadership in service design, configuration and best practice service delivery."

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ASMS letter to DHBs: from aspiration to real change

The minimalist assessment of *Time for Quality* is that it is a noble aspirational document. However, the health sector is riddled with noble aspirational documents that lead to no or little change for the better. The ASMS is determined to do its best to ensure that *Time for Quality* does not suffer the same inglorious fate. Including its engagement principles in the MECA greatly assists in preventing this possibility.

“the combination of *Time for Quality* and the MECA supports and extends the MECA’s potential for consultation and engagement and requires a paradigm shift by and within DHBs.”

On 10 February the ASMS wrote to all 21 DHB chief executives over the application of *Time for Quality* to the MECA’s obligations and responsibilities for consultation and engagement discussed above (letter published on page 12 in this issue of *The Specialist*). The thrust of the letter is that the combination of *Time for Quality* and the MECA supports and extends the MECA’s potential for consultation and engagement and requires a paradigm shift by and within DHBs. A major feature is the “subordinate” (support) role of managers in the second engagement principle briefly discussed above.

At the sharp end of things, the ASMS has referred chief executives to their obligation to seek ASMS endorsement of proposed reviews “which might impact on the delivery or quality of clinical services”. The ASMS has advised chief executives that endorsement will not be provided if senior medical staff have not played the lead role in the development of the proposed review including its form and terms of reference.

Health Minister’s Letter of Expectations: a bit of steel for achieving transformation

Each year the Minister of Health sends a Letter of Expectations (instructions by another name) to the chairs of each DHB. This year’s letter (19 February) was unusually written by the Minister alone. It includes some interesting instructions relevant to the transformation perspective of *Time for Quality* and the MECA (the full letter and an article about it are published elsewhere in this issue of *The Specialist*).

The Hon Tony Ryall is requiring DHB chairs to, among other things, ensure that DHBs:

- Adopt “good staff practices aimed at developing cultures that value employees and promote trust.”
- Clearly demonstrate this “through measures of increased retention, genuinely reduced vacancy rates and greater staff satisfaction”.
- Foster clinical leadership as a fundamental driver for improved care.
- Actively “foster the development of a culture of clinical leadership within your DHB including supporting the development of clinical networks and regional co-operation.”

Political steel is provided by the Minister for achieving these expectations. He firmly states that DHB chairs are to be held “directly accountable for your performance” in achieving them (along with the other expectations in the Minister’s letter). Further, DHB chairs are also expected to “hold Chief Executives and management teams accountable for improved performance within each DHB.”

More political steel: the “In Good Hands” report

The latest step in the cause of transforming DHBs to achieving clinical leadership is an influential report from a task group appointed by Health Minister, Tony Ryall and convened by ASMS National President, Jeff Brown. Appropriately named *In Good Hands*, it builds on and seeks to contribute to the operationalising of *Time for Quality*. *In Good Hands* assesses the implications of increasing disengagement of clinicians in DHBs and outlines transformative changes which must occur if clinical leadership is to occur (the full report is published on page 6 in this issue of *The Specialist* and is also available on the ASMS website).

The significance of the report is that it now forms part of government policy with Mr Ryall advising DHBs accordingly. It complements his Letter of Expectations. DHBs are required to implement it. ‘Transformation’ and ‘transformative’ are arguably the most used words in this profound report. Imperatives are identified which involve DHBs reporting progress in their District Annual Plan (a statutory obligation requiring sign off by the Health Minister), their Statement of Intent to Parliament (attracting health select committee scrutiny), and Health Ministry scorecards. Achieving clinical governance and clinical leadership are to be important factors that Board and chief executive performance is to be assessed on.

Among the requirements of *In Good Hands* are:

- Establishment of governance structures which ensure effective partnership of clinicians and management.

- Strong clinical leadership and decision-making at all levels of each DHB.
- Devolvement of decision-making to the most appropriate clinical unit or team.
- Identification and supporting the development of actual and potential clinical leaders.

With specific regard to the aligned requirements of demonstrating both clinical involvement at all levels and devolving decision-making, *In Good Hands* expects clinicians to be involved in the reporting of progress to government. In the case of senior medical staff the report specifies the ASMS Joint Consultation Committees (a MECA creation) in each DHB as the form of engagement for this reporting.

Getting there

Never have senior doctors and dentists been better placed to achieve clinical leadership in their DHBs. The convergence of the MECA and *Time for Quality* compounded by the political steel of the Health Minister's Letter of Expectations and *In Good Hands* is powerful.

“The convergence of key dynamics, despite the challenges of economic recession and residual legacies of managerialism, has never been so powerful”

Also powerful, however, are managerial reluctance, hesitation and downright opposition in some quarters. There has been a culture of managerialism whose prevalence in past years has been such that it will not go away on its own. In response to the ASMS letter to DHBs on the application of *Time for Quality* (discussed above), they have bridled at the word “subordinate” over the application of the second engagement principle.

Unfortunately the three Auckland DHBs (Waitemata, Auckland and Counties Manukau) provide a negative example. Although only three out of 21, they cover over a third of the DHB employed senior medical/dental workforce. They have developed the practice of declaring challengeable positions on issues (unilaterally or within limited consultation) and tacking on the signatures of the chief medical advisers to give the appearance of clinical engagement (but having the counter-productive effect of undermining the credibility of the roles of the CMOs among their senior medical peers). These have involved matters related to terms and conditions of employment (eg, watering down the approval process for sabbaticals).

They have ignored an ASMS formal request to engage over the effects of RMO shortages on senior doctors in the wider Auckland area. Further, although no position has been confirmed they have also tried to embark upon a path towards disestablishing unfilled RMO positions with the expectation that senior doctors and nurses would cope with the extra work; but no engagement with either the ASMS or NZNO.

Perhaps the greatest irony is the Auckland DHB adopting a top-down approach to re-examining clinical leadership, (including failing to engage with the ASMS despite opportunities and expressions of willingness from the ASMS to do so), which has generated a mix of angst and disenfranchisement of the DHB's own senior doctors. This is an unfortunate example of an own goal!

These are regrettable cases which, nevertheless, serve as a timely reminder of the attitudinal managerial backwardness we are still confronted with. On the other hand, there are positive signs. In another larger DHB (Waikato) in two different separate processes (one, like Auckland, involved clinical leadership, while the other involved the form of clinical leadership in a particular service), management proceeded in a manner inconsistent with the engagement requirements of the MECA and *Time for Quality*. However, following an exchange with the ASMS (including at the Joint Consultation Committee), management pulled back and agreed to new paths consistent with these requirements.

But just as this requirement for transformation to clinical leadership requires DHBs and their management systems to change their cultures, it also requires ASMS members to step up. If senior doctors and dentists don't and instead allow themselves to give up because of past legacies or new obstructions, then we will not get the transformation that will benefit them, managers, DHBs and patients so much. The convergence of key dynamics, (despite the challenges of economic recession and residual legacies of managerialism), has never been so potentially powerful. But it will not last forever if ASMS members don't step up.

Ian Powell

Executive Director



Time to step up

It is up to you now. A chance to really, truly, make a difference. To step up and take charge. To lead.

The Minister has released *In Good Hands*, a report that instructs DHBs to embed clinical leadership at all levels within their organisation. And to measure that establishment. The very jobs of chief executives could depend on the success of clinical governance, as judged by clinicians.

Of course, clinical leadership depends on clinicians being prepared to lead. Clinicians who may feel burned, or bored by yet another blandishment. But this time it is for real. There is a confluence of forces and beliefs which makes “now” the time to step up and seize the moment. Some say this opportunity may never come again in their working lifetime.

What has come together to create this propitious moment?

Your MECA laid the foundation of non-clinical time as a necessary part of your regular schedule. This protected time is now a part of many job schedules, and if it is not in yours, it needs to be.

Time for Quality, signed last year, admitted that there was disengagement between clinicians and management which had damaged the health system and prevented it delivering best care. The previous Minister of Health witnessed a commitment by DHBs and ASMS to transform relationships between managers and clinicians and to ensure that clinicians were supported to lead service design, configuration and best practice service delivery. Some DHBs have made some progress, but many have failed to put these words into sufficient action.

The new Minister demands more action, and sooner. He asked me to chair a Task Group over the holiday period to prepare a report for him to send to DHBs. This report outlines transformative changes in DHBs that must occur, specifies some measures of that transformation, and identifies the challenge of nurturing clinical leadership.

In Good Hands is explicit in expectations of DHB Boards, chief executives, and management at all levels. It emphasises the need to identify and support clinical leaders. Leaders who must maintain both their clinical standards and the confidence of their peers.

Your DHB will be expected to have quality and safety at the top of all agendas and activities. Quality and safety will require a transformation in clinical leadership in all aspects of its work. This transformation will require you to step up and take on roles and responsibilities you may desire or may have little time for.

Over to you

- You need to work out with your immediate colleagues who leads what and how you determine your collective voice.
- You need to work out with your immediate manager how you can be supported to lead decision making on service delivery.
- You need to work out with your general manager how you or your representative can be supported to lead decision making on service configuration.
- You need to work out with your chief executive how you or your representative can be supported to lead DHB decision making on quality and safety.
- You need to work out how you can be involved in the measurement and reporting on clinical leadership to ensure the truth is made clear.
- You need to do all this, and now.

Overcome obstacles

Some managers will be eagerly seeking your leadership and will embrace *In Good Hands*. Others may feel threatened and regress to bad behaviours and horrible habits. They may put their private spin on words and aspirations to preserve the comfort of control. They will only accede if you insist on actions outlined in the report.

You may have to carry *In Good Hands* around with you, to wave under noses at every opportunity, to leave on every manager's desk, to discuss at every gathering. Until its words become the reality of your working life.

This report, the confluence of imperatives it represents, and the political support it has, gives us a rare opportunity. Welcome it. We have worked hard for it. We must now work even harder, and together.

A quote from this year in the report,

“Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients. A deep commitment to patient care and to traditional clinical skills will always remain the core of a clinician's identity. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organisations must complement these traditional values. All the evidence suggests that patients will see the benefit.”

Let us walk that essential road for the benefit of all.

Now is your hour. Your time. To step up.



Careful what you wish for, you might get it!

While in opposition the National Party, especially its health spokesperson Tony Ryall, railed against the cost of health bureaucracy, with particular reference to DHBs and the Health Ministry. It became a populist theme of valuable health dollars wasted on bloated health bureaucracy which should be transferred to the clinical frontline for the benefit of patients. In other words, bloated health bureaucracy was preventing patients from receiving the treatments that they deserved and needed. There is little doubt that regardless of accuracy and veracity this was a message that resonated in the public arena and among many health professionals of various descriptions.

It is helped by the fact that the terms 'bureaucracy' and 'bureaucrat' have assumed a pejorative connotation. They have become expressions of insult rather than their neutral meaning of working in an office setting.

The ASMS's own position was different. While accepting that in DHBs at least there may be an oversupply of managers, we were more concerned about the under-supply of managerial talent. But we also appreciated the fact that there are many managers, including in service management and clinical support, who are dedicated, hardworking and competent, and who played important roles in making things better for patients including access to treatment and quality of care.

Further, we are also aware that downsizing management produces limited cost savings. If not cost saving, effectiveness and efficiency are more likely to be improved instead by improving managerial decision-making processes.

From populism in opposition to populism in government

Following the outcome of November's general election, Mr Ryall, now Health Minister, has continued the populism of opposition into the populism of government. Again it is likely to resonate among many. The new government's slogan is 'from back office to clinical frontline'. Who can argue with that? In part the politically selected group appointed by the Minister to look at quality and performance (chaired by company executive and former Treasury head, Murray Horn) will be looking at this. In addition, DHBs advise that the Minister has capped administration staffing numbers.

But caution is required. First, the Ministerial Group chaired by Murray Horn is particularly weak on health professional involvement which is best placed to advise on those non-clinicians who provide essential support for clinicians in DHBs.

Second, the scope of management is so wide to go well beyond corporate and service management. It also includes clinical support (eg, ward clerks), administrative and clerical

staff, and information technology personnel. They do the vital support work that enables doctors, nurses and other health professionals to focus on treating patients. Targeting them will not improve the service for patients and arguably may contribute to undermine it. In fact, in some of these areas (eg, medical secretaries, personal assistants for clinical departments, IT staff) we presently suffer from shortages.

Bagging the Ministry

An even easier target is the Ministry of Health, particularly as sometimes its conduct helps make it so. Sometimes I think that the Ministry's worst enemy is the Ministry. On the other hand, while I have been critical of various Ministry decisions and practices over the years, I would never accuse them of slackness. Overwhelmingly, Ministry officials I have interacted with have been hardworking, committed and, in the main, competent.

Further, perspective over the cost of the Ministry is required. New Zealand spends around \$12.2 billion a year on our health services. Less than 2% of this is spent on the Ministry. A significant part of this is spent on regulatory functions that if not undertaken by the Ministry would have to be undertaken elsewhere. Further, unless we are going to have 21 separate fragmented health systems (DHBs) not talking and collaborating with each other, some central leadership and planning capacity is necessary.

This is not to say that reviewing the functioning, including non-clinical structures and systems is inappropriate for organisations the size of DHBs. It is most appropriate. Big organisations can easily lapse into less effective ways of doing things and can be slow to adapt to changing needs. This is equally the case with the private sector; it is a feature of size rather than public versus private.

We should also be careful to prematurely judge the role of others when we don't understand what they do or the purpose of the role. We can all be the victims of unhelpful and unfair stereotypes – doctors, bureaucrats and even union officials! A bit of tolerance all round that we don't know what we don't know would not go astray.

If we run with the populism of anti-bureaucracy we risk getting what we ask for – less ward clerks, less IT staff, less medical secretarial support, and increased fragmentation between DHBs.

Instead of being underpaid senior doctors and dentists, they risk becoming overpaid secretaries. Is this really what we want and will it really benefit patient care?

Ian Powell
Executive Director

In Good Hands

In Good Hands (February 2009) is a report commissioned by the Minister of Health to provide guidance to DHBs on implementing his instruction to them in his Letter of Expectations (published on page 11 of this issue) to foster clinical leadership. DHB chairs and chief executives will be taken to account by the Minister over whether they have implemented clinical leadership. The report assesses the extent and risks of clinician disengagement, outlines transformative changes that must occur, and specifies a range of reporting obligations for DHBs on progress in achieving effective clinical leadership. The report also has an appendix which is not published here but is available as part of the full report on the ASMS website www.asms.org.nz.

Transforming Clinical Governance in New Zealand

"Healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical."

Task Group, 2009

This report outlines transformative changes to clinical leadership that must occur, specifies some measures of that transformation, and identifies the challenge of nurturing clinical leadership.

Purpose of this Task Group Report

Throughout the New Zealand health system there has been increasing disengagement between clinicians and managers. Many clinicians have felt less and less able to influence decisions on the delivery of health care, while being held increasingly to account for the results of those decisions, or at least responsible for the outcomes. Many clinicians have decided to abrogate the responsibility for managing the health system at many levels, and just to get on with the clinical work. Many managers, left to make decisions without clinical expertise, feel less and less able to influence the clinicians who deliver the healthcare and who determine the quality and safety, and cost, of that care.

Clinical networks in primary care, developed in recent years, report effective partnerships between managers and clinicians at the network level, but poorer engagement with DHB management and governance structures.

Recognising the detrimental effects on quality and safety from increasing disengagement, all 21 DHBs and hospital specialists signed up to "Time for Quality" - an explicit commitment to a health professional partnership and principles of engagement.

This report "In Good Hands" develops that commitment to greater clinical engagement in order to improve the quality of care in our health and disability services. The Ministerial Task Group on Clinical Leadership was convened by the Minister of Health to:

- describe how we can establish strong clinical leadership and governance in the health system.

- describe and develop aspects of leadership required for good clinical governance
- develop examples of how processes for clinical governance can be established

Summary of Report

- "In Good Hands" defines clinical governance.
- It discusses components and attributes of leadership that can identify leaders, both formal and informal, and can be used to measure their performance.
- It advises transformation to structures within DHBs to achieve better quality and safety through clinical governance.
- It recommends that DHBs be required to report on outcomes of such transformation.
- It recommends action to foster and train leaders.
- It recommends sharing successes.

Definition of Clinical Governance

Clinical governance is the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

Sally, Donaldson, 1998 (adapted)

Clinical governance is the system. Leadership, by clinicians and others, is a component of that system.

Introduction – the Problem

Decisions around the planning of health care now demand a balance between clinical, community and corporate governance. This balance is increasingly important as services develop population health focus (area, region, nation) as well as individual patient care, and integrate the patient journey through primary to tertiary services (and back) across specialty silos.

A lot of effort has gone into corporate governance, and reporting corporate outcomes, and processes are being

established for community governance. However, clinical governance, and reporting on clinical outcomes, has not been the prime focus of many DHBs, especially in their hospitals. Primary care clinical networks have shown that successful clinical governance requires distributed leadership (at practice, network, and national levels), and much of primary health care governance is “in good hands”.

The challenge for the rest of the healthcare system is to transform clinical governance into an every day reality at every level of the system, to ensure the whole system is in good hands.

Principles

A process for the New Zealand healthcare system to transform towards clinical governance needs to be based on the following six principles.

- 1 Quality and safety will be the goal of every clinical and administrative initiative.
- 2 The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
- 3 Clinical decisions at the closest point of contact will be encouraged.
- 4 Clinical review of administrative decisions will be enabled.
- 5 Clinical governance will build on successful initiatives.
- 6 Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Components of Clinical Leadership

Extensive expertise in other health systems explores components and attributes of effective clinical leadership. The NHS Leadership Qualities Framework lists 15 qualities or competencies. The Canadian model (CanMEDS) listing 7 domains of performance is common to, and forms the basis for, accreditation of undergraduate and postgraduate, and vocational medical education programmes, and continuing professional development programmes, throughout Australia and New Zealand, and internationally.

These competencies, outlined in the Appendix, can form both a guide to identify and develop future leaders, and a framework for measuring and reporting on clinical leadership.

Structure of Clinical Governance in the New Zealand Health System

“If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that

they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.”

Professor of Surgery, the Lord Darzi, Parliamentary Under Secretary of State, Department of Health UK. NHS Next Stage Review Final Report, 2008

The structure necessary to operationalise the Time for Quality agreement and the Quality Improvement Strategy for the best care of citizens/patients within the New Zealand health system encompasses the whole spectrum of care, from primary to tertiary and national services.

The following adjustments are imperative for the successful transformation of healthcare and effective clinical governance.

- 1 **DHB Boards** must establish governance structures which ensure effective partnership of clinical and corporate management. DHB Boards must be required to report on clinical outcomes and clinical effectiveness, via a nationally consistent framework. Quality and safety must be at the top of every agenda of every Board meeting and Board report.
- 2 **The Chief Executive** must enable strong clinical leadership and decision making throughout the organisation. Assessment of Chief Executive performance must include clinical outcomes, clinical effectiveness, and the establishment of clinical governance.
- 3 **DHB Governance** will promote and support clinical leadership and clinical governance at every level of the organisation. DHBs must report on clinical leadership and clinical governance through their District Annual Plans, their Statement of Intent, and scorecard reports to the Ministry. This reporting includes, but is not limited to, the functions of their Clinical Board.
- 4 **Clinical governance** must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services. Tangible examples of clinical governance, which DHBs must report on, include:
 - a) Clinicians on the Executive Management Team as full active participants in all decision making
 - b) Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
 - c) Decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.

- 5 **Clinical leadership** must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of their activities, aligning management to clinical activities.
- 6 DHBs and the health system must **identify actual and potential clinical leaders**, and foster and support the development of clinical leadership at all levels. To this end DHBs must together establish strategies to:
 - a) Provide on the job training to strengthen the competencies and attributes of clinical leaders
 - b) Measure the achievement of leadership competencies in their workforce
 - c) Link with Universities, Colleges, and professional associations to coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

Clinical engagement is about more than simply appointing people to particular positions or forming committees. It is about recognising the diffuse nature of leadership in healthcare organisations and the importance of influence as well as authority. Within health professions a range of leaders also exist who may not be official leaders in the eyes of the organisation; however they may be influential for other reasons amongst their peers, for example academic appointments, positions in professional organisations such as Colleges and Societies, or elected representation.

“Leadership is emphasised as a mechanism for effecting change and enhancing quality - with opportunities for this more likely to arise... at a local than a national level. [It] requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients.”

Darzi, *High Quality Care For All*, 2008

Empowerment of clinicians is the best means of realising this obligation, and will be accompanied by a willingness to accept responsibility and accountability, including for best use of resources.

Reporting on the Transformation

Quality and safety will improve when DHBs, and their Chief Executives, are required to report clinical outcomes, and the establishment of clinical governance within their healthcare organisations, as part of their routine “bottom line” and their own performance measures.

The Task Group recommends that, at a minimum, DHBs must:

- 1 Report on clinical outcomes and clinical effectiveness, in a nationally consistent manner.
- 2 Ensure that quality and safety are at the top of every agenda of every Board meeting and Board report.
- 3 Assess their own and Chief Executive performance on measures that include clinical outcomes and the establishment of clinical governance.
- 4 Report on clinical leadership and clinical governance through their District Annual Plans and scorecard reports to the Ministry.
- 5 Demonstrate clinician involvement at all levels of the organisation including the Executive Management team.*
- 6 Demonstrate devolvement of decision making and responsibility to the most appropriate clinical unit or team.*
- 7 Identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels.
- 8 Coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

* The mechanisms for reporting on 5. and 6. must include clinicians themselves. An example is existing Joint Consultative Committees.

Nationally Consistent Reporting

The health safety and quality literature clearly states that measurement is a very effective tool for driving change. The existing well established and validated international leadership metrics should be applied to the New Zealand healthcare industry.

The Task Group recommends that a small group be tasked with developing an initial national framework for reporting on clinical outcomes, clinical effectiveness, and clinical leadership within DHBs. This evidence-based framework should be part of existing reporting mechanisms such as “balanced scorecards” to the Ministry, and should be validated for accuracy by clinician groups within DHBs.

The initial framework should be reviewed and updated regularly as part of a national process to improve the quality and safety of health and disability services.

“...where change is led by clinicians and based on evidence of improved quality of care, staff are energised by it and patients and the public more likely to support it.”

Darzi, *High Quality Care For All*, 2008

Sharing Successes

DHBs, through clinical networks and other networks, should share the successes of effective clinical governance. Some current examples of these successes include:

- Quality Improvement processes eg Cornerstone in primary care
- PHO accreditation - Te Wana programme for Healthcare Aotearoa
- Regional quality and education programmes through primary care networks
- Hospital medical department credentialing in MidCentral and Counties Manukau
- Regional cancer networks
- Joint Consultation Committees – local DHB and national
- Newborn Life Support Course – nationally consistent training in resuscitation
- TelePaediatrics – videoconference network linking child health professionals
- New Zealand Incident Management System – training and standards

The Task Group is aware that many other examples of clinical leadership have led to major improvements in quality and safety. Supporting and sharing these successes requires transforming leadership throughout the entire system, including not just DHBs but also at Ministry level and national advisory groups.

“Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients. A deep commitment to patient care and to traditional clinical skills will always remain the core of a clinician’s identity. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organisations must complement these traditional values.

All the evidence suggests that patients will see the benefit.”

Mountford and Webb, 2009

Who wrote *In Good Hands?*

The group convened by the Minister of Health to author a report on clinical leadership in DHBs *In Good Hands* comprised:

Dr Jeff Brown Chair
ASMS National President and paediatrician at MidCentral DHB

Dr Andrew Connolly
Head of general surgery,
Counties Manukau DHB

Ron Dunham
Chief Operating Officer,
Counties Manukau DHB, and former
Bay of Plenty DHB Chief Executive

Dr Anne Kolbe
Paediatric surgeon and former
Chair of Australasian College of Surgeons

Dr Harry Pert
Rotorua GP and incoming
Chair of NZ College of GPs

Helen Pocknall
Chief Nurse, Wairarapa DHB



Letter of Expectations from Hon Tony Ryall to District Health Board Chairs

Every year the Minister of Health sets out his or her expectations of District Health Boards in a formal letter of expectations to the Chair of each Board. It is the primary mechanism for a Minister to set out proactively their expectations for all DHBs in contrast to reacting to annual or five year plans from the DHBs. The letter sent by the new Minister of Health to the chairs of each of the 21 DHBs (and printed in full below) is a key part of his endeavours to set the new direction he wants DHBs to take.

There are interesting features from the point of view of Association members:

- There will be a focus on hospital services this year. This is welcome as the previous government's emphasis was on primary health care (despite an extensive hospital rebuilding programme). Electives volumes are to increase each year achieving genuine reductions in waiting times. Emergency department waiting times are to decrease (both in terms of triage indicators and length of stay targets).
- Despite this, the Government is committed to the primary health strategy and the Minister intends to transfer some secondary services to the primary care sector (at no cost to patients) in 2010/2011. It is not clear that these services will be provided by GPs (meaning that they will charge for some services but not for others) or be provided by

DHB staff in primary care settings. The Government will also be establishing "multi-disciplinary Integrated Family Care Centres" in 2010/2011 which appear to have some similarity with the proposed polyclinics in England (a mix of primary care and 'lower level' secondary care). DHBs have a responsibility for planning their development but funding is unclear.

- DHB Chairs will be held accountable for performance and will be expected to hold Chief Executives (and management teams) accountable for performance. They will be expected to deliver on the government's priorities within budget. This is likely to prove anything from challenging to impossible as all the priorities are to be funded from within the current Vote Health.
- The DHBs will be expected to improve the retention of frontline clinical staff by developing cultures that value frontline clinical staff and promote trust and demonstrate this by increased retention, genuinely reduced vacancy rates and greater staff satisfaction.
- A culture of clinical leadership is to be actively fostered including the support of clinical networks and regional co-operation (see the article on the *In Good Hands* report in this newsletter).

Angela Belich,
ASMS Assistant Executive Director

ASMS services to members

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

ASMS email Broadcast

In addition to *The Specialist* the ASMS also has an email news service, *ASMS Direct*. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at ke@asms.org.nz

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3000 doctors and dentists, over 90% of this workforce.
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services - www.asms.org.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements. We welcome your feedback as it is vital in maintaining the site's professional standard.

Support Service for Doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service. The support service provides access to a free professional counselling service.

Doctors seeking help can call **0800 225 5677 (0800 Call MPS)**. The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support. The service is completely confidential.

ASMS Job Vacancies Online

www.asms.org.nz/system/jobs/job_list.asp

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using the facility. Substantial discounts are offered for bulk and continued advertising.

How to contact the ASMS

Phone 04 499-1271
 Fax 04 499-4500
 Email asms@asms.org.nz
 Web www.asms.org.nz
 Post PO Box 10763, Wellington
 Location The Bayleys Building
 Cnr Brandon St &
 Lambton Quay
 Wellington

19 February 2009

Letter of Expectations for 2009/10

This letter sets out the new Government's expectations for District Health Boards (DHBs) and their subsidiary entities for 2009/10.

The new Government wants the public health system to deliver **better, sooner, more convenient** healthcare for all New Zealanders. We want shorter waiting times, less bureaucracy, and a trusted and motivated health workforce.

New Zealanders made it clear during the general election that they are concerned about the availability and quality of hospital services. Reflecting this widespread concern, the public health service's priorities this year will be sharply focused on hospital services.

Having said that, commitment to the Primary Health Care Strategy (PHCS) is bi-partisan and remains important. In 2010/11 we expect to build on the PHCS by shifting some secondary services to more convenient primary care settings (at no cost to patients), and establishing multi-disciplinary Integrated Family Health Centres. Activities during the next year should lay appropriate foundations for the successful implementation of these initiatives in 2010/11.

The new Government intends to hold you, along with all other DHB chairs, directly accountable for your performance. We expect Boards, in turn, to hold Chief Executives and management teams accountable for improved performance within each DHB. We will meet with you twice a year to discuss performance. We will be looking particularly closely at your ability to deliver in the Government's priority areas, while keeping within budget.



Expectations of all District Health Boards:

Improve service and reduce waiting times

New Zealanders should have timely, high-quality access to healthcare services when they need it. For many, confidence in the health system over recent years has been damaged by excessive waiting and delays. Resources should be moved away from the back-office and from poor quality spending into frontline services. We must improve patient outcomes and satisfaction. Specifically, we expect you to:

- **Increase elective volumes year on year** – We expect improved volumes of both first specialist assessments and elective surgery. These improvements should achieve genuine reductions in waiting times for patients.
- **Improve emergency department waiting times** – We expect improved service in ED's in relation to both the current triage time indicators and the new emergency department length of stay target.
- **Improve cancer treatment waiting times** – We expect shorter intervals between patients' diagnosis and treatment, particularly radiation treatment.

Improve workforce retention

High clinical staff turnover rates exacerbate workforce shortages. Trusting, valuing, and fully engaging health professionals will improve patient care and job satisfaction, and assist recruitment and retention.

Specifically, we expect you to:

- **Improve clinical staff retention** – We expect you to adopt good staff practices aimed at developing cultures that value employees and promote trust. This will be clearly demonstrated through measures of increased retention, genuinely reduced vacancy rates and greater staff satisfaction.
- **Foster clinical leadership** - Clinical leadership is internationally recognised as a fundamental driver for improved care. We expect that you will actively foster the development of a culture of clinical leadership within your DHB including supporting the development of clinical networks and regional co-operation.

As the Ministers of Finance and State Services advised in December, the new Government expects all crown entities – including DHBs – to maintain a strong focus on improving productivity and value for money. The deepening world financial crisis and the impact it is having here in New Zealand means all crown entities will have to look at their performance very hard, to make sure every dollar spent is well spent.

While the new Government is maintaining the future health funding track set out by the previous Government, the priorities signalled in this letter will need to be met through your existing resources. You will need to maintain strong financial discipline to ensure resources are available to meet expectations.

Increased regional co-operation is an essential part of our future direction. You continue to have operational flexibility to re-prioritise efforts and costs internally to achieve these objectives.

In your District Annual Plan and Statement of Intent for 2009/10 we look forward to your plans to progress these priorities – plus the initiatives set out in the December funding letter.

We recognise the huge challenges faced by DHBs and want to thank you for your assistance in meeting the public's priority for improved service in key parts of the public health service.

Yours sincerely

Hon Tony Ryall

Minister of Health

ASMS letter to DHBs on application of *Time For Quality* agreement to engagement and consultation responsibilities

The following letter was sent to the chief executives of all 21 DHBs on 10 February. Its objective was to advise them of the ASMS's position on how the Time for Quality Agreement (signed by the ASMS and the 21 DHBs) supports and extends their consultation and engagement obligations under the ASMS/DHBs MECA. It has had the effect of rattling some managerial cages, presumably those fearful of the paradigm shift now required if it is to be honoured (it has also been positively received by others). Among its implications are reviews which directly relate or affect the work of senior doctors and dentists.

The purpose of this letter is to convey to you, in a formal way, the very great importance we attach to our *Time for Quality* agreement with all 21 District Health Boards, including your own, and to consider its relationship with the general and specific "consultation" provisions of the New Zealand District Health Boards Senior Medical and Dental Officers Collective Agreement (the MECA).

Implicit in *Time for Quality* is an acknowledgement that there will need to be a paradigm shift in the DHBs' relationships with the health professionals they employ, including the senior medical and dental officers (SMOs) who are our members, if the Agreement's aspirational goals are to be met.

Time for Quality is linked to the MECA (through Clause 57) but it also stands alone as a separate and distinct agreement whose status and gravity are greatly enhanced by the fact that it was witnessed by the then Minister of Health. The effect of MECA Clause 57 is to bring into the MECA all the obligations and responsibilities that flow from the Time for Quality Agreement.

As a stand-alone agreement however *Time for Quality* is quite independent of the MECA and records the parties' explicit commitment to a health professional partnership founded on:

- 1 Recognition and acknowledgement of the problem;
- 2 Legitimation of a new view through principles of engagement;
- 3 A work plan of active steps.

The Problem

The "problem" referred to in 1 above, as acknowledged by the *Time for Quality* Agreement, includes: systemic failures and disconnect in sections of the system; underperformance in the sector; under-utilisation of the experience and expertise of health professionals; the poor state of relationships between health professionals and management.

Principles of Engagement

For the purposes of this letter and in the context of consultation, I wish to draw your attention to three specific principles of engagement from *Time for Quality*.

By doing so however, I do not seek to minimise the significance of the remaining principles which we acknowledge are equally important. It is simply that we consider these three particular principles as going to the heart of a health professional partnership and being fundamental to the DHB's other specific obligations to consult our members (and the Association) on a wide range of matters.

- Health professional-management partnerships are founded on teamwork and respect;
- Managers will support health professionals to provide leadership in service design, configuration and best practice;
- Managers and health professionals explicitly agree that decision-making and responsibility will be devolved to the appropriate level.

Essential to "teamwork and respect" in the first principle is recognition that the partners will work closely together at every step of the way (i.e. throughout the decision-making process to ensure there are "no surprises" and that clinical considerations and implications are paramount).

This is actually explicit in the second principle which acknowledges the leadership or primacy of health professionals (i.e. practicing clinicians in service design, configuration and delivery). This principle requires close consultation with our members **before** any decision is made to review a service, or any aspect of a service. More to the point, it acknowledges that the role of managers is a subordinate one, of support. This is a major feature of the paradigm shift required by *Time for Quality*.

This second principle clearly confers an obligation on a DHB to consult affected SMOs **even before** exercising its obligation under MECA Clause 43.3 to seek the Association's endorsement as to the purpose, extent, process and terms of reference of any review. This

particular principle highlights the paradigm shift I referred to in the first paragraph of this letter.

The third principle also reinforces this paradigm shift by agreeing that decision making and responsibility is to be devolved to the appropriate level. In **all** matters affecting service design, configuration and best practice, the decision making must be led by the health professionals, including our members.

I appreciate that these additional or more explicit obligations to consult our members may not rest easily with some Planning and Funding divisions within DHBs and with some managers but the obligations are none-the-less real and must be honoured.

Work Plan of Active Steps

In this section of my letter I would like to highlight the first and last steps in *Time for Quality's* work plan:

- *Acknowledge that participation of health professionals in quality development and service improvement is a core aspect of their roles;*
- *Give life to the partnership so it becomes 'business as usual', through the spreading and sharing of progress made across the system.*

The first active step above is particularly important because it reinforces the parties' agreement that a core aspect of our members' job description and role is participation (which under the second Principle of Engagement means **leadership**) in service design, configuration and delivery.

The last step above is also very important because of its explicit objective to enshrine the particular partnership of *Time for Quality* as simply being the normal way of doing things.

You will probably sense from my comments above that the Association regards *Time for Quality* as both supporting and extending the consultation provisions of the MECA. At the risk of labouring the point I do want to highlight some of the key MECA provisions relating to consultation because of the way they point to and neatly complement the provisions of *Time for Quality*. I refer in particular to:

MECA Clause 1.1

Under this provision the parties acknowledge the importance of collegiality within the workplace and undertake to actively encourage collective negotiations and responses to workplace challenges and issues.

We have always (and continue) to regard this provision as requiring an employer to consult closely and early with

affected SMOs to deal with any workplace challenges and issues as they arise. Regrettably, all too frequently in the past, such close and early consultations have not occurred; consultation when it has occurred, has all too often been **after** management has identified a problem, developed a proposal and presented it to SMOs for comment; that is not proper consultation and is certainly contrary to the obligations inherent in MECA Clause 1.1.

Clause 1.1 clearly envisages negotiations or discussions with affected SMOs on all kinds of issues, including such matters as staff shortages, workload imbalances, roster changes, waiting list management, workplace redesign, suggestions that services might be contracted out, or consideration of other suggestions that a "review" of some kind might be beneficial.

MECA Clause 43.1

This is a very important provision and has explicitly recognised for a very long time, what *Time for Quality* also recognises, namely that the involvement of employees will contribute to improved decision-making and greater co-operation between employees and their employer.

The sad irony of this is that *Time for Quality* expressly acknowledges the poor state of relationships between health professionals and management as being part of the problem it seeks to address.

MECA Clause 43.3

Although this provision is sandwiched in the middle of Clause 43 it is perhaps the most important and the one that should be thought of **first** (i.e. at the time the DHB including where applicable its Planning & Funding division) is beginning to think that maybe a review might be useful. Clause 43.3 is absolutely clear: it requires the employer to consult the Association about the need for a review (i.e. its very purpose) at the time it begins to think there might be a "problem" or "issue" to deal with.

The clause expressly recognises that consultation at this point is to discuss what the problem or issue is, or indeed whether there actually is a problem or issue, and how best to deal with it. Arising from this consultation, a decision may be reached that the matter does not require a review but may be resolved in some other way.

Consistent with the obligations and responsibilities of *Time for Quality* discussed above, one condition of the Association providing the endorsement that you are required to consult over and seek is that affected and applicable SMOs (and other health professionals where applicable) have played the lead role in the development of the proposed review including its terms of reference.

MECA Clause 43.2

Having consulted the Association, by which is meant the national office of the Association, under Clause 43.3 and having decided that a review is required and having recognised the possibility of “significant change” of the sort described in the clause, the DHB is now obliged to invite the employees concerned to participate in the review.

MECA Clause 43.4

On completion of the review, there is a further obligation to advise both the association (i.e. the national office) and affected employees of the review’s recommendation to determine whether they throw up any serious professional or clinical concerns. If they do, the remainder of clause 43.4 requires an effort be made (and by implication, time allowed) to deal with those serious concerns.

These obligations have not been unilaterally imposed on DHBs; they were agreed to some years ago by DHBs and the Association. The obligations are not light, in some respects they are quite heavy but that is for good reason: in essence that reason is that the parties recognised some years ago, *Time for Quality* recognises today: that a health professional lead workforce and health service will deliver the best results in terms of allocation of resources, configuration of service and clinical outcomes.

That takes me back to the beginning and the purpose of this letter: I am keen to convey to you and your

fellow Chief Executives just how importantly the Association regards our *Time for Quality* and the equally important consultation provisions of the MECA and our determination to see them honoured.

In summary, our request and expectation is that your service managers, your senior executive team, human resource and employment relations managers, **and** your Planning and Funding division understand and will honour both the provisions of *Time for Quality* and the consultation provisions of the MECA, thereby ensuring time and resources are not wasted in confronting workplace surprises and resolving workplace disputes.

Please be assured that the Association and its members are keen to work with you and your team in a partnership provided that clinical considerations as articulated by health professionals are given primacy, in accordance with *Time for Quality*.

I am sure we will continue to discuss these matters, including at the next Joint Consultation Committee, and I look forward to a strengthening of the Association’s relationship with you and your senior management team and a strengthening of the relationships between our members, their managers and other colleagues in their workplaces.

Yours sincerely

Ian Powell
Executive Director

New Industrial Officer, Lloyd Woods joins the ASMS team



The Association’s industrial team consists of the Assistant Executive Director, the Senior Industrial Officer and two industrial officers. Lloyd Woods has been appointed to the Industrial Officer vacancy left by the resignation of Sue Shone. Sue has joined the Legal Services Agency. Lloyd began work with the Association on 5 January this year. He is an experienced industrial advocate and organiser who has worked for the Association of Staff in Tertiary Education (ASTE) and on a short term contract with the National Distribution Union. He was President of ASTE for four years and acted as joint advocate in their collective agreement negotiations. From 1989 to 2003 he was a lecturer at the Christchurch Polytechnic Institute of Technology. His early training was as an automotive engineer.

Lloyd will be taking responsibility for the industrial work for all the South Island DHBs and for the bottom half of the North Island (Hawkes Bay, Tairāwhiti, Whanganui, Taranaki, MidCentral, Wairarapa, Hutt and Capital & Coast). Lyn Hughes will continue with her responsibility for the top half of the North Island (Northland, Waitemata, Auckland, Counties, Waikato, Lakes and Bay of Plenty).

Senior Industrial Officer, Henry Stubbs, works four days a week. His role is to support and advise the industrial team and to supervise the management of the more complex industrial and medico-legal issues. Assistant Executive Director, Angela Belich, is responsible for the overall management of the industrial team.

Leadership

Below is an article from Peter Glensor based on an address he gave to the ASMS Annual Conference last November. Mr Glensor is the newly elected Chair of the DHB Chairs Board of Governance (ie, 'lead' chair of the 21 DHB chairs) and also the Chair of Hutt Valley DHB.



Dr Jeff Brown had, in his Presidential Address to the ASMS Annual Conference, spoken of the importance of leadership. He spoke about leadership, and the role of doctors as leaders. So close to the General Election, the ASMS Conference was also a good opportunity to see how our

collective DHB work was aligned with the priorities of the new government.

In acknowledging ASMS, I recognise the importance of collectivity in our public health system. It is a whole system, not a disjointed collection of individual hospitals and health services. I also affirm the place of strong, confident, competent trade unions - committed not just to the personal aggrandisement of their members, but the "greater good" of a public health system that is world class.

The recently published Health Targets (set by the Minister of Health and administered by the Ministry of Health) again reinforce that as a health system we are doing very well. Internationally we are seen as an innovative and relatively efficient health system. However, we are not very good at telling our story to the public of New Zealand and politicians. The perception that our sector has become less productive and less efficient rankles with many of us. We all know that so many things are different - services traditionally delivered through theatres now as outpatients, outpatients now in primary care, and so on. But somewhere along the way we have not been able to demonstrate that - it's urgent that we do so.

DHBs have also grown in our ability and commitment to collective action. So much of our business is now tied into regional and national decision making. Examples are MECAs (40+% of our direct spending), Aged Residential Care contracts, pharmaceutical budgets, and national pricing policies.

Within our national collective, we have focused on a few key priorities and work hard to stick to those:

- First is a portfolio named "Quality", incorporating Value for Money Initiatives and Quality Improvement Projects. With the significant shifts in the world global economy,

the fiscal constraints within the sector are going to increase. The challenge that we will collectively need to address is how best we address and tackle these issues without spending lots of time disagreeing. An agreed common pathway of travel is increasingly important.

- Our second priority focus is "Collective Procurement" - leveraging off our collective economic base to get maximum benefit from our purchasing decisions.
- Third is "Workforce Development" - acknowledging the vital importance of a strong, stable, growing, and capable health workforce - not just our 60,000 direct employees, but also the other 60,000 working outside of our own employ.

We face many challenges with shortages within the workforce. This is an issue facing every Western health economy. The days of being able to just add more doctors, nurses, midwives, allied health etc are largely gone as there are no more people to put into health. So how do we face the challenges of the future? We do know that the solutions of the past are no longer going to meet the challenges of the future. More, now than ever we need strong, effective and inclusive leadership. No one is going to come to our rescue - but collectively we have the solutions that we will need for the future.

- Fourth is "Employment Relations". In this portfolio is our work together on the MECAs, ensuring that all DHBs work together to make our public hospital sector a "preferred employer".
- Fifth priority is "Information Systems" - determined that in such a small, spread out, country we have strategies and systems in place that can speak with one another, and allow us to operate one health system, not many.
- Finally, we have "Primary Health Care" ensuring that the massive new investments of money and energy will lead to real gains in improved health outcomes. What are emerging as high priorities are team work, and improving the primary/secondary interface.

I'm sure you see in each of these areas of work a high degree of relevance for the senior doctor workforce. We certainly do. So, we welcome the two initiatives we have taken with you - the Time for Quality Agreement, and the Health Sector Relationships Agreement. Both signal a commitment that health professionals are seen as subjects, not objects, of the health system. All our work in planning

and implementation of the development of our health system must engage with and draw on the resources of, our health professionals.

When I read the *Time for Quality* Agreement principles of engagement, I'm struck by how sensible and practical they are. They emphasise that managers and health professionals (and I also want to add – governors) are part of one complex system, and need one another to make the system work. This is not rocket science for any of us, yet we so often get it wrong. I want, in this forum, to state again my commitment to this agreement, and these principles, and that of the other 20 DHB Chairs who signed it.

In my own DHB – Hutt Valley – this has long been our preferred mode of working – and it constantly bears fruit – whether there is a major crisis – like industrial action by a section of the workforce – or a much more specific issue – like re-organising of the geriatric care we offer – we ask for and receive the full input of all the health professionals. They can make or break what we do, and we are delighted with how much better we work when we commit to a collaborative way of working.

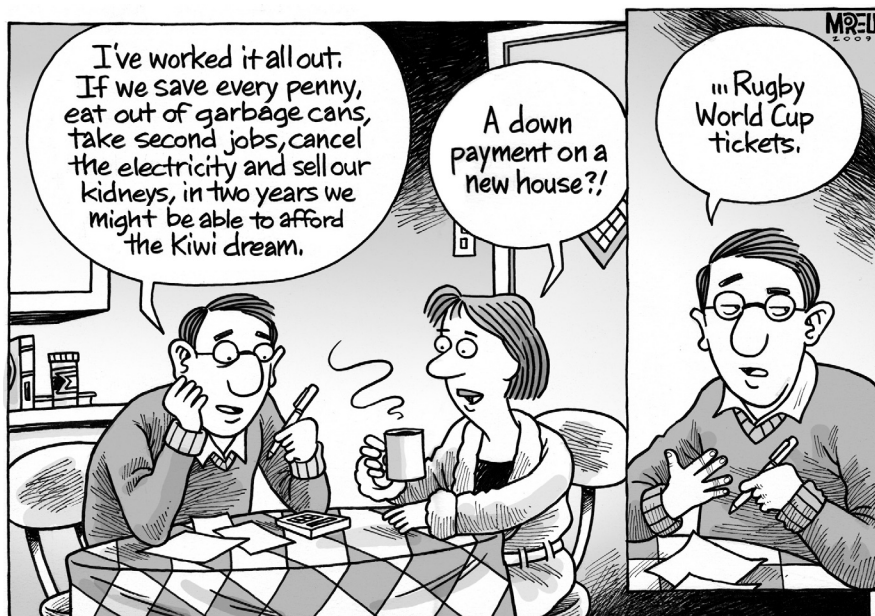
The Central Region Clinical Services Plan [Hawke's Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley and Capital & Coast] is an example of the thinking and planning that is underway to paint a picture of the future that is different from today. The process that this plan has gone through has been dramatically shaped and influenced by clinicians. Throughout the sector, the role that clinical networks will play needs to be greatly enhanced, and these networks will increasingly transcend traditional DHB boundaries.

The bipartite and tripartite forums we run, following the *Time for Quality* and Health Sector Relationship agreements [the latter is an agreement between the government through the Ministry of Health, the 21 DHBs and the CTU affiliated health unions (Nurses Organisation, Public Service Association, Service Workers, and ASMS) which focuses on enhancing constructive working relationships within and between DHBs], will include a series of encounters this year – where all our DHB staff can interact, and we can explore what it means in practice to collaborate more.

We are also moving into a more “grunty” phase – beginning to engage on some of the more difficult stuff – including the parameters of how we can engage in forthcoming wage and salary rounds. I believe we can and will succeed in moving into this new sphere of work together.

The future that we face is less certain. The solutions of the past are less appropriate. The pace of change is going to increase. Within all of this is a wonderfully exciting future that no one has written. It will however be a future that we collectively write. How will future generations judge our collective leadership, vision and wisdom as we stand at the edge! I'm confident that this work I've just outlined is completely in tune with the declared priorities of the new Government.

Thanks again for the way you as an association have engaged in the past period. It's been very tough. There have been at times harsh words spoken and strong actions contemplated. I think we are now in a position where we can move ahead together with confidence.



Cartoon courtesy of Mike Moreu and The Dominion Post

Am I covered?

Below is an article kindly provided by the Medical Protection Society. Dr Peter Robinson is a MPS Medico-legal Consultant.

Has the headline caught your attention? Good – because if you don't know who is providing your indemnity cover, now is the time to pause and check.

It is becoming an unfortunate and increasingly regular situation at the Medical Protection Society (MPS) for a doctor – in a time of need, such as becoming involved in an inquest or receiving a complaint from the Health and Disability Commissioner or Medical Council – to ring for assistance, only to find that their subscription has either expired or was not in place at the time of the clinical incident under investigation.

One overseas physician had been practising in New Zealand for ten years before deciding that he needed assistance via his supposed MPS indemnity cover. Unfortunately, he then found out that he was not actually an MPS member.

How can such a situation occur? The most common statements in such matters are “the hospital has arranged my preferred indemnity with MPS” or “I thought the hospital was arranging my indemnity with MPS”. It is important to be absolutely sure about this and not assume that everything is in place.

There are a number of ways that you can confirm your membership of MPS. If you have paid the subscription yourself, you will receive a receipt and membership certificate, which will cover the year you have paid for.

If you are part of a group scheme – covering a hospital – then you will not receive the receipt but you will still get the certificate of membership for that year. It is also worth noting that group schemes with MPS are not available in every DHB or other employer, so it is imperative that this is checked to discover if you have to arrange individual MPS membership yourself.

If doubts still linger with regards to your membership, then call us on 0800 CALL MPS (0800 2255 677). Press “2” for membership enquiries and you will be able to have your membership status confirmed.

MPS indemnity is unique in New Zealand because it is occurrence-based – which means that if you are a member at the time of an alleged incident giving rise to the complaint, you are covered by MPS. This is the case even if you have since left MPS, or have ceased medical practice altogether. Your estate is also covered if the complaint occurs after your death.

And, with latest MPS research showing that the longest period between an initial consultation and a complaint in New Zealand is 50 years, the importance of what happens after membership cannot be underestimated.

Remember – MPS is a mutual society. This means that you as a member own it, and no profits are paid to shareholders.

Key messages

- If you have not received a certificate of membership within a month of your renewal date, you should check your membership status by calling MPS on 0800 CALL MPS (0800 2255 677).
- If a new doctor, particularly from overseas, joins the staff, make sure he/she is indemnified with MPS.

Dr Peter Robinson
MPS

Make sure you join the MPS

ASMS members are strongly advised to join the Medical Protection Society. If you are employed by a DHB then there is an entitlement for this subscription cost to be reimbursed by the DHB as a work-related expense. It is also possible that it might be reimbursed if you are employed by a non-DHB employer (eg, community trust).

The ASMS works closely with the MPS over cases which straddle employment and medico-legal law. While overwhelming doctors are MPS members, the few that are not, sometimes through misunderstanding are placing themselves at considerable potential risk.



MEDICAL PROTECTION SOCIETY

Facts on ACC Controversy

The material below on the criticisms made against the ACC board by the ACC Minister is taken from a fact sheet prepared by the Council of Trade Unions. It does not represent the position of the ASMS but is published in the interest of understanding the debate. Dismissed ACC chair, Ross Wilson is a former President of the CTU and during his term had a close and constructive working relationship with the ASMS including supporting our initiatives to promote clinical leadership in DHBs. One of the main areas of over-expenditure has been the extension of ACC coverage to medical treatment related injuries which meant that patients no longer have to prove error by a clinician. This extension was based on a policy decision of the former government that was promised by then ACC Minister, Ruth Dyson at an ASMS Annual Conference and was subsequently developed after widespread consultation including with the medical and nursing professions. The ASMS was one of the organisations actively engaged and we strongly supported the change.

Introduction

This fact sheet has been prepared to provide some answers to questions being asked by union members about the current political controversy around ACC, including the removal of former CTU president Ross Wilson as ACC Chair.

Is ACC Insolvent?

The Minister of ACC claims that ACC is insolvent. This is untrue. ACC has revenue of about \$4 billion a year. It also has reserves of more than \$10 billion.

A leading actuary, John Eriksen, in the Dominion Post (12 March) described the ACC Minister's claims as "ill-founded scaremongering by a poorly informed government... in reality there's nothing wrong with it".

ACC has a total liability of \$22 billion for the future cost of claims. It is in transition to full funding (i.e. collecting in the year of the accidents enough revenue to cover all current and future costs of the claims) from pay-as-you-go (i.e. collecting enough revenue to meet the cost of claims in the current year only) and the \$10 billion reserve fund will increase over time which (with investment returns) will fund future claim costs.

Are ACC costs "out of control"?

The Minister of ACC has claimed that "ACC costs are out of control". This is untrue. However it is true that the number and claims is increasingly at a rate greater than population growth and the cost of claims is increasing at a rate higher than inflation. Reasons include legislation changes extending coverage, high increases in medical and physiotherapy treatment costs, and New Zealand's higher accident rates than other countries. The ACC Board has been considering, and implementing, operational changes to manage these costs and some legislative fine-tuning is necessary, but costs are certainly not "out of control".

As already noted ACC is also in a transition to full funding from pay-as-you-go. This has to be achieved by 2014 and is putting additional upward pressure on levies. The CTU supports moving the deadline to 2019.

Is the ACC scheme expensive?

ACC is one of the most cost-effective injury compensation schemes in the world. Employer levies (as a % of payroll) are more than twice as high in Australia, Canada, and the USA than under ACC in NZ. Similarly, comparable motor vehicle no-fault schemes (such as Victoria in Australia) have substantially higher motor vehicle levies.

Is ACC poorly governed and managed?

ACC is widely regarded internationally as a well run scheme. An extensive review last year confirmed that ACC is achieving international best practice and has comparatively low administration costs.

Has ACC suffered major investment losses?

Like all other investment funds ACC has suffered a reduction in the value of investments as a result of the international financial crisis. However, it has done better than almost every other fund manager, public or private

"For the Government to wrap legitimate concerns about slippage in ACC's performance in a whole lot of shrill scaremongering and scapegoating is gratuitous.

...ACC is a civilised and cost effective approach to dealing with the injured. Why undermine confidence in the scheme, unless you plant to undermine the scheme itself?"

Brian Fellow, Economics Editor, New Zealand Herald 12.3.09

over the past 12 months. In the first seven months of the current financial year to January 2009, ACC's investments showed a return of 2.73%

What is the billion dollar cost blowout the Minister and the media keep on about?

That is a reference to the increased taxation funding required from Government to fund the ACC Non-Earners Account. This has been caused substantially by increased, and costly, claims for medical treatment injury as a result of legislation changes passed by parliament in 2005, as well as increased medical treatment costs for non-earners' injury claims. In fact the amount is about \$300 million per year (\$1 billion over 3 years).

The government is concerned that this amount was not made public in the Pre-Election Fiscal Update (PREFU) which a Ministerial Inquiry has found was the fault of Treasury, not ACC.

Why has Ross Wilson been sacked as ACC Board Chair?



The real answer is probably that the National Government doesn't want a former union leader as Chair, and because of his known opposition to ACC privatisation. He has been replaced by an accountant who is an Associate Member of the NZ Business Round Table.

The reasons which have been given by the Minister and government spokespeople include: **"The ACC total liability for future costs of claims has increased from \$18 billion to \$22 billion over the past 12 months."** In fact the ACC Board is able to influence less than 20% of the increases in liability most of which is related to economic impacts beyond its control. Although this was the reason stated by the Minister in a letter to the ACC Board he is now quoted in the DomPost (11th March) as saying that the real reason is not controlling increases in physiotherapy costs.

"That ACC has suffered major investment losses." In fact the ACC investment performance is better than almost any other fund manager, public or private.

"Failing to force Labour Ministers Cullen and Street to disclose in the Pre-Election Fiscal Update the expected additional funds required for the ACC Non-Earners Account." In fact the Mills Inquiry only last week found treasury at fault and the Labour Ministers and the ACC Board were exonerated.

"ACC costs are out of control and financial skills are needed." The existing Board has a mix of skills and experience including financial. The new Chair has no knowledge of ACC matters.

"Not controlling increases in physiotherapy costs." In fact only the government can effectively control physiotherapy costs by legislative or regulatory changes.

"Deterioration in rehabilitation and return to work rates." In fact ACC has the best rehabilitation rates of any comparable scheme in the world (PWC Report 2008). There has been some decline over the past several years mainly due to legislative changes requiring ACC to do more to assist retraining etc. But ACC performance remains excellent on international standards.

"Unacceptable lev increases" ACC consulted on levies in October 2008 and all the pressures the Government is expressing surprise about were made public at that time.

"All this talk of liabilities being blown out is complete nonsense. It's ill-founded and smacks of scare-mongering, which, given the current economic picture is the last thing people need to be told.

...on paper the losses have ballooned when in reality there's nothing wrong with it."

Jonathan Eriksen, Managing Director, Eriksen & Associates
(international actuarial and strategic investment consultancy)

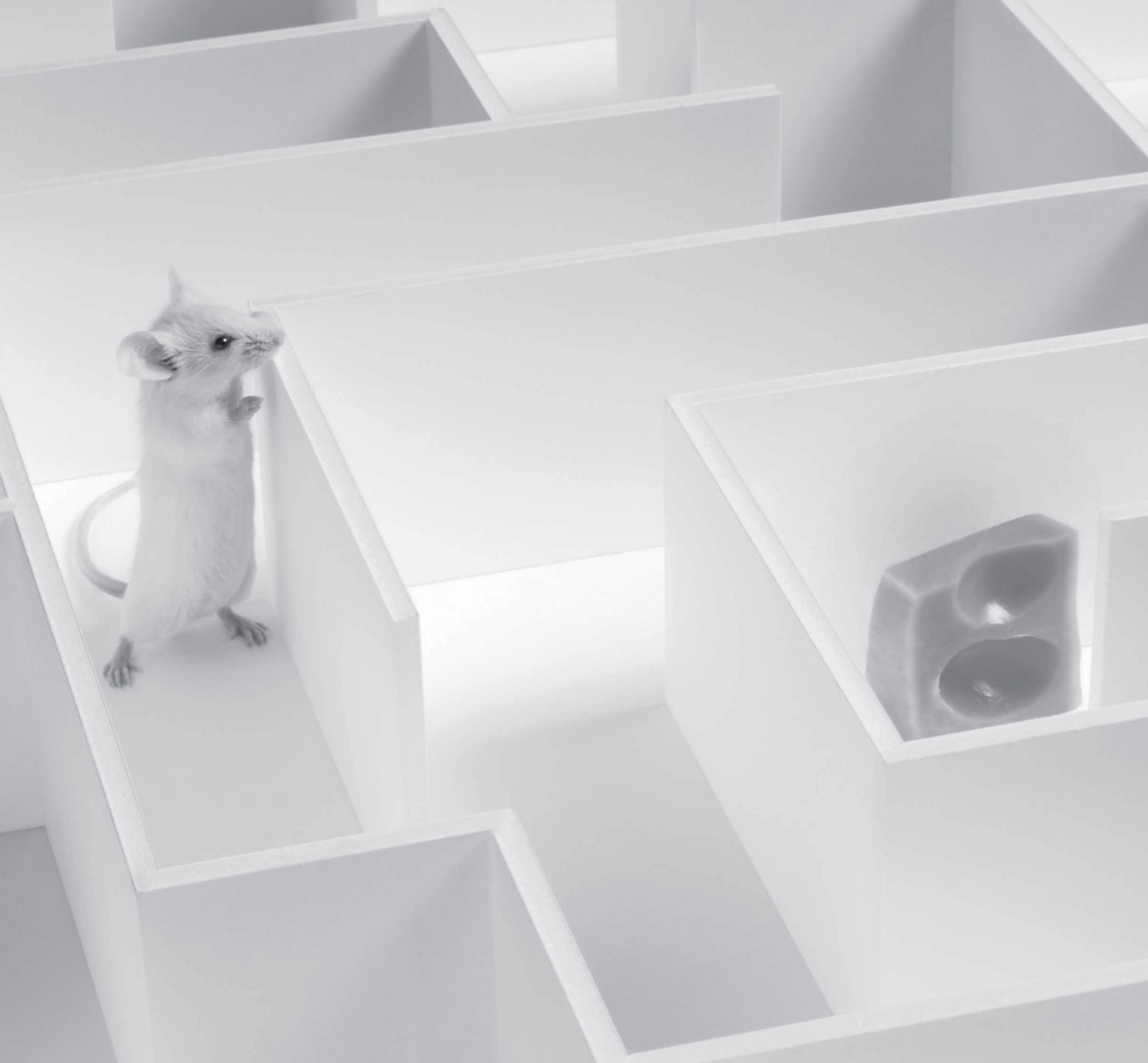
Voice your concern

CTU Secretary Peter Conway said in a media release on 9 March 2009:

"It is vital that a worker/union perspective remains on the Board and Board members should not be politically scapegoated and gagged by the Minister from disclosing the truth.

"We urge the Government to take extreme care in its deliberations on ACC. This scheme has been built up over decades and we do not want it destabilised. There is always room for improvement in any scheme and the Government should recognise the social contract basis of the scheme and work with social partners on issues"

13 March 2009



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