ASMS
TOI MATA HAUORA

26th Annual Conference

ANNUAL REPORT

2014

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Annual Report 2014

The major events and challenges since the 25th Annual Conference in November 2013 have been the 25th commemorative conference and visit by Professor Martin McKee, the development of strategic choices for the Association, and clinical leadership.

The National Executive comprises:

President	Hein Stander (Tairawhiti)
Vice President	Julian Fuller (Waitemata)
Region 1	Judy Bent (Auckland)
	Carolyn Fowler (Counties Manukau)
Region 2	Jeff Hoskins (Waikato)
	Paul Wilson (Bay of Plenty)
Region 3	Tim Frendin (Hawke's Bay)
	Jeff Brown (MidCentral) – National Secretary
Region 4	Murray Barclay (Canterbury)
	Seton Henderson (Canterbury)

Their biennial term expires next 31 March and elections for a National Executive to take office on 1 April will be conducted early in 2015. The constitutional amendment adopted by Annual Conference last year increases the term of the new Executive to triennial.

The National Executive will have met on six occasions in Wellington since the last Annual Conference.

On 19-20 February the National Executive held its annual two day meeting to discuss strategic directions for the year, the first day being informal. The informal day included:

- Planning for celebration of the Association's 25th year.
- Application of the Association's strategic direction developed in 2013 and planning for the national DHB collective agreement negotiations in 2016.

The National Executive agreed on the following actions:

1. Investigate the possibility of a research scholarship (discussed further below).
2. Develop background information on health spending (this became the *Health Dialogue* published in advance of the 25th commemorative conference).
3. Ensure that at least one medical or dental officer (general registrant) be on the Association's negotiating team for the next DHB MECA negotiations.
4. Invite the Chair of the Medical Council to meet the National Executive.

The National Executive was pleased to have the following guests attend parts of their meetings during the year:

- Ben McBride and John Marney from Treasury's health policy unit.
- Andrew Connolly and Philip Pigou, Chair and Chief Executive respectively of the Medical Council.

Other key activities were Joint Consultation Committees in the 20 DHBs, collective bargaining with non-DHB employers, and individual employment-related cases and disputes.

The national office comprises 12 permanent staff — Ian Powell (Executive Director), Angela Belich (Deputy Executive Director), Henry Stubbs (Senior Industrial Officer; part-time), Yvonne Desmond (Executive Officer), Cushla Managh (Director of Communications; commencing in March), Lyn Hughes (Industrial Officer; part-time), Lloyd Woods (Industrial Officer), Steve Hurring (Industrial Officer), Lyndon Keene (researcher; part-time), Lauren Keegan (Assistant Executive Officer), Kathy Eaden (Membership Support Officer; part-time), and Ebony Lamb (Administration Assistant; part-time). We engage additional accounting support on a weekly basis to assist with financial accounting and reporting. Terry Creighton (Administration Officer) resigned last December to take up another position. While we reassess our administration team capacity, we have filled his position with two temporary appointments.

Last year the National Executive established the position of Director of Communications. The position attracted a strong field of applicants leading to the appointment of Cushla Managh. She has had more than 20 years' experience as a journalist, including as a senior reporter, producer and presenter at Radio New Zealand, and in the press gallery for both the *Dominion* and *Auckland Star*. Immediately prior to her appointment she was engaged as a communications contractor for both the Health Quality & Safety Commission and the National Health IT Board. She has already made a move into social media, improved the professional appearance of *The Specialist* (including the use of cartoons), and improved internal Association publications.

At its July meeting the National Executive agreed to a proposal from the Executive Director that all permanently employed national office staff be entitled to (a) two weeks long service leave after each 10 years (based on the usual formula in those DHBs where this entitlement is provided to members) and (b) a redundancy entitlement based on the formula provided in the MECA.

The Association has for many years received valuable counsel and support from Bruce Corkill QC, barrister. He is no longer able to continue this service because of his well-deserved appointment as an Employment Court Judge. The National Executive is grateful for the excellent support Mr Corkill has provided the Association and wishes him well in his new life on the bench. We continue to use Bartlett Partners and other law firms for employment law and medico-legal advice.

Strategic Choices

In March the Executive Director attended a workshop organised by the Council of Trade Unions on strategic union leadership which discussed two contrasting concepts - strategic planning and strategic choice.

Strategic planning attempts to set out a vision and strategy of where the union seeks to go and provide a broad outline of the organisational structures necessary to move forward. *Strategic choice* is the process of turning the overall statement of direction into a means of ongoing decision-making.

In May the National Executive considered his report with a particular focus on strategic choice. Building on the Association's strategic direction reported in last year's Annual Report and discussed at the 2013 Annual Conference, he recommended a move towards strategic choice, looking at how we mobilise and deploy our resources.

In this context the Executive considered:

- Strategic leverage (eg, collective bargaining, Joint Consultation Committees).
- Organisational capacity (membership density, National Executive, branch officers and national office).

Five areas have been identified to form the basis of this approach:

1. *Membership density* – the Association's density is probably the highest in the country for a union. Density is the most critical thing for achieving influence. Consider setting a membership level objective, noting that in DHBs we have for some years been around 90%.
2. *Collective bargaining* – noting that the DHB MECA expires on 30 June 2016, how the Association focuses on addressing entrenched shortages of specialists in public hospitals and the relationship with unmet patient need.
3. *Membership empowerment* – involving a focus on clinical engagement, distributive clinical leadership and formal clinical leadership positions.
4. *'Know your collective agreement'* – the effective promotion of members' rights and entitlements including job sizing and professional development and education.
5. An accessible and comprehensive quality public health system.

The Executive held a special meeting on 16 October to further develop this approach. Background material was provided by the national office. The following emerged out of this meeting:

- The Association's high membership density (over 90% of permanently employed permanent senior medical staff in DHBs) gives us more influence and strength than if it was noticeably lower.
- The Association should continue its 'know your MECA' strategy, including advising members through *ASMS Direct* of specific entitlements under the theme of 'Did You Know'; membership workshops in DHBs (subject to resource practicalities of the industrial officers); branch officer training; and proactive organising over sabbatical.
- Develop the narrative, reinforced by `story-telling', in advance of the MECA negotiations with DHBs in 2016, highlighting the pressures and consequences of entrenched shortages; the challenge of coping with increasing unmet need; and the importance of investing in the DHB specialist workforce.
- Reaffirm that the promotion of the public health system is a defining feature of the Association.

25th Special Commemorative Conference

Recognising 2014 as the 25th year of the Association, the National Executive determined to hold a special commemorative conference on 26 August in Wellington. It invited Dr Martin McKee, Professor of Health Policy at the London School of Hygiene and Tropical Medicine and a Director of the European Observatory on Health Policies and Systems (aligned with the World Health Organisation) to speak at the conference and other events.

The conference had a quality range of speakers and panellists:

- National President Hein Stander on our strengths, foundations and branches.

- Founding National President George Downward reflecting on the first 25 years.
- Professor Martin McKee along with panellists Professor Peter Crampton, Colin James and Rod Oram.
- Dr Michael Chen-Xu reflecting on the next 25 years, along with panellists Dr Helen Frith and Medical Students Association President Marise Stuart.

The conference was well attended by 91 delegates and 28 observers, including four DHB chief executives, and was followed by a successful social function.

Features of Professor McKee's visit included:

- His theme of health spending as an investment contributing to economic wellbeing, not just as a public good, was well-received and is likely to form part of the Association's advocacy work and strategic direction.
- His presentation at Treasury with about 90 people attending (including Ministry of Health officials) and good engagement. He also met with the Acting Director-General of Health, Chai Chuah.
- His two presentations at the branch officers' national workshop the following day on (a) the state of the National Health Service in England and (b) the use of social media.
- His presentations in both Christchurch and Auckland were well received and generated good discussion.
- Coverage of both his visit and the conference in the *Otago Daily Times*, Radio New Zealand's *Checkpoint* programme (as well as news bulletins), and *NZ Doctor*, which ran articles online and also a page and a half (three articles) in its printed magazine.
- His addresses (two in Wellington, one each in Christchurch and Auckland) were videoed and are now posted on the website.
- His participation at the APAC forum the following week organised by Ko Awatea (Counties Manukau) and the Victoria Department of Health in a workshop chaired by the Executive Director.

The National Executive is appreciative of the organisational work of the administrative team led by Yvonne Desmond and the media profile and organisational work of Cushla Managh.

Following Professor McKee's final presentation (APAC), the Executive Director was approached by the Chief Executive of Waitemata DHB suggesting they and the Association jointly sponsor a visit by Professor McKee to Waitemata next year. This is currently being explored.

While the first 25 years and next 25 years featured in the commemorative conference, the National Executive is looking to emphasise the role of the Association founders during the November Annual Conference.

Incoming Minister of Health

When each new government takes office, government departments prepare a document called a 'Briefing to the Incoming Minister' (BIM) for each of the cabinet portfolios. These have sometimes been enormously powerful. Non-government organisations have picked up this BIM approach and accordingly the incoming Minister of Health is the recipient of a number of documents framing issues in the sector based on the views of many drafting organisations.

The National Executive initially decided to submit a BIM to the new Minister of Health, Dr Jonathan Coleman. A small working group, including the National President, National Secretary and Executive Director, met on 10 October to develop a draft document. Discussion evolved into a different approach, noting that the Executive Director had congratulated Dr Coleman on his appointment, advised the Association's willingness in a collaborative relationship with him, requested an introductory meeting, and invited him to address Annual Conference.

The working group drafted a letter from the National President outlining why it was advantageous to the Minister and to the health system to actively engage with the Association given its expertise and experience. That letter was delivered in a distinctive form (including the ASMS 25th commemorative mug). The letter developed our theme that in order to get world-leading health care, New Zealand must have equitable health care gained through distributive clinical leadership by a stable, energised specialist workforce in DHBs.

On the same day the letter was delivered, the Executive Director received a positive response with the Minister agreeing to meet Association representatives (on 6 November) and address Annual Conference (on 27 November).

The National Executive, at its meeting on 16 October, considered a BIM to follow up the letter to the Minister, but, given the progress that had been made, this was unnecessary. We could present him with our recent publications on the temperature of the specialist workforce in DHBs and health spending myths at the 6 November meeting. This meeting was positive. The Association was represented by the National President, Vice President, National Secretary and Executive Director. The Acting Director-General of Health also attended. There was mutual willingness expressed to actively engage over a range of matters, acknowledging that from time to time there will be different views on some of them.

Life Membership

In our 25th year the Association has five life members – Drs John Hawke, James Judson, George Downward, Allen Fraser and Peter Roberts. The Constitution (6.2) states that the National Executive, branches or individual members can nominate and that the Annual Conference determines life membership. The National Executive has a formal process and criteria for life membership.

1. The three national officers (President, Vice President and Secretary) meet each year to decide on possible nominations (if any) for life membership of the Association.
2. They seek advice, including from the Executive Director.
3. They report their recommendations (if any) to the National Executive at its first or second meeting of the year.
4. The National Executive considers the recommendations (if any) and nominates any life membership for ratification at the next Annual Conference.
5. Before forwarding the recommendation for life membership the nominee/s will be asked in advance if they would accept nomination.
6. Annual Conference determines life membership.

In respect of criteria the Executive has two measures:

1. Contribution to the Association that is extensive in terms of duration and value.
2. At any time there are likely to be only a few life members.

Based on the recommendation of the national officers at its February meeting, the Executive nominated Dr Brian Craig for life membership.

Dr Craig is a psychiatrist employed by Canterbury DHB. He was elected to the National Executive as one of the Region 4 (South Island) representatives in 1995 and served as National Secretary from 1997 until standing down in 2013. Dr Craig has also been active in local Canterbury Association's activities since our formation and continues to be involved on the Canterbury JCC.

Clinical Leadership – Distributive and Formal

The National Executive attaches high priority to promoting distributive clinical leadership as promoted *In Good Hands*, the *Time for Quality* agreement and in the national DHB MECA, and also advice to members in or considering formal clinical leadership positions. Clinical leadership is promoted through the Joint Consultation Committees and in our various communications. The Deputy Executive Director, with the assistance of her industrial team, is developing some practical advice for members about applying the principles of distributive clinical leadership in an environment of financial constraint and resulting managerialism.

The Executive is developing practical advice for members in or considering taking up formal positions of clinical leadership (eg, clinical director, head of department).

The draft document will be circulated to branch officers and a network of selected chief executives, chief medical officers, clinical directors and human resource managers. After consideration of feed-back and further discussion by the Executive it will be published and distributed to members and DHBs as either an *ASMS Standpoint* or *ASMS Advisory*.

Employment Relations Amendment Bill

The Employment Relations Bill progressed slowly through the parliamentary process in 2013-14. Its thrust is retrograde in that it seeks to reduce existing rights of collective bargaining and increase the vulnerability of employees. The Association's concerns are largely around the Bill's provisions that would:

- Weaken a union's ability to bargain, removing the duty of both parties to conclude a MECA by allowing a party (almost always the employer) the ability to apply to the Employment Court to say bargaining is concluded.
- Provide for an employer to opt out of a MECA and, less importantly, the same time frame for initiation of bargaining between employer and union.
- Increase vulnerability for new employees (in particular international medical graduates) by removing the 30 days when a new appointee is automatically covered by the terms and conditions of an applicable collective agreement in place in their workplace.

The Government had hoped to pass the Bill in the last parliamentary session before the general election but, with the resignation of ACT MP John Banks and the opposition of the Maori Party, the Government lost its majority. However, it regained a majority in the new Parliament and the Bill has been the first to be quickly passed. The National Executive will have to consider implications of the law change, especially in respect of removal of the 30 days protection.

Official Information Act: Health, Safety and Privacy Implications for Members

The Association has advised and supported a number of members in the past year who have been the subject of Official Information Act (OIA) requests seeking information about them, their work and their research interests.

In one case a lobbyist for the tobacco industry sought detailed information about a member's CME expenses for accommodation and food while attending a conference about the adverse health effects of tobacco. This occurred within the broader context of attacks on public health professionals by social media bloggers with the intention, the Association believes, of discrediting and silencing them. This practice has been detailed in Nicky Hagar's *Dirty Politics* and Professor Martin McKee's recent article in the British Medical Journal, *Social media attacks on public health advocates* (BMJ 2014;349:g6006).

In that particular instance, a DHB took a very supportive role, refusing the request for information on the grounds it breached the member's privacy and had no public interest, being a contractual matter between the DHB and the member.

Another challenging OIA request involved an ACC client accessing private information about ACC Branch Medical Advisors (BMAs). ACC initially refused to provide this and the client appealed to the Ombudsman. The Ombudsman decided the client's right to information was limited to viewing the names of BMAs, but not being given a copy of that list. There is nevertheless a risk for some members of even these details being made public, particularly where work performed on behalf of a public entity may be of a controversial nature.

A third OIA request involved a journalist requesting individual statistics about the number of complaints received and the number of procedures performed by a particular member. The DHB declined to provide this information as it considered it a breach of the member's privacy. The Ombudsman took a preliminary view that such information is in the public interest, and should be made available so that performance comparisons can be made publicly available. The Association took strong issue with this preliminary view on the basis that it undermines the Health and Disability Commissioner's policy, which is designed to allow clinicians to openly and honestly disclose mistakes they or others have made in the knowledge this information will be used to enhance patient safety, but not be used to publicly blame or humiliate the clinician. The Association also believes that going down the path of 'league tables' will erode and undermine collegial approaches to the practice of medicine. The Association has had support for its view from the Health Quality & Safety Commission, the Medical Council and the DHBs' Chief Medical Officers Group.

Activity in the Non-DHB Sector

It has been a relatively quiet year for negotiations but Angela Belich, Steve Hurring, Lloyd Woods and Lyn Hughes have all been involved at some stage. Negotiations have been difficult due to cuts in funding in many cases. We rely on support from members at these sites and are very grateful for the work they put in on behalf of the ASMS and their colleagues. Non-DHB membership has increased slightly.

General Practice

This year has seen a continuation of a 'buy up' of general practices across the country and a subsequent increase in the number of general practitioner employees. We have not actively recruited in this area but are slowly getting expressions of interest, particularly where there are several doctors employed. In many cases the initial employment packages look favourable but these tend to fall off over time due to a lack of annual increases or automatic progression through salary steps. These are not easy places to organise, let alone negotiate collective agreements, but our long-term strategy is to increase membership density among salaried general practitioners. We are negotiating a new collective agreement in Golden Bay and are at the early stages for another at a student health practice (owned by a separate trust rather than a university).

Our biggest GP grouping is the multi-employer collective agreement called the 'Doctors MECA' that we have with the four Wellington Union Health Centres. We have 18 members and expect

more when we renegotiate later this year. Our biggest stand-alone practice is Te Runanga O Ngati Toa Hauora in Porirua with 14 members (up two). Overall we have 12 GP based sites covered by eight collective agreements (one still to be finalised.)

Rural Hospital Medicine

Most rural hospital medicine specialists (vocational registrants in a faculty within the College of General Practitioners) in New Zealand are Association members, either through their DHB employment at smaller hospitals such as Greymouth, Ashburton, Thames, Taupo and Queenstown, covered by the national DHB MECA or employment on Association-negotiated collective agreements in non-DHB sites such as Hokianga, Dunstan and Oamaru. Numbers are steadily increasing as we see the demand for 'generalists' at smaller sites increasing. There are some challenges around shift work or on call conditions.

Hospices

We renegotiated our Hospice MECA this year and included two more employer parties. We have 11 hospices inside the MECA and have managed to almost get a 'mirror document' to that of the DHB MECA. We have single members at four other hospices and have a collective agreement at one of them (Otago). Eventually we expect to bring all into the Hospice MECA.

ACC

We have 26 members at ACC employed as Branch Medical Officers. We finally concluded the renegotiation of their collective early in 2014 after a difficult struggle. ACC was determined to bring in a performance appraisal and pay system and after a lot of effort to include suitable safeguards, this was reluctantly agreed. Notably our members all enjoyed good salary increases but time will tell if this has been a good move. We have had some personal cases at ACC and also some serious issues around the release of private information.

Agreements at Other Health Services

We have collective agreements at Family Planning, Queen Elizabeth Hospital, NZ Blood Service and Compass Health. Family Planning is the biggest with 19 members and Queen Elizabeth Hospital now has only one member. We continue to move towards parity with the DHB MECA, with varying degrees of success.

Summary of Non–DHB Matters

The non–DHB sector is very large and, in terms of GP practices, we have only 'dipped our toes'. There is scope for increased recruitment but this is resource intensive once establishing employment agreements is taken on. We continue to look after our non-DHB members and continue to grow in this area.

Industrial Team Activities

The Association has a very experienced industrial team of six, led by Deputy Executive Director Angela Belich and including Senior Industrial Officer Henry Stubbs and Industrial Officers Lyn Hughes, Lloyd Woods and Steve Hurring.

Lyn Hughes has responsibility for Northland, Waitemata, Auckland and Counties Manukau DHBs; Steve Hurring for Waikato, Lakes, Bay of Plenty, Hawkes Bay, Tairawhiti, Taranaki, Whanganui and MidCentral DHBs; and Lloyd Woods for Wairarapa, Hutt Valley, Capital & Coast, Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs. Henry Stubbs has responsibility for medico-legal issues, mentoring, developing and codifying advice to members; he also takes referrals from other members of the team.

Much of the work is offering advice by telephone or email to members about their entitlements, the application and interpretation of their employment agreements and advising, representing and otherwise supporting them as they respond to complaints arising from their employment

and other workplace issues. The team is based in Wellington but travels frequently to meet both members and management. The team meets together at least monthly to ensure advice is consistent, to discuss more challenging issues and to develop resources for members.

Quality of Human Resources & Employment Relations Advice

Our industrial officers find themselves contending with a significant variation in the quality of human resource and employment relations advice across the employers we deal with, whether in the DHB or non-DHB sector. Where the human resource staff are experienced and open to engagement with the Association, there are fewer employment relations problems and those that do arise are quickly and amicably resolved.

On the other hand, where the human resource service is inexperienced or prone to act unilaterally, silly and unnecessary problems arise that require more industrial officer effort and time to roll back or correct.

We have noticed an increase in more complex individual 'case work', as opposed to the usual email and telephone enquiries. This increase requires more time out of the office meeting members face-to-face, with a corresponding increase in time spent travelling throughout the country.

Job Sizing

Advice and assistance in job sizing is an important part of the industrial officers' work but a number of DHBs have now completed their big job size reviews and we are likely to be assisting members deal with job sizes at a service level and a noticeable erosion of non-clinical time by 'clinical creep'.

Backpay Claims

A number of substantial back pay claims, some involving hundreds of thousands of dollars have been resolved during the year, resulting in substantial payments to individuals or groups of individuals. These claims have arisen either from back-dated job size reviews or the incorrect application of provisions in the national DHB MECA or other historical agreements.

Bullying Complaints & other Inappropriate Workplace Behaviours

Personal or relationship conflicts within the workplace appears to have increased and are likely to grow as public understanding and intolerance of bullying and harassment in the workplace grows. These cases are complex, time consuming and emotionally demanding for all concerned. Increasingly they are being resolved with the assistance of independent external investigators. An uncomfortable development is members' expectation that the Association should assign different industrial officers to support both the complainant and the member being complained about. In these situations we have to be very careful not to transfer the members' dispute to the Association office, being waged by Association industrial officers acting as proxies for the principal protagonists.

Service Reviews and Changes to Working Arrangements

Stringent financial constraints under which DHBs and other employers are operating have led to an increase in service and wider organisational reviews; some relating to the search for 'new models of care'; others in the quest for immediate cost savings through 'efficiencies' or cost shifting, all heightening workplace anxiety and consuming large amounts of members' energy and time, often to little apparent effect.

Advice to New Appointees

Members of the industrial team continue to provide a very positive and welcome service to prospective and new employees before they accept and take up their new appointments. The Association's updated and improved website is a useful resource for applicants.

International Medical Graduates

The New Zealand health service relies heavily on international medical graduates (IMGs) to fill our hospital vacancies. Inadequate orientation, cultural and societal differences or an IMG's own naïve assumptions and expectations usually underpin the problems too many IMGs encounter. The Association is determined to work with employers and other agencies to address this problem and to make our health service a more welcoming place for the large number of IMGs who we will continue to rely on for the foreseeable future.

Complaints by or about Members

The industrial team has seen further increases in complaints against members and a more adversarial, less tolerant approach by DHBs with regards to these complaints. In some cases this has resulted in harsher penalties for members than in previous years.

Despite the industrial team endeavouring to have complaints dealt with informally in the first instance, it is becoming commonplace for formal processes to be instigated by DHBs much earlier than in the past.

Long-term Illness and 'Return to Work' Plans

It is pleasing to note there has been a reduction in the number of members experiencing long-term illness requiring lengthy periods of time off work and a graduated return to work plan. A small number of members have had to give up work or had their employment terminated on grounds of ill-health. Our industrial officers are experienced and sensitive when supporting members in these difficult and stressful situations.

Annual Leave Issues

An increasing number of DHBs are beginning to grapple with the complexities of our members' annual leave entitlements and their recording. A member's contractual entitlement to annual leave is certain and prescribed (usually six weeks, converted to working days or hours) but the rate at which annual leave is debited from a member's accrued leave is by no means prescribed or certain: there is no nationally prescribed number of hours that should be deducted for a day, a session, a clinic or a list. How should non-clinical time, a member's after-hours call or other "non-scheduled" hours be accounted for when the member takes leave? It's not easy and different employers have developed their own systems.

It becomes even more complicated in those services where individual members or groups of members may have 'negotiated' and agreed on practices many years ago; in some cases it can be argued that these practices are contractually embedded within particular employment agreements. Some DHBs have successfully addressed this issue but others are struggling and will do so for as long as they fail to accept that long-standing practices may have a contractual basis.

'Involuntary' Termination of Employment

Involuntary terminations include: dismissals, resignations or retirements on grounds of poor health or in anticipation of dismissal (usually in response to a looming disciplinary process or investigation of some kind) and redundancy. This year the team has dealt with 11 'involuntary terminations'.

Mediation and Major Employment Law Cases

There is one major case in the pipeline for the Employment Relations Authority (ERA) and probably the Employment Court and two other potentially big cases (one for a group of members, the other for a dismissed member) that may well require aggressive prosecution by the Association and our legal advisers. During the year, the Association has taken six cases to formal mediation, with successful outcomes for the member(s) in all instances.

Health Sector Relationship Agreement Steering Group

Four meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group have been held this year with the fifth clashing with Annual Conference. The participants are the Ministry of Health (through the National Health Board), all 20 DHBs, and each of the CTU-affiliated four main health unions (NZ Nurses Organisation, Public Service Association, Service and Food Workers Union, and the Association). All are signatories to the HSRA. The significance of this body is that it is the primary means by which the Government, through the Ministry of Health, DHBs and health unions, engages on a national level.

Participation in the Steering Group continues to be a valuable opportunity for the Association, a regular feature is the opportunity to raise current issues at the beginning of each meeting.

The main issues and agenda items in the meetings have been:

- An excellent presentation from Professor Gregor Coster, Chair of WorkSafe New Zealand, the crown entity arising out of the Pike River tragedy, on the health and safety bill currently before Parliament (with strong multi-party support) and the role of this new agency.
- The new direction of Health Benefits Ltd with increasing DHB control.
- DHBs' collective bargaining parameters in the context of this year's difficult negotiations covering mental health nurses, allied health professionals and clerical staff.
- The State Services Commission's integrity survey with particular reference to the poor performance of DHBs in respect of bullying relative to the rest of the sector.
- Concern over intimidation of public health specialists in the areas of tobacco control, sugary drinks and alcohol. This was raised by the Association but the discussion broadened to include fluoridation.
- Two sessions with Health Workforce New Zealand which demonstrated a lack of awareness of the state of the specialist workforce in DHBs.
- Regular reports from the National Director of the National Health Board on NHB issues.
- Presentation from the State Services Commission on its general election guidelines.
- Consideration of a survey of HSRA Steering Group members on how the group functioned last year (generally positive and constructive).
- The effect of intense financial pressures on the quality of DHB decision-making (raised by the Association).

National Joint Consultation Committee

The National Joint Consultation Committee is set up under the national DHB MECA for the purposes of constructive engagement and decision-making between the Association and the DHBs collectively. This year it met four times. All four meetings have been useful and stimulating, including discussions with Pharmac, Health Benefits Ltd, the Medical Council, Health Workforce New Zealand and the National Health IT Board. Other issues were the resident medical officer pipeline (mainly PGY1), travel insurance (where the option of purchasing insurance for annual leave days was regained), the Vulnerable Children's Bill, partnering for better care, quality and issues that emerged from JCCs.

Joint Consultation Committees

In their ninth year of operation JCCs are a vital part of the Association's work. Three JCCs have been held in each DHB this year except for Wairarapa (two held). Overall, attendances have improved compared with the previous year.

The following have been raised in all (or nearly all) JCCs:

- We have initiated discussion on the extent of distributive clinical leadership relevant to service design, configuration and delivery by senior medical staff who do not hold formal clinical leadership positions. The objective is that management provides to each JCC a written summary, in advance, of distributive clinical leadership in new initiatives since the previous JCC. Progress has been uneven and slow but incremental and has led to some useful discussions.
- At the beginning of the year we asked each DHB for their response to the recommendations of the report of the New Zealand Oral Health Clinical Leadership Network Group to the Ministry of Health (2012) titled *Oral Health Services for High Needs and Vulnerable Populations*. We were seeking to ensure that the report was on their radar and it led to a number of positive and useful discussions.
- We are obtaining the contracted FTE data for specialists, medical officers and resident medical officers that DHBs provide to the National Health Board for the end of March and September. This is the data the former Minister of Health used as the basis for his claims on hospital doctor numbers; we are also seeking a breakdown of permanent and fixed term appointments for senior medical and dental officers.
- The change of direction of Health Benefits Ltd involving greater DHB control, most immediately in the work on Finance, Procurement and Supply Chain but also in the decision to abandon the work on human resource information systems.
- We are looking at what is being done to improve quality of care in individual departments, arising out of discussion at the National JCC, with a view to discussions with the Health Quality & Safety Commission next year. Owing to its abstract nature this has been difficult to pursue, the best discussion being at Waitemata over their early work developing specialist-led quality indicators in departments.
- Arising out of the national workshop of branch presidents and vice presidents on 27 August, we have started to raise the inadequacy of administrative, secretarial and typing support.
- Promotion of our August publications *Taking the temperature of the public hospital specialist workforce* and *Reality Check: the myth of unsustainable health funding and what the Treasury figures actually show*.
- Sabbatical use (indications that these conversations are generating some increased interest and applications but there is also retrenching by Auckland DHB).
- Medical Council's new prevocational curriculum framework requirements (now concluded).
- Clinical engagement in Pharmac's role with medical devices (now concluded).
- Placement of post-graduate year ones and consequential 'pipeline' issues (now concluded).
- In some JCCs there are regular updates on information technology developments.
- In some JCCs either the planning for or evaluation of joint senior medical staff engagement workshops.

In addition to the above, some issues specific to individual JCCs were:

Northland — encouraging taking of sabbaticals; car parking; risks of making 'bad' appointments; and masterplan for the public hospital sites in Whangarei and Kawakawa.

Waitemata — failure to engage affected members in important surgical appointments and job description design; priority of workforce requirements for facilities planning; and quality indicators in departments.

Auckland — the financial position in the context of the end of the last financial year and medical staffing costs; misleading management comments on CME usage; impact of 'management churn'; new leadership structure; annual leave liability; application of sabbatical entitlement; and the implications for the DHB and its staff of the health and safety bill currently before Parliament.

Counties Manukau — development of a list of members 'gripes'; hospital-wide wireless; loss of quality radiology registrars; environmental sustainability project; car parking; managerial responsiveness to improvement initiatives from senior medical staff; Project Swift (IT); poor quality and range of food; senior medical staff involvement in appointment processes; failure to move radiology service into a new building; information technology including performance of the DHB's servers; and a withdrawn unilateral attempt to change the CME application form.

Waikato — pressures to make large financial savings; Ministry of Health's review of DHB; cultural obstacles to engagement in distributive clinical leadership; teleconference with the Chair of Medical Council on prevocational curriculum framework; CME policy issues; drafting a handbook on job sizing; and a forthcoming 'medical efficiency review'.

Bay of Plenty — position of Medical Director (Chief Medical Officer); lack of a hospital-based oral health unit; barriers to senior medical staff engagement; preparing for departmental planning of clinical work; the new Clinical Health Information Portal; car parking pressures; and campus planning.

Lakes — disengagement with psychiatrists in key decision-making; failure to adhere to MECA appointment clause in clinical director positions; DHB document on values and commitments (*The Lakes Way*); need for minimum acceptable safety standards in departments; internal audit of overseas travel arrangements and CME approval process; and implementation of Concerto.

Tairawhiti — targeted areas for financial savings; feasibility study into potential for collaboration with private hospital over surgical services; mental health staffing levels; review of services on East Coast; delays in implementation of Concerto; lack of consistent approach to provision of electronic devices; and inconsistent application of annual leave.

Taranaki — high level of clinical engagement in base hospital upgrade; review of sabbatical policy; application of sabbatical entitlement; use of CME funds for 'tools of the trade'; and proposed performance appraisal policy.

Hawke's Bay — DHB's *Transform & Sustain* programme to improve health and wellbeing; concern with over-use of fixed term appointments; use of psychometric testing for clinical leadership positions; 'donating' of part of JCC time for a staff session with Treasury officials; frustrations with progress over central region IT system (CRISP); an initiative on the health and well-being of doctors; and the results of a survey on resident and senior medical officer engagement.

Whanganui — extra burden of high numbers of short-term locums; management upset over Association survey of commitment to distributive clinical leadership; CME policy; hospital wireless system; management initiated proposed job sizing of after-hours' call arrangements and 'non-clinical activity'; central region IT agreement; possibility of a joint chief executive with MidCentral; and chief medical officer appointment process.

MidCentral — disconnect between some members and their clinical leaders; deterioration of financial position; capacity pressures in ophthalmology service; failure to adequately staff psychogeriatric service; risk of inappropriate disclosure of clinical data; draft strategic plan with Whanganui DHB; and new draft CME devices policy.

Wairarapa — sub-regional collaboration with Hutt Valley and Capital & Coast DHBs; upgrade of Central Sterile Services Department; the need for better engagement over management's approach to employment of locums; and a review of the high dependency unit.

Hutt Valley — sub-regional collaboration with Capital & Coast and Wairarapa DHBs; lack of progress by management on business case over need to recruit more specialists to the emergency department; Association survey of commitment to distributive clinical leadership; proposed establishment of a new clinical council; new approach to conflict resolution; concerns over engagement with pathologists in laboratory reviews; and recruitment issues.

Capital & Coast — fluoridation; auditing compliance with MECA appointment clause; potential privatisation of public hospital laboratory; and sub-regional collaboration with Hutt Valley and Wairarapa DHBs (the final JCC for the year will be held soon).

Nelson Marlborough — approach to capital expenditure; structure of appointment committees for Nelson and Marlborough; meetings between clinical leaders and managers over 'culture' and relationships; application of 'Top of the South' review; strategic workforce planning; physical space pressures in intensive care unit; information technology infrastructure; CME reimbursement processes; and negative media publicity over elective surgery (specifically a negative comment from a senior manager).

West Coast — redevelopment of Grey Hospital and the Buller site; Trans Alpine collaboration; payments to GP registrars; problems with DHB's stores working through Canterbury; review of role of rural nurse specialists; discontinuation (subsequently rescinded) without clinical input of the thrombolysis care service by South Westland nurses; and maternity care in Buller.

Canterbury – location of oral health services in new hospital rebuild; increased workload pressures in mental health; and pressures on specialists to approve force feeding of patients in prisons.

South Canterbury — insufficient planning for arrival of new general surgeon; lack of engagement with physicians over purchase of new exercise machine; hospital site redevelopment plan; draft policy on provision of cellphones as 'tools for the trade'; protracted physician job sizing process; information technology failings (eg, emergency medicine discharges) and initiatives including eSCRB and travel insurance concerns.

Southern – lack of adequate resourcing for echocardiography; access to operating theatres for after-hours acute surgery in Dunedin Hospital; processing of CME applications; confusion over sabbatical policy; development of a profile of the DHB's population and services in order to be used for service planning; urology staffing levels; staffing levels in Kew Hospital emergency department; administration review; differences in the availability allowances between Otago and Southland; workloads in mental health; and the DHB's draft strategic health services plan (including misleading assertions about medical staff employment costs).

Joint Association-DHB Engagement Workshops

For six years the Association and individual DHBs have been holding joint senior medical officer engagement workshops. Almost always they are a half-day and have involved the rescheduling of elective activity.

In the year December 2013 to November 2014 there have been workshops at:

- Waitemata (Service development and planning, Professor Richard Bohmer on organisational performance, and the Medical Council Chair on the prevocational training curriculum framework).
- Counties Manukau (Project Swift and the Medical Council on Chair on the prevocational training curriculum framework).
- Taranaki (evaluation of the new acute services block and distributive clinical leadership).
- MidCentral (secretarial and administrative support for SMOs, achieving equity in access to elective clinical services, and initiating and managing change within a DHB).
- Capital & Coast (medical officer job satisfaction and stress, burnout in legal situations, and the need for recovery time).
- Canterbury (updates on innovation and progress in cardiology, COPD response, recovery after surgery, use of IT, electronic prescribing, medical physics, facilities planning, and environmental sustainability).

National Branch Officers' Workshop

In 2011, following the first nationally coordinated elections for the newly established branch officer positions of president and vice president, the National Executive trialled a national branch officers' workshop as a form of orientation. In both 2012 and 2013 two workshops were held.

This year the National Executive held one workshop in recognition of the time commitment also required to attend the 25th commemorative conference. It was held the following day (27 August) beginning with a moving tribute from Branch Vice President Neil Stephen to Hutt Valley Branch President Sheila Gordon who had recently passed away.

There was a major session on local 'burning issues' identified by the branches. The main issues were:

1. CME, including variance in application across the country in part due to differences over what is interpreted as 'reasonable' (eg, accommodation), reimbursement process delays and pettiness, and managerial obstructiveness.
2. Sabbaticals, including equity of access, transparency, treatment of very small services, and blanket refusals to accept eligible applications by some clinical directors.
3. Targets and unmet patient need, including financial constraints impacting on patient care, punitive measures when an elective target isn't complied with, inability to develop a service taking 'need' into account, managerial 'gaming' to achieve targets and key performance indicators, and distorting clinical priorities.
4. Time for non-clinical duties, including 'clinical creep' encroaching on to this entitlement.
5. Resident Medical Officer-related issues, including the need for community practice for PGY1 & PGY2, extra time for supervision and training, and the difference in work-life balance between senior and resident medical officers.
6. Inadequate administrative, secretarial and typing support for senior medical officers. This is now being raised by the Association in the Joint Consultation Committees.
7. Information technology deficiencies.

Other features were:

- A stimulating and interesting presentation on the National Health Service in England by Professor Martin McKee.
- The use and relevance of social media supplemented by an introduction to our new revamped website and a fascinating insight on social media from Professor McKee from a public health standpoint.
- Supporting international medical graduates. The National Executive is now considering ways of progressing this important issue.

Membership Electronic Surveys

Since the last Annual Report the Association has conducted three electronic surveys of DHB-employed members. As well as the very useful information gathered, we also learnt some valuable lessons particularly with respect to ambiguous questions.

Between 13 November and 9 December 2013, the Association conducted a survey of all members employed by DHB's on distributive clinical leadership. The response rate was good, with 1,060 (30%) of the total 3,537 DHB members who received the survey completing it.

- 47% of respondents felt their DHB was not genuinely committed to 'distributive clinical leadership' in its decision making processes.
- Over half of the respondents (54.6%) felt the culture of their DHB did not encourage 'distributive clinical leadership'.
- Wairarapa had the highest number of senior medical officers (86%) who felt that their DHB was not committed to distributive clinical leadership, followed closely by Southern (68%) and Bay of Plenty (67%).
- Canterbury and Lakes had the highest number of respondents who felt their DHB is committed to distributive clinical leadership (62% and 56% respectively).
- Members at West Coast and Canterbury DHBs believe their senior management is promoting distributive clinical leadership. The majority of respondents from South Canterbury, Bay of Plenty and Hutt Valley feel senior management are not doing enough to promote distributive clinical leadership.
- Human resources departments had the poorest results across all of the DHBs with most respondents feeling they did not enable effective distributive clinical leadership to any extent.
- A comment box for respondents to provide feedback on the topic of distributive clinical leadership. This was a very successful feature with many senior medical officers providing feedback and suggestions which have been included as part of the survey results.

The second survey took place between 14 May and 6 June 2014 and was intended to provide a snapshot of the senior medical officer staffing situation in DHBs. The response was disappointing, with only 637 out of 3616 members replying despite a very encouraging initial response (166 responded in the first 24 hours). It appeared that some members were aware that their clinical director was answering on behalf of the department and therefore didn't respond. We were subsequently able to disaggregate some of the responses and hopefully limit double counting of departments, but this was a useful lesson as to what questions we ask and of whom.

On a national, DHB and specialty level, some interesting findings emerged:

- Recent overseas recruits are concentrated in some DHBs and specialties. The three Auckland DHBs appear to have had most of their latest service or departmental vacancies filled by a New Zealand-trained recruit. A second group is fairly evenly split between overseas recruits and New Zealand-trained applicants (Canterbury, Capital & Coast, Hutt Valley, Nelson Marlborough and Taranaki). For all other DHBs, the last departmental recruit was from overseas, sometimes by an overwhelming margin of respondents.
- Most members in anaesthesia departments reported that their recent recruits had been New Zealand-trained, as did diagnostic and interventional radiology, paediatrics, general surgery, geriatric medicine, intensive care, orthopaedic surgery, pathology and public health medicine. By way of comparison, most respondents in psychiatry, obstetrics and gynaecology and medicine reported that the last recruit in their specialty came from overseas.
- Members were also asked how easy it is to fill vacancies in their service or department, with 36% of people saying it was hard to fill vacancies, 36% that was reasonably easy and 16% that it was easy.
- The number of respondents saying vacancies were hard to fill outnumbered those saying it was easy to fill in the following DHBs: Hutt Valley, Lakes, Nelson Marlborough, Northland, South Canterbury, Southern, Wairarapa and the West Coast. Some suggested this was because it was difficult to find applicants that met particular requirements.
- Nationally, 29% of respondents said their service or department was recruiting. Of that group, 57% reported they were looking for one senior medical officer, with 24% reporting recruitment for two senior medical officers and 7% for three (two respondents reported that their department was looking for four, one that their department was looking for five, and one for six).
- In response to a question about how many FTE they believed their department should have, which we then compared with their responses about current FTE, 44% of respondents said they needed at least one to two more FTE. Another 15% said they needed three to four, 11% said they needed between five and nine more FTE and 4% said they needed more than 10 more FTE in their department. In contrast, 24% said that the FTE in their department didn't need to change and 2% of respondents said they needed fewer FTE.
- Some commented that their DHB regarded the department as fully staffed or that there was no funding for extra staff despite a job sizing, College visit or increased workload indicating that more senior medical officers were needed

Between 17 July and 15 August 2014 we ran an electronic survey of new appointees. It was sent to 471 members who were new appointees in DHBs and had started employment in the past two years. A total of 226 new appointees completed the survey – 48% of the total approached. A good response rate and the spread of DHBs and specialities seem to indicate that it is representative. Results of interest include:

- A 50/50 split between international medical graduates (IMGs) and New Zealand graduates.
- 45% came to New Zealand for lifestyle or work-life balance.
- 30% sought Association advice before taking up their appointment; 38% of New Zealand trained doctors did so but only 22% of IMGs.
- Nearly all of those who sought Association advice found it helpful.
- 35% rated the support they received from the DHB as excellent whereas 73% rated the support they received from their colleagues as excellent.
- 29% had a DHB mentor.

- 75% believed DHBs had provided them with all relevant information.
- 20% were appointed to fixed term positions.
- Some of the reasons given for a fixed term appointment were of questionable legality.

Social Media Opportunities

In July 2013 the National Executive considered the results of an electronic membership survey on social media, specifically its usage by members (which was reported in the 2013 Annual Report). Based on the relatively low membership usage, potential risks and resource implications, the Executive resolved not to pursue social media further, at least at that stage.

Subsequently the Association created, and appointed to, the position of Director of Communications. Soon after her arrival she discussed with the Executive Director her advice that our non-use was a wasted opportunity and, on his request, prepared a report on the opportunities that social media might provide the Association. This was considered by the National Executive at its July meeting.

Three points in the report stood out when considered by the Executive:

1. In July 2013 the Executive was looking at members as users. Her report looks from the standpoint of access by the media, opinion makers and the public.
2. The Association can be on social media without us being involved and our names can be used by others on social media. If we don't shape our use of social media, others will shape it for us (but not with our interests in mind).
3. There are options within the various forms of social media to reduce resource implications. Further, when the Executive has previously considered this issue we had not established the position of Communications Director.

She recommended the Association establish a Facebook page and promote this to members and others; update the current ASMS Wikipedia entry (created by others); establish a LinkedIn page for the Association, investigate the feasibility and risks of using QR codes, develop a schedule of blog posts to use on the website; look into the feasibility of a mobile MECA application; and, after six months of Facebook use, establish a Twitter account for ASMS.

These recommendations were adopted by the National Executive in July and are being incrementally implemented with the Facebook page commencing in August and LinkedIn in September. The Wikipedia entry for the ASMS is in the process of being updated. Plans to develop a mobile MECA application have been overtaken by a refresh of the ASMS website, which now includes a searchable MECA on the site.

The ASMS Facebook page has a small but growing following, currently numbering 111. It is early days for the ASMS' foray into social media but so far it is going as expected. Data from the page shows the most popular items to date have included coverage of the Trans Pacific Partnership Agreement (TPPA), the ASMS 25th commemorative conference and Professor Martin McKee's visit, an article by political commentator Colin James about health being more than simply fixing up sickness, media coverage of high-level clinical resignations from Southern DHB, an interview with Ian Powell about the Southern DHB, and an essay on the end of life by Atul Gawande. Most viewings of the page happen in the early morning or at night, and mostly from within New Zealand.

The next step will be to establish an ASMS Twitter account which will enable us to follow some of the top commentators on health issues globally and within New Zealand.

National Bipartite Action Group

The National Bipartite Action Group (NBAG) was established in 2010 as the result of a joint settlement between the 20 DHBs and the three other main health unions affiliated to the Council of Trade Unions (Public Service Association, Nurses Organisation and Service and Food Workers Union). Since then the Resident Doctors' Association, APEX and the Medical Laboratory Workers Union have signed up to the terms of reference and are now full members of the NBAG. The Association remains an observer.

NBAG meets two monthly on a face-to-face basis with a one hour teleconference in the intervening month. The Deputy Executive Director attended the six face to face meetings this year plus two teleconferences.

There has been ongoing and quite pointed engagement with Health Benefits Ltd at these meetings, particularly over its failure to consult, engage and produce grounded proposals.

Useful progress has been made with a consensus between DHBs and unions over vaccination guidelines, adverse weather guidelines and agreement that the Auckland DHB efforts to bind people who get jobs in one Auckland DHB to pay back redundancy paid by another are inappropriate. Information about other union bargaining is useful from time to time. Progress on training the unregulated workforce and on the DHB/NZNO safe staffing initiative is also of interest.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

The Association has been running this survey since 1993, but the survey's purpose has changed over the years. Originally it was used to compare DHB (or their predecessors) salary levels for the purposes of single employer collective bargaining. Now it provides information on the number and gender of senior doctors and dentists, and their spread over the salary scale. The survey is of base salary as at 1 July 2014.

The information supplied by DHBs this year was on 4,230 specialists (1,420 females and 2,810 males) and 527 medical and dental officers (249 females and 278 males). This is an increase of 208 specialists since last year and an increase of 7 medical officers.

There has been an increase of 1.2% in the mean salary of specialists from 2013 and an increase of 0.8% for medical officers. The highest average base salary for specialists is in Wairarapa and the lowest in Counties Manukau. The highest average base salary for medical officers is at Tairawhiti and the lowest is in Auckland.

For the last nine years we have had good data on the gender of senior doctors. Half (50%) of specialists on step one as at 1 July are women; 20.5% of those on step 13 are female. This is probably a cohort effect as the increasing numbers of female students and registrars work their way through the system. Also of interest is the distribution of senior doctors on the salary scale. There are 1,411 specialists on step 13, and 509 on step 3 as at 1 July.

Health Sector Directions Forum

This forum, on 27 June, has been held for a few years now post-Budget. It is attended by representatives of unions, DHBs (including a few DHB Board Chairs) and senior Ministry of Health officials. Executive Director Ian Powell, Deputy Executive Director Angela Belich and Researcher Lyndon Keene represented the Association. The level of trust is now such that the discussion has become much more valuable. Though the presentations are fairly predictable, the discussion is less so.

This forum had presentations by;

- Chai Chuah (Acting Director–General of Health) on the direction of travel of the system.
- Treasury officials predicated on low levels of overall government spending.

- Ministry of Health officials on the actual budget outcomes for Vote: Health. Discussion covered the difficulties of maintaining this restrained spending over time with both threats to infrastructure and pent up wage demands.
- Bill Rosenberg, the CTU Economist, showed that New Zealand's level of government debt was very low compared with the rest of the OECD. The Health shortfall this year was a 1.5% cut in real terms.
- Graeme Benny from Health Workforce New Zealand. His assertion of an oversupply of doctors rather than an undersupply of positions was challenged by the Association.

Another forum is to be held on collective bargaining settings that unfortunately clashes with Annual Conference.

Medical Workforce Taskforce Governance Group

Last year Health Workforce New Zealand established a Medical Workforce Taskforce Governance Group in response to the challenges over the placement of increased numbers of post-graduate medical students into PGY1 positions. Through planning and coordination failures there were insufficient positions for these increased numbers. The Group is convened by HWNZ Chair Professor Des Gorman and included representatives of DHBs (Chief Executives and Chief Medical Officers), Medical Schools, Medical Council, Colleges and the Resident Doctors' Association. This year Executive Director Ian Powell was added and has participated in two teleconferences since May. Recently the New Zealand Medical Association and Medical Students Association were also added. A drawback of the meetings to date is that they have been by teleconference which seriously impacts on the ability for effective engagement. These concerns have been raised with Professor Gorman who is sympathetic and interested in having some of the meetings 'face-to-face'.

Features of the meetings have been:

- Compilation of data on the profile of the resident medical officer workforce including placements and positions, distinguishing between house surgeon and registrar, DHB regions and specific DHBs.
- The case to the Human Rights Commission by overseas medical graduates with NZREX.
- Basic premises of HWNZ funding of trainees who are New Zealand citizens and permanent residents. Both groups are given priority.
- Increased applications for doctors seeking to enter the December intake of the GPEP1 year.

In a significant step HWNZ has decided to widen the scope of this group to include the fuller career of the medical profession. This is a positive initiative that presents the Association with an opportunity to improve its input to medical workforce development.

Health Benefits Ltd

Health Benefits Ltd (HBL) is the crown entity charged with making $700 million cumulative savings (initially over five years but subsequently continually rolled over). HBL continues to be an important issue for the Association at National Executive meetings, National Joint Consultation Committee, National Bipartite Action Group and Joint Consultation Committees. The process, issues and concerns have been regularly updated to members in *ASMS DHB News*.

Earlier this year there was a significant change in HBL including senior staffing changes. Previously DHBs had felt were marginalised to one degree or another and cast into a reactive mode. Increasingly the work of HBL came under scrutiny and attracted criticism, including from the Association. DHBs were 'top sliced' to fund HBL's work, which has cost them several million dollars. In theory this was to be first recouped (before moving on to achieve large

financial savings) by savings but there is little sign of this materialising and many DHBs are sceptical whether the aspiration will ever be realised.

The significance of the changes in HBL is that DHBs now have considerably greater control over HBL with particular reference to the *Finance, Procurement & Supply Chain* business case. Other HBL initiatives include:

- Food services – the three Auckland DHBs are proceeding to establish a new 'metro' food service which includes moving from cook-fresh to cook-chill. The other 17 DHBs are reserving their decision and it is possible the objective of a national food service will not be achieved.
- Linen & laundry – a preferred national provider for linen and laundry services has been decided. But it appears that individual DHBs will have the right not to opt into it.
- HR information services – this ambitious project has been wisely shelved.
- IT infrastructure – this project is ongoing despite changes to the above initiatives. This is generally seen as a positive decision although doubts are emerging over its viability.

Overall, despite the avoidable de-stabilisation and financial losses, this change in direction is a move in the right direction. However, there is an underlying tension that may not be able to be resolved. This tension with its associated implications is over the difference between the northern 'Health Alliance' and South Island DHBs respective approaches.

The former is the shared service agency of the four northern DHBs. It is more structural, contractual and transactional. In contrast, the approach of the South Island DHBs is more relational and network-based and less transactional. It is difficult seeing how these different approaches can be resolved in a national initiative.

Southern Cross 'Think Tank' Initiative

On 9 May Executive Director Ian Powell and Researcher Lyndon Keene attended by invitation an all-day event in Auckland organised by Southern Cross in collaboration with Massey University which they titled 'Tomorrow's Healthcare Think Tank.'

It was attended by around 45 people, mainly from private sector interests, business and economics consultants, and some academics. A small number of Ministry of Health (including Acting Director-General) and Treasury officials attended. The only known DHB attendees were a Board Chair and Chief Medical Officer. The only other representative health professional organisations were NZMA and College of Nurses. The workforce was overwhelmingly underrepresented.

In an unusual move, with the exception of the keynote speaker (Sir Malcom Grant, Chair of NHS England) and the summing up session that followed him, Chatham House rules applied which limits any reporting to what was said but not who said it. This included Minister of Health Tony Ryall in his address and to a panel discussion involving representatives of the opposition parties. This was not due to any action by the politicians.

Presented to the gathering was a questionable survey conducted by the 'College of Health and Auckland Knowledge Exchange Hub' (Massey University). In particular, it was limited to 32 of the participants in a process where a private health insurer and hospital operator with obvious vested commercial interests had a significant influence in determining the interviewees. Despite this, the results did not provide support for the position that the private sector and private health insurance, in particular, should be more involved in publicly provided services, although it did assert that 44%, in response to what were the big issues facing New Zealand's health sector, identified 'revise current funding and allocation strategies', including compulsory health insurance and introduction of user charges.

There were three separate panel sessions, although the standard of contributions was variable and not well connected:

1. Health sector efficiency and quality.
2. Current funding and allocation strategies.
3. Public health promotion initiatives.

Following these panel discussions and the other speakers there was a session that struggled to pull things together and during which Ian McPherson, Chief Executive Southern Cross Healthcare (he also gave the opening address), tried to put the case for private health insurance being part of the policy mix and private hospitals doing more or all of DHB electives, that would be developed by a new 'think tank'. The purpose of this appeared to be to create a climate conducive to the promotion of the private health insurance market and hospitals in which Southern Cross is the dominant player.

On 12 May Dr Ian McPherson emailed the Association inviting us to participate in a 'think tank'. At its meeting three days later the National Executive determined to take no further action on this request. He has continued to lobby government over this initiative up until the general election. This is expected to continue in the new parliamentary term.

Concept of an Association Research Scholarship Attached to a University

In part arising out of a suggestion at the previous Annual Conference and further discussion the previous day at its informal strategic planning meeting, at its meeting on 20 February the National Executive adopted the following resolution:

> *That the national office investigates the concept of a research scholarship attached to a university.*

The investigation was carried out by Researcher Lyndon Keene. The tenor of his conclusion, after identifying advantages and disadvantages, is that the Association should not go down this path.

There are too many legitimate requirements by the universities which would be rigidities for the Association including, for example, relating to intellectual property and publication rights. There is also the potential for conflicting directions the student might want to take.

The National Executive decided to proceed no further on this matter although it noted the advice from Otago that if a donor organisation wished to have a very specific research project undertaken, it would be better to approach their research department to commission the work.

Council of Trade Unions

The Association first affiliated to the Council of Trade Unions (CTU) in 1990. As in previous years the Association continues to benefit from our affiliation at both a national office level and with the affiliates. This was evident this year by its advocacy over the formation of WorkSafe New Zealand and the health and safety bill before Parliament, and the Trans Pacific Partnership Agreement. Its work on analysing health spending and Vote Health in the Budget continues to be very valuable. The Executive Director usually attends the CTU's quarterly National Affiliate Council.

There have been three National Affiliate Council meetings to date. Issues considered by the Council included:

- The new health and safety reform bill.
- The Employment Relations Amendment Bill.
- The Vulnerable Children's Bill.
- Trans Pacific Partnership Agreement.
- The plain cigarette packaging bill.

Meetings with Director-General of Health

The Executive Director had four scheduled meetings this year plus a teleconference and an additional meeting with the Acting Director-General of Health, Chai Chuah. These meetings are very useful to the Association. They are an opportunity to raise issues, perspectives and differences that might not otherwise be brought to the Director-General's attention. Topics included:

- The Acting Director-General's interest in enhancing leadership in DHBs (including clinical).
- Direction of Health Benefits Ltd.
- The 25th anniversary of the Association and the Professor Martin McKee visit.
- Southern Cross 'think tank'.
- Confusion over regional and sub-regional DHB collaboration.
- Grey Hospital business case.
- Difficulties in specific DHBs.
- Social media attacks on public health and other specialists.

International Travel

The following international travel was undertaken by national office staff since the previous Annual Conference:

- Executive Director Ian Powell and Deputy Executive Director Angela Belich reported positively on their attendance at the APAC Conference in Melbourne in early September. Organised by Ko Awatea (Counties Manukau DHB) in collaboration with the Victoria Health Department, it was also attended by National President Hein Stander in a personal capacity along with, from New Zealand, a number of other specialists and some DHB chief executives and managers. Subsequently there have been informal discussions with Ko Awatea about possible future collaboration.
- The Executive Director attended both of the Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation. The first was in Canberra in April. Issues discussed included the dispute over proposed radical changes to the employment of senior doctors in Queensland public hospitals; employment prospects for doctors in Australia; a new collective agreement for specialists in Western Australia; and the Queensland Audit Office report into private practice arrangements in public hospitals.
- In September the Executive Director attended the second Industrial Coordination Meeting held in Sydney. Some of the issues he reported on were employment of salaried doctors in Queensland public hospitals in the aftermath of the settlement of the bitter dispute; the anti-bullying regime under Australia's federal employment law; the unsatisfactory resolution of the public sector 'wages' dispute in New South Wales; further progress in representation of resident medical officers in New South Wales; and pressures to restrict CME entitlements in Victoria.
- The Deputy Executive Director is attending a conference on the theme of 'Healthy People Successful Economy' in Melbourne on 13-14 November organised by the World Medical Association and Australian Medical Association (both Federal and Victoria).
- The Executive Director is attending a two day conference organised by Physicians for a National Health Programme (a doctors group advocating for a universal health system) on 'Seeking Health Equity' in New Orleans on 14-15 November.

Association Publications

The *Specialist*, the Association's quarterly newsletter (generously sponsored by MAS) is a cornerstone of our advocacy and communications work. Since the last Annual Conference the failure of DHBs to support distributive clinical leadership (two issues based on membership electronic surveys), climate change, and teaching doctors have been the feature of issues from December to September.

Other feature articles were on the following subjects:

- 'When did you last remember why you became a doctor?' (National President Hein Stander's Presidential address).
- Queensland specialist employment contracts dispute.
- Community water fluoridation.
- Greymouth Hospital – a test case.
- Health and the proposed Trans Pacific Partnership Agreement.
- The Auditor-General's report on regional health service planning.
- Drilling down in clinical leadership.
- The risk of fatigue for patients and doctors.
- Interviews with past and current National Presidents in 25th year.
- A snapshot of senior medical officer staffing in DHBs.

In addition, issues covered included:

- 2013 senior doctor and dentist salary survey in DHBs.
- Recovery time.
- Taking the temperature of the New Zealand medical workforce.
- A quarter century of Association engagement.
- Taranaki DHB going the extra mile for international medical graduates.
- Five minutes with Jeanette McFarlane (commencement of a new series of interviews with members).

There have been regular columns by the National President, Executive Director and the Medical Protection Society.

With the June issue we introduced cartoons (two per issue) by cartoonist Chris Slane as a new feature of *The Specialist*.

ASMS DHB News supplements *The Specialist* and plays an important role in local matters and supplying other relevant information. The main theme in all *DHB News* has been the joint consultation committees. This communication vehicle is adapted for our members employed outside DHBs, largely in relation to collective bargaining.

We have continued our email publication, *ASMS Direct*, which is produced on an as-needed basis. It is increasingly being used by journalists as a resource and source of information and comment. *ASMS Direct* links with news items on the website homepage. The membership circulation list is over 3,900. Four issues were produced between the last Annual Conference and the end of last year with a further 14 issues to date this year. Some focussed on reporting the summary results of electronic membership surveys, promotion of 25th commemorative conference in August, alleged fraud case by Southern DHB against South Link Health, promotion of the APAC conference, and Medical Council matters (appointment of new Chair and review of advertising by doctors).

Other subjects covered included:

- Coverage of the 2013 Annual Conference.
- Whakatane senior medical staff support for administrative staff over Health Minister's 'back office cap'.
- Employment Relations Amendment Bill.
- Pharmac proposal to list a range of wound care products.
- Queensland specialist employment contracts dispute.
- 'Battle' over Grey Hospital at West Coast DHB.
- Warning to Southern DHB members over management's approach to consultation.
- Auckland DHB's financial panic.
- Concern over impact of Trans Pacific Partnership Agreement on health.
- The Budget and Vote Health.
- Waikato DHB chief executive appointment controversy.
- Counties Manukau DHB after-hours' food options.
- NZNO petition for funding to support a one-year entry 'nurse entry to practice' programme.
- Association Facebook page launch.
- New Minister of Health.
- Collective agreement deliver pay rises.
- Whale Oil attacks on public health specialists.

The national *ASMS Direct* is also supplemented by local *ASMS Directs* on Association activities and local issues, mainly around the Joint Consultation Committees.

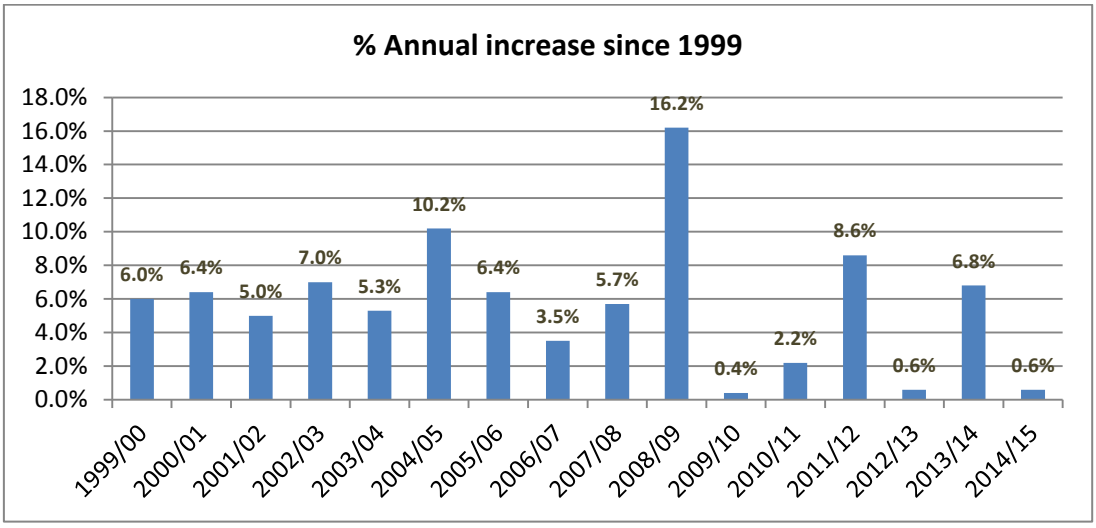
Four issues of our electronic publication, *Executive Direct*, reported on the February, May, June and September Executive meetings.

The Executive Director has for several years had a regular column in the fortnightly *NZ Doctor*.

Membership

Once again the Association has had a record membership year (the fourteenth in succession). Membership, as of 31 March 2014 was 4,167 compared with 3,901 at 31 March 2013 representing an overall increase of 266 (6.8%). It represents a 189% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 140 senior medical and dental staff this year; to date 211 bargaining fee payers have converted to full financial members.

It is interesting to note the annual membership pattern increase since 1998-99 (the last year where we had a membership decrease): 1999-2000 (105 – 6%), 2000-01 (118 – 6.4%), 2001-02 (98 – %), 2002-03 (146 – 7%), 2003-04 (117 – 5%), 2004-05 (239 – 10%), 2005-06 (164 – 6.4%), 2006-07 (95 – 3.5%), 2007-08 (162 – 5.7%), 2008-09 (486 - 16%), 2009-10 (15 - 0.4%), 2010-11 (76 – 2.2%), 2011-12 (306 - 8.6%), 2012-13 (23 - 0.6%) and 2013-14 (266 – 6.8%) an overall increase of 125% over this period.



The annual average increase since our formation is 109 (7.6%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the average annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, to date the annual average increase has been 169 (8.5%).

Currently membership is 4,222, an increase of 55 since 31 March 2014. Although membership growth in the latter part of the year is generally offset by factors such as retirements that arise at the end of our financial year, we expect the 31 March 2015 membership to exceed current numbers. The combination of actively recruiting new members and strong membership loyalty continues to be the key to our effective representation in both collective and individual matters.

About 90% of our members pay their subscription by automatic salary deduction (about 82% of new members employed during the past year opted for fortnightly payments).

Despite incomplete information, it remains the case that few Association members are also members of the NZMA. Those who were NZMA members at the time of joining the Association represent an estimated 10% of our current members; 14% of members who joined the Association in 2014 were also members of the NZMA compared with 22% in 1996.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves our industrial officers working with the MPS representatives and lawyers on specific cases which have been to the benefit of members. There has been a

small restructuring in the MPS New Zealand office with the roles of 'Head of Professional Services' and 'Operations Manager' disestablished to be replaced with one new 'Country Manager' position to which Rebecca Imrie was appointed.

In August the Executive Director, Deputy Executive Officer and Senior Industrial Officer met MPS Medical Director Dr Rob Hendry while visiting New Zealand. This was a positive discussion which included:

- Representation of our common members and a possible review of our Memorandum of Understanding agreed in March 2012.
- Making greater use of the Cognitive Institute (based in Brisbane and owned by MPS) to help members develop and improve their workplace relationships and communication skills.
- MPS assistance to research the incidence of difficulties faced by international medical graduates in their first few years in New Zealand.

The two organisations are also endeavouring to organise a meeting between their medico-legal advisers and our industrial officers later in the year.

Medical Assurance Society

The Association's collaborative 'preferred provider' relationship with MAS continues to strengthen. This includes the Society's substantial sponsorship of *The Specialist*. The Society has generously agreed to continue to sponsor the pre-Conference function this year (this sponsorship has been provided for several years). It also agreed to sponsor the visit of Professor McKee to New Zealand in August for the 25th celebration and hosted him for lunch. The National Executive is grateful for this generous support.

Quarterly advisory consultancy meetings between the Executive Director, Executive Officer and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Glenys Powell (no relation)) continue.

Discussions at these quarterly meetings have included the 25th commemorative conference and Martin McKee visit, the general election; tightening of hardline managerial attitudes in DHBs towards members' entitlements, the privatisation threat to the public hospital laboratories in Capital & Coast and Hutt Valley, our social media decision, the sub-regional collaboration challenges in Capital & Coast, Hutt Valley and Wairarapa, increasing signs of the marginalising of senior medical staff in DHB decision-making, and the Grey Hospital business case dispute.

Association Finances

The Association's financial position was further strengthened following another successful year. Higher than anticipated income levels have resulted in an after tax gain of $414,443 for the financial year ending 31 March 2014. The 2014 budget was for a surplus of $30,700. This outcome is due to a combination of fiscal responsibility, ongoing membership growth and bargaining fees exceeding expectations. The surplus has raised our cash reserves to $3,585,000.

The reserves policy adopted late last year is subject to annual review. It specifies target levels totalling $3,200,000 and incorporates four specific categories summarised below:

1. Operational Reserves Fund ($1,500,000) to cover six months' operating costs in the event that day to day funding is impaired or ceased;
2. Contingent Obligations Fund ($1,000,000). The theoretical cost of winding down or restructuring;
3. Major Litigation Fund ($500,000); and
4. Strategic Reserves Fund ($200,000) - collective bargaining.

Administration

The administration team now comprises Yvonne Desmond (Executive Officer), Lauren Keegan (Assistant Executive Officer), Kathy Eaden (Membership Support Officer), Administration Officer (currently temporary appointment) and Ebony Lamb (Administration Assistant).

The ASMS re-brand which incorporates the new logo and a fresh style is now complete. Taking inspiration from our gifted Maori name Toi Mata Hauora, we applied the pinnacles theme (representing both the peaks and facets of health leadership) across all of our publications, communications and signage. The Association's new website also reflects the new style.

After securing the lease of the whole floor of the Bayleys Building in 2013, the now concluded refurbishment of the additional space was completed in stages to minimise disruption. Improvements include increased natural light, additional work spaces to accommodate recent and future staff increases, a larger boardroom, extra meeting areas and retractable doors. Our new logo and branding have been incorporated into the refurbishment, showcasing our identity throughout the office.

Our focus on efficient communication with members continues, working closely with Communications Director Cushla Managh to streamline our numerous printed and electronic publications.

During the year much emphasis was put into creating an improved, functional website giving it a fresher look and making it easier to access the latest information by smart phone, tablet or computer, further strengthening our communication abilities in this important area.

Website

After a significant planning and development period the Association was proud to reveal its new website in August this year. The new site has been a great success and the redesign has delivered on all of the targets we hoped to achieve.

In contrast to the previous site, the new website, which has been built on the Wordpress platform, is far more efficient, allowing back-end administration to be completed with speed and ease. The redesign has been created with our users in mind, with the new layout easier to search through and navigate.

The website continues to attract, on average, over 2,500 unique users per month and we have incorporated some excellent new features such as:

- A searchable version of the national DHB MECA which allows users to text search any specific topic or clause they might be interested in, for example, parental leave.
- Links to various Standpoints and advice articles within the MECA allowing users to access in-depth information on issues of interest
- An online events calendar incorporating JCC and SMO senior medical officer engagement workshop dates, as well as Association Annual Conference dates and the ability to register interest for the Conference online.
- Improved search functions and related documents to allow users to easily find information on subjects of interest.

The updated website encompasses our new branding which has given the site a fresh, modern feel. The feedback to date indicates that our members are enjoying using the new website and we will continue to maintain and advance this essential piece of our toolkit.

Job Vacancies Online (jobs.asms.org.nz)

The vacancies section of the website advertises a comprehensive listing of senior hospital doctor and dentist job vacancies in New Zealand. With the update of the Association website we have

seen an anticipated rise in the amount of visits to the jobs section, jobs.asms.org.nz. The average amount of listings on the site at any one time is 50 and the vacancies section has over 860 unique visits every month. Most DHBs are now making use of our job advertising facilities and we have seen a rise in advertising from other employers.

Other Matters

Minister of Health's Annual Letter of Expectations to DHBs

Each year the Minister of Health sends all DHB chairs a 'Letter of Expectations'. This year's letter (30 January) focused on the national health targets (especially those that fit in with the Prime Minister's key result areas for public services – immunisation of children, rheumatic fever and reducing assaults on children). A new feature was the term 'clinical integration', referring to close collaboration between secondary and primary care. Clinical leadership featured as "important and remains essential", but reads as rote rather than the pivotal concept it was in previous Ministerial Letters. The Minister also referred to a new patient satisfaction survey developed by the Health Quality & Safety Commission, the requirement for Boards to strongly support implementation of the Health Benefits Limited savings programme, and that chief executives are to be held accountable by Boards, especially on keeping to budget.

Queensland Staff Specialists Dispute

The Executive Director closely followed the bitter dispute in Queensland where the state government fast-tracked employment legislation that enable it to unilaterally change, for the worse, the core terms and conditions of employment of staff specialists employed in public hospitals despite the fact that they were covered by a certified collective agreement. The Australian Salaried Medical Officers Federation, supported by Federal Australian Medical Association, fought an impressive rear guard campaign. While it failed to prevent the loss of the fundamental right to collective bargaining (a severe loss) it did manage to protect most of the employment conditions for currently employed staff specialists. However, it does mean that new specialists will be employed on remuneration up to 30% less than those currently employed for the same or similar work. What has emerged to date is that public hospitals are now struggling to recruit to positions vacant through attrition and facing increased overtime costs with an overstretched workforce. Consequently the Association has advised members considering taking up a position in Queensland's public hospitals not to unless there are exceptional circumstances.

Medical Council Prevocational Curriculum Framework

The Medical Council's work on pre-vocational training requirements was an emerging issue throughout 2013 and continued into this year. Deputy Executive Director Angela Belich attended a further stakeholders meeting convened by the Council on 7 April which followed the sign-off of the new curriculum by the Council earlier in the year. While the Council believes that this change will not increase workloads of specialists in DHBs, there are doubts from others, including Association members. The new framework has been the subject of discussion in all JCCs. It has been pleasing that Council Chair Andrew Connelly has been willing to meet with doctors to discuss the change including the National Executive and giving presentations to two joint Association-DHB engagement workshops.

Medical Students Association

In September the New Zealand Medical Students Association approached the Association about developing a closer working relationship. This was welcomed by the National Executive as a positive initiative and as a first step we have encouraged and helped fund NZMSA to send observers to our Annual Conference. We are also setting up a meeting between the two associations to explore this opportunity further.

New Zealand Climate and Health Council

The National Executive received a request from the NZ Climate and Health Council in September to support a letter endorsed by some professional organisations titled 'Health Professionals Call for Action on Climate Change and Health.' Last year's Annual Conference voted to urge the government to take immediate action to mitigate the detrimental effects of climate change on New Zealanders by ensuring that government policies and actions support environmentally sustainable practices. However, while sympathetic to its tenor, the National Executive did not believe it had sufficient mandate to endorse the detail of the Council's letter.

Surveying DHB Senior Medical Staff Superannuation Entitlements

The superannuation figures supplied by DHBs have proved to be increasingly problematic as memory of the closed NPF and GSF schemes fades and we have found it hard to get accurate figures from DHBs. After querying some unlikely responses a few times, DHB figures show 323 senior doctors are on the NPF or GSF schemes. The bulk of our members (3,749) are receiving an employer subsidy of up to 6% for superannuation under the national DHB MECA.

NZMA Specialist Council

Last year the Association was been invited to send a representative to the New Zealand Medical Association's Specialist Council (the NZMA also has two other councils for general practitioners and doctors-in-training). No Executive member is also an NZMA member and none are Wellington-based where the meetings are held. It was agreed that Judy Bent would attend. To date she has attended two meetings in March and August (plus the NZMA Annual Meeting in May) with the subjects including the Medical Workforce Taskforce, designated nursing prescribing rights, promotion of the Medical Council election process, Vulnerable Children's Bill, timeframes for resolution of complaints to the Health & Disability Commissioner, and the Southern Cross affiliated provider scheme.

New Zealand Rural Clinical Directors Forum

On 21 October the Executive Director gave a presentation on clinical leadership to the first Rural Clinical Directors Forum which was held under the auspices of the Royal New Zealand College of General Practitioners. He also participated in a panel discussion.

Employment Exit Survey

For some time the National Executive has been receiving the results of an 'exit survey' of those members who resign their membership. This is usually due to retirement, moving overseas or moving to another DHB (where overwhelmingly they rejoin). The national office invites these members to respond (the response rate is around 30%). Reports are provided twice a year. The Executive is interested in aggregating some of the data over a period of time which may be useful for the Association's advocacy but some of the questions in their current format do not lend themselves to this new direction. Consequently the Executive has approved changes to the questionnaire.

2015 Annual Conference

Under Clause 10.1(a) of the Constitution, the National Executive has the authority to determine the date and place of the Annual Conference. It has determined that in 2015 the Conference should be held in Wellington on 19-20 November (Thursday-Friday).

Jeff Brown
ASSOCIATION NATIONAL SECRETARY 12 November 2014