ASMS ANNUAL REPORT 2017

ASMS 29TH ANNUAL CONFERENCE 2017

ASMS
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Note: The quotes used throughout this annual report are from ASMS surveys of members.

CONTENTS

FOREWORD

Another busy year for your Association has drawn to a close. Highlights have included:

- The conclusion of negotiations for a new multi-employer collective agreement (MECA) for DHB-employed members. This took nearly 14 months including ratification and involved considerable work by your negotiating team and national office staff. We were pleased to eventually achieve what we consider a good settlement.
- The Association has continued to build good relationships, and strengthen existing ones, with key individuals and organisations in the past year.
- The Association's industrial officers continued to robustly and effectively support our members during the year with advice, representation and advocacy.
- Our policy team continues to produce high quality analysis and original research that help senior doctors and dentists have a clearer voice in the wider discussions about our public health system.
- Our communications team produces high quality publications, timely and pertinent media statements, and critical support to the policy and industrial teams.
- The Association's administrative staff continued to provide high quality support to members, National Executive and the rest of the national office.

In December 2016, the Association wrote to the then new Prime Minister Bill English, congratulating him on his election as Prime Minister and highlighting issues of relevance to the senior medical and dental workforce: the impact of severe financial constraints on DHBs, the lack of strategic investment in the health workforce, ASMS research on high levels of burnout, presenteeism and workforce intention, and failure to progress distributive clinical leadership among senior medical staff in DHBs.

These issues remain on the table following the general election in September and formation of a new coalition government. We will be pressing for progress in 2018.

I am pleased to present this report to members.

Jeff Brown
ASMS National Secretary

NATIONAL EXECUTIVE AND BRANCH OFFICERS

There has been one change in the National Executive since the last Annual Report. Region 1 representative Jeannette McFarlane resigned in February 2017 and was succeeded in a by-election by Julie Prior, who attended her first Executive meeting in April.

The National Executive comprises:

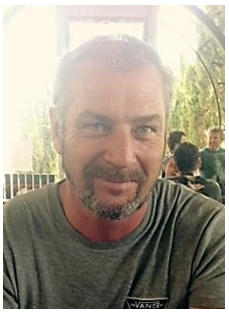
President
Hein Stander
(Tairawhiti)

Vice President
Julian Fuller
(Waitemata)

Secretary
Jeff Brown
(MidCentral)
Region 3

Julie Prior
(Waitemata)
Region 1

Jeff Hoskins
(Waikato)
Region 2



Paul Wilson
(Bay of Plenty)
Region 2

Tim Frendin
(Hawke's Bay)
Region 3

Carolyn Fowler
(Counties
Manukau) Region 1

Murray Barclay
(Canterbury)
Region 4

Seton
Henderson
(Canterbury)
Region 4

This is the first Executive to have a three-year term as a result of an amendment to the Constitution. Its term expires on 31 March 2018 with the new Executive taking office the following day. Nominations will be called before the end of the calendar year to enable an election ballot to be conducted early next year.

The Association has a democratic structure with branches aligning with DHB boundaries (or within them in three DHBs). Branch officers (branch President and Vice President) advise on issues of local concern and support branch members as needed. The current three-year term for branch officers ends on 30 June 2018. Nominations will be called in sufficient time to enable election ballots to be held before the end of the term.

The top decision and policy-making body is the Association's Annual Conference.

Your National Executive appoints the Executive Director and provides strategic direction for the Association and national office in Wellington. The Executive Director manages the operational affairs – including staffing, membership support and work programmes - of the national office and reports regularly to the Executive.

By the time of the Annual Conference, the Executive will have met five times in Wellington since November last year, and also held an Executive-only day. In the past year the Executive has confirmed the Association's strategic priorities, led negotiations for a new MECA for DHB-employed members, met face-to-face with key stakeholders (including the Minister of Health), initiated a review of the Association's Constitution, and considered the Association's position on a range of issues relevant to your work as senior doctors and dentists.

On the matter of the Constitution, the Executive formed a working group comprising National President Hein Stander, Executive members Murray Barclay and Tim Frendin, and Senior Industrial Officer Henry Stubbs. This group has been tasked with reviewing representation on the Executive, and management/governance issues. The results of their work, including constitutional amendments, will be presented to the Annual Conference.

The Constitution is available on the Association's website at https://www.asms.org.nz/wp-content/uploads/2015/04/ASMS-Constitution-2014-amendments_162343.2.pdf.

The strategic direction confirmed by the Executive at their February 2017 meeting included the over-arching theme of 'Achieving patient centred care', with sub-themes of unmet health need, entrenched shortages (under-supply of specialists), SMO workforce capacity, and workforce stresses. This direction has been reflected in the work carried out by staff in the national office, most visibly by the policy and research, and the communications, teams.

The Association's branch officers held their annual one-day workshop in Wellington in August 2017. As always, this was well-attended and generated good discussion across a range of topics. The agenda included discussion of the indicative membership MECA ratification ballot, the new MECA (including salary increases and steps, parental leave, new locum provision, and long service leave), the bargaining fee, 'Know your MECA' workshops being organised by industrial officers, updates on the Constitutional review and the work being undertaken on bullying.

During the term, the following branch officers resigned – Prieur du Plessis (Marlborough), Clive Garlick (Nelson) and Andrew Munro (Nelson) – and the National Executive thanks them for their contribution.

Your branch officers

BRANCH	PRESIDENT	VICE PRESIDENT
Northland	Ian Page	Lisa Dawson
Waitemata	Jonathan Casement	Ywain Lawrey
Auckland	Brigid Connor	Julian Vyas
Counties Manukau	Helen Frith	Sylvia Boys
Waikato	Annette van Zeist-Jongman	Annie Abraham
Lakes	Andrew Klava	Andrew Robinson
Tauranga	Matthias Seidel	Rod Gouldson
Whakatane	Richard Forster	Guy Rosset
Taranaki	Campbell White	Allan Binnie
Tairawhiti	Angela Freschini	Mary Stonehouse
Hawke's Bay	Kai Haidekker	Debra Chalmers
Whanganui	Bernd Kraus	Mark Van de Vyver
Palmerston North	Andrew Spiers	John Bourke
Wairarapa	Norman Gray	Naser Abdul-Ghaffar
Hutt Valley	Neil Stephen	Jeff Suen
Wellington	Justin Barry-Walsh	Sinead Donnelly
Nelson	Katie Ben	Rebecca Harris
Marlborough	Jeremy Stevens	Graeme French
West Coast	Paul Holt	Stuart Mologne
Canterbury	Anja Werno	Geoffrey Shaw
South Canterbury	Matthew Hills	Peter Doran
Otago	Chris Wisely	John Chambers
Southland	Timothy Mackay	Roger Wandless

Branch officers annual workshop 2017

Dr Chris Cresswell

The Association was greatly saddened by the death of Whanganui Branch President Chris Cresswell at the end of 2016. He died suddenly while mountain biking.

Dr Cresswell, aged 49, was the acting clinical director of the emergency department at Whanganui Hospital and was popular with his professional colleagues and well-respected in the community. He was passionate about improving the lives of his patients and working for broader change in the trade and environmental policies that affect people's health and wellbeing.

MEMBERSHIP

The Association has had another record membership year (the 18th in succession). Membership as of 31 March 2017 was 4,416 compared with 4,351 at 31 March 2016, representing an overall increase of 65 (1.5%). We had 1,440 members in our first year of existence (1989-90).

The following table shows annual membership increases since 1998-99 (the last year where we had a membership decrease):

Financial year	Total members	Increase	% Increase
1999-2000	1,856	105	6.0%
2000-01	1,974	118	6.4%
2001-02	2,072	98	5%
2002-03	2,218	146	7.0%
2003-04	2,335	117	5.0%
2004-05	2,574	239	10.0%
2005-06	2,738	164	6.4%
2006-07	2,833	95	3.5%
2007-08	2,995	162	5.7%
2008-09	3,481	486	16.0%
2009-10	3,496	15	0.4%
2010-11	3,572	76	2.2%
2011-12	3,878	306	8.6%
2012-13	3,901	23	0.6%
2013-14	4,167	266	6.8%
2014-15	4,271	104	2.5%
2015-16	4,351	80	1.9%
2016-17	4,416	65	1.5%

The average annual increase since our formation is 110 (7.1%). Under the period of the Employment Contracts Act (1991-92 to 2000-01) the average annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, the annual average increase has been 163 (7.9%).

Currently membership is 4713, an increase of 357 on the same period last year (the recent surge in numbers coincides with the ratification of the MECA and the imminent implementation of the DHB bargaining fee). Although membership growth in the latter part of the year is generally offset by factors such as retirements, we expect the 31 March 2018 membership to exceed current numbers.

85% of our members pay their subscription fortnightly by automatic salary deduction (about 70% of new members employed during the past year opted to do so).

"I find my DHB role rewarding, satisfying and challenging, both clinically and from an operations perspective."

NEGOTIATING THE DHB MECA

After lengthy negotiations, the Association managed to negotiate a new multi-employer collective agreement (MECA) for members employed by district health boards. The new MECA is effective from 1 July this year until 31 March 2020.

During the negotiations, which commenced in 2016, the DHBs tried to claw back some existing entitlements and rights, such as job sizing agreed hours of work, annual leave, sick leave, above-MECA remuneration in certain circumstances and, at the penultimate phase in the process, they attempted to undermine members engagement rights.

Your bargaining team successfully resisted every effort to dismantle or undermine entitlements and rights, and achieved what the National Executive considered to be a good outcome. As always, it was not possible to achieve everything we wished, such as improved remuneration for hours worked on after-hours' rosters and shifts. However, we agreed to establish a joint working group to work on remuneration for (a) average hours worked on after-hours call rosters and shifts, and (b) the availability allowance in order to "inform" the next MECA negotiations. This wording includes the legally important words "good faith". Significant gains have been made – especially in the areas of salaries (steps and increases), recovery time, and paid parental leave.

The negotiation team comprised:

- Executive Director Ian Powell as advocate, supported by Deputy Executive Director Angela Belich.
- All 10 National Executive members
- Ian Page, Northland (obstetrics & gynaecology)
- Jonathan Casement, Waitemata (intensivist and anaesthesia)
- Julie Prior, Waitemata (emergency medicine medical officer)
- Brigid Connor, Auckland (radiology)
- Julian Vyas, Auckland (paediatrics)
- Willem van der Merwe, Auckland (emergency medicine medical officer)
- Helen Frith, Counties Manukau (anaesthesia)
- Angela Freschini, Tairawhiti (anaesthesia)
- Kai Haidekker, Hawke's Bay (radiology)
- Neil Stephen, Hutt Valley (dentistry)
- Justin Barry-Walsh, Capital & Coast (psychiatry)
- Sinead Donnelly, Capital & Coast (palliative medicine)
- Andrew Munro, Nelson Marlborough (emergency medicine)
- Prieur du Plessis, Nelson Marlborough (orthopaedic medical officer)
- Anja Werno, Canterbury (microbiology)
- Matthew Hills, South Canterbury (medicine)
- Tim Mackay, Southern (dentistry).

Members of the ASMS MECA negotiating team (some absences)

1. Following the unanimous rejection by delegates at last year's Annual Conference of a formal proposal from the DHBs for the settlement of the MECA, the Executive Director was engaged in discreet discussions on how to find a pathway through what was an impasse. This led to the following process:

    - Informal discussions between considerably shortened team from both parties with the DHBs' team including chief executives and their external adviser.
    - Resumed formal negotiations with a larger but still shortened ASMS team leading to a provisional settlement on 21 June that both teams agreed to recommend for ratification.

2. On 22 June, the National Executive agreed to recommend the provisional settlement to members for ratification in an indicative ballot. The vote in favour was 91% although the turnout was our lowest ever at 50%. The National Executive then confirmed ratification (the chief executives had earlier ratified on behalf of the DHBs).

A summary of the negotiations and gains achieved is on the Association's website at https://www.asms.org.nz/wp-content/uploads/2017/08/Special-MECA-Bulletin.pdf. This was written before members voted to ratify the MECA and provides an overview of the issues involved.

A copy of the new MECA itself is at https://www.asms.org.nz/wp-content/uploads/2017/10/2017-2020-DHB-MECA-Signed.pdf.

It's also worth reading our Q&A about the new parental leave provisions at https://www.asms.org.nz/wp-content/uploads/2017/08/paid-parental-leave-FAQs-July-2017_168331.3.pdf.

Bargaining fee ballot

The ante penultimate episode of the DHB MECA negotiations saga was the bargaining fee ballot, which was conducted at all DHBs in mid to late August.

The process requires DHBs and the Association to agree that a bargaining fee will be levied on SMOs who are not members of the Association, and then for a ballot to be held at each DHB of both ASMS members and SMOs who are not members to decide whether a ballot will apply at that DHB.

That ballot resulted in the overwhelming majority of SMOs at every DHB agreeing that a bargaining fee will be levied.

Non-members have now had the opportunity to opt out of the MECA (and the bargaining fee).

The fee is now being taken out of bargaining fee payers' salary in four equal instalments over four successive pays beginning in the pay period following 15 September.

DHB	In favour	Against	Invalid
Northland	81	9	3
Waitemata	169	3	1
Auckland	247	24	4
Counties	113	1	0
Waikato	198	16	0
Lakes	37	2	0
Bay of Plenty	69	6	0
Tairawhiti	31	3	0
Taranaki	51	4	0
Hawkes Bay	81	5	2
Whanganui	31	3	0
MidCentral	82	3	2
Wairarapa	18	1	0
Hutt Valley	66	1	0
Capital & Coast	133	3	0
Nelson Marlborough	77	6	0
West Coast	16	0	0
Canterbury	230	10	0
South Canterbury	27	2	1
Southern	103	7	0

KEY EXTERNAL RELATIONSHIPS

The Association maintains a number of relationships with influential individuals and organisations. These relationships provide opportunities to communicate the concerns of members, articulate broader issues to do with the quality of public health care, work collaboratively on issues of shared interest, and to shape policy, decision-making and perceptions.

Some of these key relationships are outlined below.

The Minister of Health and Ministry of Health

The Association has a tradition of inviting the Minister of Health to address each year's Annual Conference. That happened last year and is due to happen again at the 2017 Conference. In addition, the Minister met with the National Executive for a frank discussion on a number of health issues, which was very useful. The then Labour health spokesperson, David Clark, also met with the Executive during 2017.

The Executive Director continued to meet regularly with the Director-General of Health, Chai Chuah, in the past year. These meetings covered a wide range of issues, including MECA negotiations, senior medical workforce intentions in DHBs, the proposed funding model for vocational medical training, the Ministry's relationships with DHBs, the proposed Waikato medical school, the 'High Performance High Engagement' (HPHE) approach, and issues involving specific DHBs.

The Association will be seeking to continue these meetings in 2018.

Sector meetings

New Zealand Health Symposium

The Executive Director attended the New Zealand Health Symposium in February, organised by the Ministry of Health. The core themes were 'Explore Innovate and Transform', with the programme focusing on the potential of new technology to transform the health system.

Health Sector Directions Forum

The Association attended the Health Sector Directions Forum in June 2017 and gave a joint presentation with the General Manager Human Resources at Waitemata DHB on 'building a shared approach to workplace wellbeing'. It was an opportunity to demonstrate that our MECA provisions and industrial approach, combined with the Association's policy and research work, offer strong levels for effective engagement with DHB leadership. Other presentations focused on harm reduction, fatigue and recovery time.

"I would like to see more flexibility in hours, eg school hours, in order to optimise time with family."

Medical Workforce Taskforce Governance Group

The Executive Director attended meetings of the Medical Workforce Taskforce Governance Group established by Health Workforce New Zealand (HWNZ). The meetings were chaired by Ken Clark, Chair of the Chief Medical Officers' Forum and Chief Medical Officer of MidCentral DHB. Attendees included the Chair of the Medical Council, HWNZ Chair, DHB Chief Executives national Chair, and representatives from a wide range of organisations including the New Zealand Medical Association, Council of Medical Colleges, Royal New Zealand College of General Practitioners, Faculty of Medical and Health Sciences at Auckland University, the ACC, and the Ministry of Health.

The meetings discussed the proposal for a new national school of rural health, proposed funding model for vocational training, and the Waikato medical school proposal. The meeting on 15 September discussed the medical school proposal further and agreed to write to HWNZ about the importance of longer term planning for a third medical school and workforce distribution for rural health training. This has since been done.

Chief Medical Officers' forum

The Association has engaged with the Chief Medical Officers' forum and the Health Quality & Safety Commission in the past year about the possibility of a Mid-Staffordshire situation happening in New Zealand, an issue raised by National President Hein Stander in his address to last year's Annual Conference.

National Joint Consultation Committee (NJCC) meetings.

These are a national version of the local JCC meetings and can be a useful forum to discuss matters arising at more than one DHB. The Association is normally represented by five Executive members (varies according to availability), the Deputy Executive Director and Executive Director.

Due partly to MECA negotiations and cancellations for other reasons, the only meeting in 2017 was not held until August. Issues discussed were 'High Performance High Engagement', 'Choosing Wisely', and the GMs HR shared approach to talent and leadership.

Health Sector Relationship Agreement (HSRA)

The Association has attended several meetings of the HSRA Steering Group during the year. These have been attended by representatives from the CTU affiliated health unions, DHBs and the Ministry of Health. Topics discussed have included new health and safety legislation, the 'High Performance High Engagement' approach, direction of the Ministry of Health, efforts to address workplace bullying and inappropriate behaviour, funding of vocational training, quality improvement, public private partnerships, and the future of work.

ASMS and Waitemata DHB partnering on SMO wellbeing

The Association's branch officers and staff have been working with Waitemata DHB on several projects targeting improved SMO well-being. Focus areas include: service debrief systems, the blue form dispute resolution trial (an informal low level way of raising inappropriate behaviour issues), better support for parental leave, and personal health for SMOs. This partnership is in its early stages and there is a shared intention to continue to develop this work. The Association co-presented on this shared approach, at the Health Sector Future Directions Forum, held in July 2017.

National Bipartite Action Group (NBAG)

NBAG is a national body of health unions and DHBs that meets face to face or by teleconference every two months. The Association is normally represented at these meetings by Senior Industrial Officer Lloyd Woods.

Bipartite Action Groups are similar to the Joint Consultative Committees (JCCs) and were established in each DHB for the other CTU unions. We do not normally attend local DHB BAG meetings.

Nationally DHBs are represented by a Chief Executive, Head of Allied Health, Head of Nursing and CMO with administrative support and input from DHB Shared Services. Union representatives attend from NZNO, NZRDA, Medical Laboratory Workers and APEX, E Tu, PSA and the Association.

Face-to-face meetings have the most value, and contentious issues are often discussed.

Work of note this year includes a joint approach to bullying and harassment, health and safety issues, national payroll issues, incident reporting, issues around well-being and issues related to good faith (or the lack of it) by DHBs in bargaining.

"Life is too short to be spending most of it working like a dog for very little recognition and job satisfaction."

Meeting of women ASMS members at the 2016 Annual Conference

Relationships with medical and professional organisations and unions

New Zealand Resident Doctors Association (NZRDA)

The Association has kept the NZRDA informed of developments in our DHB MECA negotiations as these have progressed, and also issued a supportive media release during the RMO strikes in 2016, along with advice to our members.

New Zealand Medical Students Association

Over the past three years, the Association has been developing a closer relationship with the New Zealand Medical Students Association (NZMSA), on the basis that these students are the future faces of the senior medical workforce.

NZMSA representatives will continue to attend the Association's Annual Conference with Association financial support. We have also involved them in various activities, including membership of the administration group for the new 'Women in Medicine' Facebook page, and interviews for *The Specialist* magazine.

This relationship has continued to develop in the past year with the Executive Director addressing two NZMSA national events in Christchurch and Tauranga and with NZMSA drafting a Memorandum of Understanding for the National Executive to consider. The Executive Director also had a session with the MSA Executive in Auckland on 17 November.

New Zealand Medical Association

The Association maintained a good working relationship with the New Zealand Medical Association, which included attending NZMA's annual general meeting and annual Council meeting in May 2017. It was the first time we had attended for many years. Topics discussed included the results of the NZMA elections, destabilisation of international labour markets and the ethics of purchasing immunity from employers.

Medical Council of New Zealand

The Executive has enjoyed a good relationship with the Medical Council in the past year, and have appreciated this contact; in particular, with Chair Andrew Connolly. Following our submission to the Council raising concerns about aspects of a proposal to strengthen recertification for vocational registration, Andrew Connolly attended part of an Executive meeting to discuss what was happening and why. While subject to the usual 'Chatham House rules' to enable free and frank discussion of the issues, this discussion was very useful and resulted in a subsequent article from Andrew Connolly, written at the Association's request, for *The Specialist* magazine.

The Association also attended a meeting jointly hosted by the Medical Council and TeORA in June 2017 to explore matters pertaining to the cultural safety of our medical institutions; and the ways in which health sector organisations might work in partnership with Maori and across communities, to improve cultural responsiveness of staff and safety of patients and their families. This is an area for development across the Association.

Accreditation

The Association attended a meeting of Colleges, unions, DHBs, HWNZ and the Ministry of Health earlier this year to discuss issues to do with the withdrawal of accreditation. The meeting was initiated by the Resident Doctors' Association due to concern about the consistency of the approach to accreditation being taken by the various Colleges. Attendees included RANZCR, HWNZ, national DHBs' CMO Forum, ACEM, Council of Medical Colleges, Hutt Valley DHB, CICM, Medical Council, Ministry of Health, RDA, RANZCOG, and the DHB chief executives group. As a result of this meeting, it was agreed the Council of Medical Colleges would research what each College currently had in place around accreditation processes to consider aligning these in some way.

Hospital and Community Dental Association

The Executive Director has been invited in recent years to give an address to the annual Hospital and Community Dentistry Conference, and did so again in 2017. His address discussed DHB leadership, specialist burnout, ongoing SMO shortages and workforce intentions. It is available on the Association's website at https://www.asms.org.nz/wp-content/uploads/2017/07/Address-to-Hospital-and-Community-Dentistry-Conference-29-July-2017_168393.2.pdf.

In addition, member of the research and policy team attend informal groupings of health professional and medical professional policy staff.

Medical Protection Society (MPS)

The Association has continued our close working relationship with MPS, including working together on cases or issues where our respective roles overlap or intersect. Much of this involves our industrial officers with MPS representatives and lawyers on specific cases which have been to the benefit of members. MPS continues to sponsor our Annual Conference dinner and provides a regular topical article for each issue of *The Specialist.*

Medical Assurance Society

The Association also enjoys a very good relationship with the Medical Assurance Society, which generously sponsors *The Specialist* magazine and the pre-Conference function we hold each year. The Association's Executive Director and other staff meet quarterly with MAS Chief Executive Martin Stokes to discuss matters of common interest. In the past year, these topics have included MAS' work on its ethical investment approach, updates on the DHB MECA negotiations, the Association's research programme, and the proposed funding model for vocational training.

'High Performance High Engagement' (HPHE)

This initiative has been the subject of much discussion within the sector in the past year, and has included a good deal of consideration within the Association at both Executive and national office level. HPHE levers off the Kaiser Permanente experience in California and has been in operation in Air New Zealand for some time. More recently, it is being trialled in Kiwi Rail.

In the health sector, there is broad agreement over its principles but no consensus over the form of application which includes the use of a particular business consultancy, a specific training programme run by this company, and purchase of its 'intellectual property'.

With regard to the Association, our focus is on membership involvement in quality and systems improvement initiatives within and across services. We have expressed some reservations about HPHE and its June meeting, your National Executive carried the following motion:

> 'That the National Executive reserves the Association's position as the union through which senior medical and dental officers engage with DHBs as expressed in the multi-employer collective agreement and as evidenced by the Association's longstanding commitment to distributive clinical leadership and engagement with DHBs including the *Time for Quality Agreement* (2008), *In Good Hands* (2009) and the joint ASMS-DHBs *Business Case* (2009) on the 'High Performance High Engagement' initiative. Reservations include:

- Concerns over where it fits in with clinically led quality and systems improvement initiatives (distributive clinical leadership).
- Concerns over the overly structural approach and the risk of high transaction costs for Association industrial staff.
- Lack of confidence in DHB leadership to the underpinning culture necessary to make the initiative succeed reinforced by the unexpected attempt by the DHBs to undermine the consultation and engagement in our national multi-employer collective agreement.
- Limitations in the relevance of the Kaiser Permanente experience to DHBs.'

There are concerns about the process used to promote this initiative which, despite its title, has more in common with 'low performance, low engagement'. Individual DHBs are free to adopt HPHE with those unions who wish to engage through this process. But with this lack of consensus (only two small DHBs at most appear seriously interested in implementing HPHE), it would undermine the robustness of the tripartite Health Sector Relationship Agreement (to which the Association is a party) should it be deemed a national initiative under the umbrella of this Agreement. The Association will continue to monitor developments.

Health Workforce New Zealand

Voluntary bonding

HWNZ's consultation on the hard-to-staff areas for the 2018 intake of the Voluntary Bonding Scheme (VBS) this year also included an invitation to comment on a review of the scheme, and accordingly we made a submission on this. The review involves plans to align the VBS "with a bundle of education sector and employer-led initiatives that combined are more likely to be effective in achieving the outcomes sought". This approach is based on a Ministry of Health analysis of the factors that make the professional groups and communities hard to staff, as well as the evidence about effective ways to address those factors.

The Ministry of Health's research suggested a range of interventions should be considered in four broad categories: education, regulation, financial incentives, and personal and professional support. The Association agreed this made sense, and also that policy interventions to support a successful VBS needed to be informed by an in-depth understanding of the health workforce. We gave examples of ASMS research into presenteeism, burnout, and workforce intentions, as well as the DHB surveys of heads of departments. Our single most important message was that in order to improve attraction, recruitment and retention of doctors in hard-to-staff areas, the broader issue of specialist workforce shortages in general must be addressed. We noted that we expect this to be reflected in any health workforce strategy.

The ASMS submission to Health Workforce New Zealand on VBS is available at https://www.asms.org.nz/wp-content/uploads/2016/06/Submission-to-the-Ministry-of-Health-on-Voluntary-Bonding-Scheme.pdf.

"My main issue is that having started as a consultant 7 months ago, I still have none of the equipment they agreed to supply in theatre to do my job safely."

Proposed funding model for vocational training

The Association made a submission to HWNZ on its flawed proposal for a new approach to funding postgraduate training. We expressed some concern about the consultation process to date – two national workshops for selected sector representatives, with lightly detailed background papers and under-representation by the medical and dental professions in particular, and the health professions covered by the Health Practitioners Competence Assurance (HPCA) Act. At some point in the process between the two workshops, without consultation or agreement with the medical profession, HWNZ unilaterally determined a shift from the funding formula for medical workforce vocational training to all the occupations covered by the HPCA Act. The funding proposal itself raises more questions than answers, which were not resolved during the limited consultation that occurred.

The proposed model was discussed further at a meeting of the HWNZ Medical Workforce Taskforce governance group in September. The meeting was advised that the then Minister of Health (prior to the general election) had approved a HWNZ proposal to set up a fund of $10 million to be available for bids from the sector for the 2019 academic year. This pool was for all vocational health training, and there appeared to be no pretence of co-design with DHBs. Priorities for the first year, at least, would be developed by HWNZ. Verbal assurances were given that the existing medical vocational training funding would not be reduced, but over time the size of the pool would increase. This outcome and the poor process that led to it remain a serious concern for the Association.

Other meetings and campaigns

Council of Trade Unions

The Association is represented on the Council of Trade Unions' (CTU) National Affiliates Council, and attends regular meetings, usually the Executive Director. Topics of discussion in the past year have included the CTU's strategic direction and the equal pay campaign. At the start of each meeting there is a standard agenda item for obituaries, followed by a minute's silence. At the February meeting, Whanganui Branch President Dr Chris Cresswell was one of those acknowledged.

Association staff attended the CTU Biennial Conference in October and participate as able in the Health Sector Standing Committee and more regularly the health policy group.

The 'WeCare' campaign

In response to a request, the National Executive agreed to support in principle the 'WeCare' campaign being led by the Public Service Association to draw attention to under-funding of the public health system. This campaign has generated a good deal of media coverage and highlighted the effects of resourcing constraints on people's lives.

Choosing Wisely

The Association has helped to promote the *Choosing Wisely* campaign since its launch in New Zealand through several articles in *The Specialist* magazine. Association staff have also attended a meeting organised by the Council of Medical Colleges to discuss the campaign, along with representatives from the New Zealand Medical Association, the College of GPs and other professional medical bodies. It was noted in the meeting that the aim of Choosing Wisely should be reframed as pushing for appropriateness in health care rather than as a cost-saving exercise. Nevertheless, it was clearly articulated that front line health workers have a responsibility for stewardship in the public health system, particularly when operating in a fiscally constrained environment.

More information about the *Choosing Wisely* campaign is available at http://choosingwisely.org.nz/.

Tri-Nation Alliance Medical Symposium, Melbourne, March 2017

The Executive Director and members of the policy and research team attended the Tri-Nation Alliance Medical Symposium in Melbourne in March 2017. There was also an opportunity to meet with representatives from the Victoria branch of the Australian Medical Association. These meetings were useful and highlighted issues that were both common and different between the two Associations. The symposium itself was organised by the Australian, New Zealand and Canadian Colleges, and was focused on culture in medicine, indigenous health care, changes in medical education, and leading changes in systems and practice.

AMA-ASMOF industrial coordination meetings

As in other years, the Executive Director has attended the twice yearly industrial coordination meetings of the Australian Medical Association (AMA) and the Australian Salaried Medical Officers Federation (ASMOF). He has also held face-to-face meetings with others during these trips to discuss issues of common interest, and these have proved useful. The industrial coordination meetings have discussed a wide range of topics, including funding of vocational training, private patients in public beds, Victoria enterprise bargaining, campaigns against sexual harassment, industrial approaches, medical staff interstate remuneration comparisons, and doctors-in-training suicides.

Executive Director travel

The Executive Director travelled to the United Kingdom in mid-2017 to observe the British Medical Association Annual Representative Meeting and to meet with elected representatives (including the new Chair of Council) and senior BMA staff. While in the UK he also met academics, researchers, health unions, Trade Union Congress and Labour's health spokesperson. Subject matters included the new 'Sustainability and Transformation Plans', the conflict in the NHS between cooperation and competition (including the regulation of the latter), and commissioning. On his trip home, he also visited the Union of American Physicians and Dentists in San Francisco.

JCC MEETINGS AND SMO ENGAGEMENT WORKSHOPS

Joint Consultation Committees (JCC)

Three rounds of JCC meetings are held in every DHB each year. These are a valuable opportunity to discuss issues directly relevant to the work of SMOs at both a national and local level. Issues regularly arise that ASMS then follows up on behalf of members.

Each JCC is preceded by a meeting with members, and we encourage as many people as possible to attend both the pre-meeting and the JCC as it enhances the contributions in these meetings if we have good representation from a wide range of specialties. The pre-meeting also provides a rare opportunity for ASMS members at a DHB to meet as a union and discuss issues. Some of these go forward to be raised with management at the JCC but others do not.

A report of the main items of discussion and other issues goes to members after each DHB's JCC.

In the past year, we have initiated discussion on a broad range of issues and asked some pointed questions of your DHB Chief Executives and senior managers about SMO wellbeing and retention.

JCC agenda topics in the past year have included ASMS research findings on SMO workforce intentions, job dissatisfaction and burnout, the impact of the Government's expectations on the balance between first specialist assessments and follow-up appointments, and the ASMS series of papers on patient-centred care and the application of some of the new MECA provisions. We have highlighted problems with the Health Workforce New Zealand proposal on funding vocational training, as well as comments made during a HDC investigation that the 'busyness' of doctors is not an excuse for an adverse outcome. We have also followed up issues to do with payroll, leave, access to sabbaticals, staffing, reviews and resourcing.

"Am not enjoying the constant pettiness being imposed on us by management with respect to things such as CME claims. Getting leave is a constant headache. Little recognition of the work we do makes us feel undervalued and does not promote loyalty to the organisation, though we still feel obligations to our patients and colleagues."

SMO Engagement workshops

These joint ASMS-DHB workshops are a regular feature of the engagement calendar within a number of DHBs. They are often organised around a central theme and include presentations by ASMS, DHB managers, clinical leaders and specialists. As with JCC meetings, we encourage all members to attend as the topics are relevant to your work.

Joint SMO engagement workshops held over the past 12 months were:

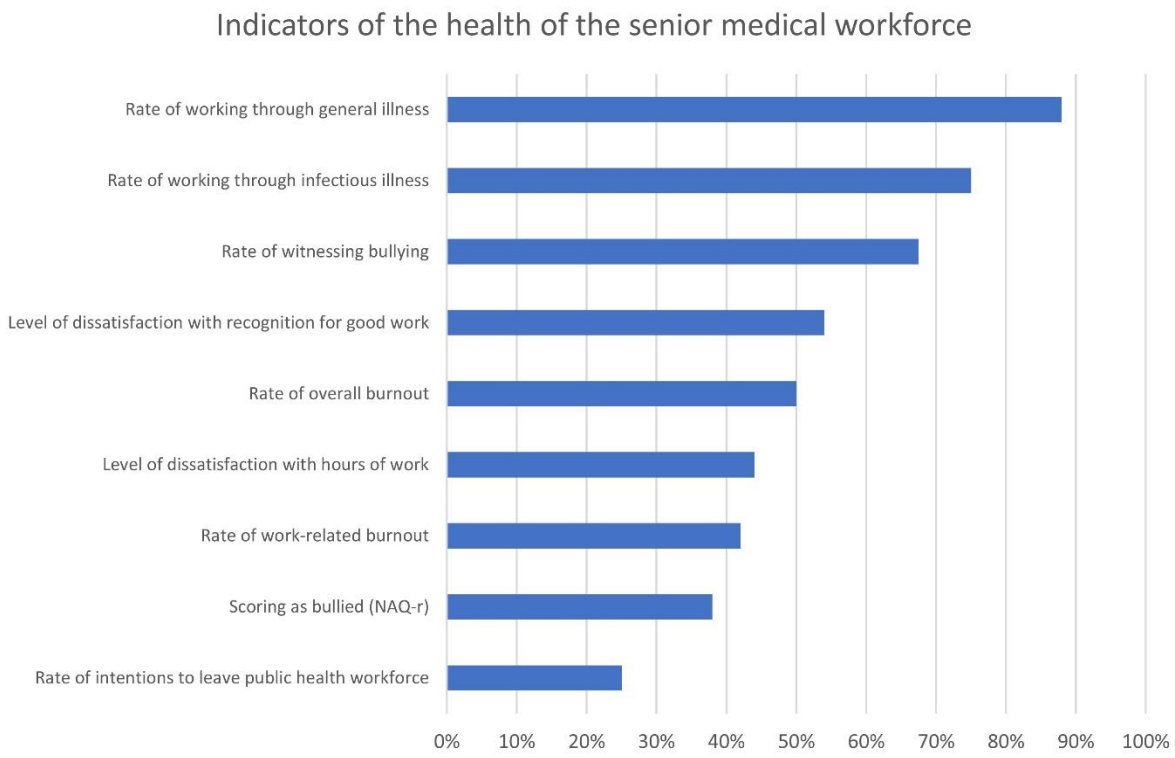
- Counties Manukau – covered the northern region long term investment plan (LTIP); and consenting patients
- Waitemata – celebrated the opening of the Whenua Pupuke building and featured a presentation by Sir Harry Burns on the biology of wellness in general society. The final workshop will occur in November.
- West Coast – discussed future proofing the rural hospital medicine specialist and funding arrangements for a new health facility
- MidCentral – discussed the changing face of the SMO workforce, along with presenteeism and burnout
- Southern (Dunedin and Invercargill) – discussed burnout, job satisfaction, workforce intentions, the findings from the DHB's engagement survey, speaking up for clinical safety, and the DHB's financial challenges.
- Canterbury – Discussed the recent debates over the DHB's fiscal position and funding issues, the drivers of burnout and changing culture behaviours and culture.

"It seems to be up to me, rather than management, to project into the future to protect my subspecialty and make sure there are potential future colleagues."

INDUSTRIAL AND ORGANISING ACTIVITY

The industrial team has seven staff, led by Deputy Executive Director Angela Belich, and consists of Senior Industrial Officers Henry Stubbs and Lloyd Woods, and Industrial Officers Steve Hurring, Sarah Dalton, Ian Weir-Smith and Dianne Vogel.

The state of the SMO workforce from ASMS research is summarised in this graph:



The surge in acute demand experienced by nearly all DHBs this winter has placed pressure on Association members to an unprecedented extent. The pressure was felt first in emergency departments but has quickly spread to other services with a cascade of effects, including on elective services. This has been coupled with a rise in demand for mental health services which most DHBs have not been able to anticipate with adequate resources. The fracture lines have been different at each DHB but features have been inadequate staffing (both SMOs and other staff), aging buildings and equipment that are inadequate for not only unanticipated extra demand, but also *anticipated* extra demands, and the toll on individual SMOs that has presented to the industrial staff across a range from requests for job sizing to illness, bullying, fractured and dysfunctional departments and burnout.

Dysfunctional cultures

Waikato DHB has been characterised by dysfunction in the past year, culminating in the resignation of Chief Executive Nigel Murray after an investigation into his expenses. A litigious approach by HR and a reluctance to spend money on sufficient clinical staff while engaging in a misguided virtual health care experiment, lack of proper systems for staff safety and issues with training accreditation are hopefully markers of only the recently defunct regime.

Tairawhiti DHB has faced a series of crises stemming from a failure of senior leadership in the past year, resulting in a high level of divisiveness and dysfunction at the DHB. Efforts are being made to revive the senior medical staff group and revive quality improvement.

Privatisation and public private partnerships (PPP)

At *Taranaki DHB* management has undone the mistakes of the past, and brought radiology services back in-house. Unfortunately, the DHB has set about outsourcing its hospital laboratory services with insufficient consultation. It is probable that fiscal constraints are a factor in this decision making.

At *West Coast DHB* the proposed PPP funding arrangement for the Integrated Family Health Care centre at Buller was a major concern which should be solved with the change of government.

PPP has also been a concern at *Southern DHB* as this was the proposal for Dunedin Hospital's redevelopment. The decrepit and deteriorating Dunedin Hospital has created extra pressures on members.

Both the Canterbury Hospital rebuild and the Grey Hospital rebuild and the Primary Urgent Care Centre development avoided having to go the PPP route.

Systemic problems with funding not reflecting demand

At *Northland DHB* the chief executive has raised serious ongoing concerns about the inadequacy of funding arrangements for this region, particularly given the high deprivation levels across their catchment. Departments showing particular strain include mental health, ED, and general medicine.

Waitemata DHB is the fastest-growing DHB in New Zealand, with particular strains experienced by staff in mental health, ED, and psychogeriatric services.

Auckland DHB has proceeded with its intention to cut SMO numbers within the sexual health service despite a syphilis epidemic and loss of skill in provision of transgender services. Although we continue to engage with the DHB regarding the consultation and patient safety, MECA clauses, at least two SMOs have decided to take voluntary redundancy. Community mental health services are dangerously stretched, both in staffing and number of in-patient and respite beds. It appears that Auckland DHB is attempting to manage funding shortfalls by targeting inter-district-flows – possibly at the expense of the other Auckland metro DHBs.

The sudden change in senior leadership at *Counties Manukau DHB* has proved highly unsettling, and was not helped by the decision to cancel the APAC conference at a very late stage. This decision was allegedly because of financial problems that had been recently uncovered. The DHB is struggling to manage 100%+ bed occupancy on a regular basis, which made the recent decision by the leadership team to instigate a voluntary cessation scheme difficult to fathom. Mental health services are also a particular area of concern.

Hawke's Bay DHB is a very lean DHB which has meant a very challenging winter. Members have difficulty envisaging how further surges in demand can be accommodated without a substantive increase in resources.

At *MidCentral DHB* a theatre improvement programme is underway and seems to be largely well supported by SMOs. An internal medicine reconfiguration project has caused much dissatisfaction, especially given that job sizings for general medicine, endocrinology, gastro, respiratory and elder health have not been completed**.**

At *Wairarapa DHB* members have felt pressure because of high demands on availability and lack of ability to take leave. With small rosters, any absence or vacancy causes a cascade of stressors. Management concern about the locum budget has translated into difficulties covering gaps. Adult Community Mental Health is a service under severe strain, especially since a retirement in June. The DHB has struggled to fill the position and to obtain locum cover.

At *Hutt Valley DHB* mental Health services are stretched and there is continuing unhappiness with the 3D model (a regional service covering all three lower North Island DHBs). Radiology and oral maxillofacial are also both services under strain. Winter saw a 40% increase in after-hours presentations.

Capital & Coast DHB has run at a major deficit for a number of years. Several pieces of work commissioned by management appear to demonstrate that this is structural and not a result of inefficiency. The new children's' hospital is a welcome addition, although the "last minute" nature of it has caused its own difficulties.

Canterbury DHB has faced fiscal challenges including issues about funding and the financial impact of PPP have dominated this year. The DHB is focusing on staff well-being as a way to manage the ongoing challenges for staff. The implications around open plan non-clinical workspace is an ongoing issue. Management's fixation on open plan appears to be motivated by cost.

West Coast DHB has been bedevilled with ongoing staffing shortfalls and issues of recruitment and retention, particularly in primary care.

Southern DHB has been under steady scrutiny in the past year for its handling of various issues and crises, such as the situations in urology, ICU and ophthalmology.

"Many SMOs doing gen med are getting frustrated with the heavy workload and limited resources we are expected to work with."

Bullying and harassment/unprofessional behaviour

The Association has been proactively dealing with issues relating to bullying and harassment for some years with publication of our first *Standpoint* on these issues in 2011. This year has seen 21 cases where industrial officers have played a role in supporting complainants and/or advising members with complaints made against them.

Nationally a taskforce was set up almost two years ago to look at the problems of bullying and harassment within the medical workforce. This group included representation from right across the DHB and professional medical sectors. ASMS involvement has been important to ensure a common-sense approach was maintained.

We were proactively seeking ways to better deal with bullying and complaints (both against and by members) well before this taskforce was formed, and industrial officers have been attending conferences and workshops for several years in order to formulate our response. Part of our proactive work was the initiative for the cross sectoral group visit to Melbourne arranged by the ASMS last year to look at the Cognitive Institute/Vanderbilt systems in use there.

Since then, despite our encouragement to use the Cognitive Institute process, only four DHBs have so far signed up. These are South Canterbury, MidCentral, Capital & Coast, and Bay of Plenty. We have congratulated them on taking on this programme. Others have struck off in different directions, using systems of various strengths, and some have done little at all.

The work of the taskforce has therefore regained importance in trying to ensure that dealing with these issues is done in a sensible way.

The Taskforce has been renamed the 'Unprofessional Behaviours Medical Taskforce'. It has recently been suggested it should be the 'Professional Behaviours Medical Taskforce' to give a more positive spin.

Progress toward clinical leadership and appropriate behaviours

Following implementation of a clinical leadership review at *Lakes DHB,* SMOs are still struggling to get real involvement in decisions that affect the delivery of clinical services.

Bay of Plenty DHB has been playing a lead role in the roll-out of restorative approaches to adverse behaviours. The DHB is still struggling with its approaches to staff safety and well-being, with a review of its health & safety services underway.

At *MidCentral DHB* there have been several instances where the DHB, rather than dealing with complaints that deserve a low key, informal type of resolution, has resorted to the more formal investigative type of approach. The DHB has also repeatedly attempted to rely on anonymous complaints.

At *Whanganui DHB* a more proactive Chief Medical Officer has led to a lower number of complaints from members, in contrast with past years. The Cognitive Institute has been engaged to develop the 'Speaking Up for Safety and Promoting Professional Accountability' programmes.

At *Hutt Valley DHB* positive feedback has been received regarding the positive leadership programme, although the jury was still out in respect of the DHB's 'Shaping our Values' Project.

SMO relationships with management have improved at *South Canterbury DHB* as the year has progressed, with better consultation and engagement. The DHB has engaged the services of the Cognitive Institute to develop a programme to improve the culture and establish 'Speaking up for Change and Professional Accountability' programmes.

Job offers

In the past year, the industrial team advised on 84 job offers. We continue to have issues with achieving appropriate relocation expenses for new appointees. Some DHBs appear to have adopted a default position of seeing how little they can offer. Getting the appointee to question the amount often leads to an improvement but many appointees do not seek our advice and will start their career knowing their employer has treated them unfairly. It is pleasing to note that, in general, applicants are now being offered the correct starting salaries.

Job sizing

Underfunding of DHBs has led to increasing pressure on SMOs to do more with existing staff numbers. One of the mechanisms we use to counter this has been job sizing. In the past year, the industrial team has been engaged in 58 job sizings. Some of these have proved both onerous and difficult to complete because of resistance by management to an outcome that demonstrates the need for more staff and hence greater expenditure. The new MECA clause relating to well-being will allow us to exert more pressure on DHBs to fill vacancies identified during job sizing

CME and sabbaticals

At *Auckland DHB* we continue to see rationing of sabbaticals at this DHB – which makes it an outlier in its approach to and management of this important MECA provision. *Counties Manukau DHB* has just introduced a new CME policy, which will be a source of ongoing issues.

Throughout the sector we have seen a niggling approach to the CME entitlement, which is an ongoing aggravation for members and an ongoing source of work for the industrial officers. When the finding from the ASMS workforce intentions survey (published as *Future intentions of the New Zealand DHB-based senior medical workforce*) that a major source of job dissatisfaction was lack of recognition for good work was discussed at Joint Consultation Committees, ASMS members cited a niggling attitude to CME as one of the markers of that dissatisfaction.

Retirement gratuities

The industrial team has been dealing with a number of refusals to grant retirement gratuities at some DHBs. While most DHBs continue to honour these grand-parented provisions, the Association has initiated legal action against one DHB over its refusal to recognise grand-parented provisions, and a claim that a retiring gratuity cannot be granted if an employee continues in private practice after leaving the DHB. This issue is ongoing.

Privacy

Earlier this year the Privacy Commissioner upheld a complaint by the Association, finding that Waikato DHB interfered in the privacy of an SMO when its human resources department intercepted and used a confidential communication between the SMO's private specialist and the DHB's occupational health physician. The DHB continues to deny any wrongdoing. ASMS has commenced an action in the Human Rights Review Tribunal seeking compensation for the SMO and a ruling regarding the DHB's systematic accessing of occupational health medical records.

Payroll

The Association is a member of the joint CTU-DHBs working group investigating DHB compliance with Holidays Act obligations, following discovery of problems at other crown entities. The working group has so far focused on general interpretation issues, with DHBs so far not being upfront about whether, in their view, their systems comply.

Other major cases

Industrial staff have dealt with 14 cases in which members faced serious "clinical" complaints against them that involved ongoing or new independent external investigations (usually, but not always under MECA Clause 42). These cases are almost always undertaken in partnership with MPS medico-legal advisers or MPS-appointed lawyers. They are always very stressful for the members involved and time-consuming for the industrial officer involved. We have also assisted 6 members who have experienced or continue to experience long-term health concerns, usually involving extended absences from work and in some cases referrals to the Health Committee of the Medical Council. Our industrial officers have also advised or otherwise supported 10 members whose employment was 'terminated' involuntarily, some on grounds of poor health, others for poor performance and some for redundancy. An additional 5 cases were taken to mediation, with all but one currently resolved.

Mapping

The industrial team has been leading a project to develop a database that will support workplace mapping. This involves the regular surveying of departments to identify senior doctors and dentists working there, identify key contacts and gather basic information about staffing levels and employment conditions. This mapping work will help the Association build membership, solve industrial problems and collect data which can then be aggregated at a national level for our broader work in research, advocacy and communications. One of the problems we currently encounter involves new SMOs employed for a period of time, unaware that they are not members of the Association, and the mapping database will help with this.

Case management system

We are hoping to be in a position to establish a case management system within the next 12 months. This will help industrial staff to keep tabs on caseloads, as well as offering a more accurate and convenient data-gathering and reporting function.

Employment Relations (Allowing Higher Earners to Contract out of Personal Grievance Provisions) Amendment Bill

The Association made both a written and verbal submission opposing this private members' bill, appearing before the Transport and Industrial Relations Select Committee. The Bill proposes allowing parties to an individual employment agreement to negotiate a term that would deny the employee access to the personal grievance provisions of the Employment Relations Act, if the employment agreement provides for an annual gross salary of $150,000 or more. ASMS considered the Bill to be very poorly drafted and made the following points to the select committee:

- The Bill's purpose was misconceived
- It adds significant additional complexity within the employment jurisdiction
- It risks de-stabilisation of international labour markets, with particular reference for the Association, to international medical graduates
- The ethics of purchasing immunity for employers are suspect.

The Association was represented at the Select Committee by the Executive Director, Deputy Executive Director and Senior Industrial Officer Lloyd Woods.

Implementation of the new DHB MECA

The new MECA for DHB-employed members is available on the ASMS website at https://www.asms.org.nz/wp-content/uploads/2017/10/2017-2020-DHB-MECA-Signed.pdf. The focus now for the Association is on ensuring implementation within DHBs and helping members to understand their entitlements.

'Know your new MECA' workshops

The Association's industrial officers have organised 'Know your new MECA' workshops in every major DHB site, and members have been encouraged to attend. These workshops provide up-to-date information about entitlements under the new MECA and also answer any questions members may have.

"The problem is that entrenched poor attitudes from hospital managers, particularly those in senior positions, to senior medical staff, discourage engagement."

Recovery time and safe shifts

Implementation of the recovery time clause in the new MECA will focus firstly on identifying models in departments or services where recovery time is in place or will be relatively easy to implement (for example, in large anaesthesia departments or mental health teams). We will then identify (in discussion with ASMS branch officers and JCC delegates) where we need to act with the most urgency to deal with members at risk from onerous call. The positive ramifications of this new entitlement for DHB employed members are considerable and should not be under-estimated.

Reviewing shift systems to ensure their safety is the other major three-year project and will involve identifying where there are shifts being worked and the standard they need to meet to be regarded as safe.

"While I find my chosen speciality really rewarding, the demands from the DHB for more clinical care, with more targets to be met, but with little regard for the impact on clinicians and their wellbeing – means I will not be able to continue full time in the DHB till I retire – not without cost to my wellbeing."

ACTIVITY IN THE NON-DHB SECTOR

There are now approximately 233 Association members employed outside of DHBs. This number is increasing each year, and there is considerable scope to grow.

The Association offers membership in non-DHB areas as a service and with the view of ensuring that non-DHB doctors are paid suitably, with good conditions.

We have increased to 17 collective agreements overall, with another two under negotiation.

Many of these are linked to the DHB MECA and we have 'rolled' over some while the DHB MECA was negotiated. We will be renegotiating these before year's end.

Delegated authority to the Executive Director under the Constitution for the ratification of non-DHB collective agreements was formally reiterated by the National Executive at their meeting on 3 April.

Collective agreements of note are:

- Hospice MECA – we have extended coverage by two new hospices and should now cover 14 hospices overall across the country
- Ngati Porou Hauora – this is a long-standing collective agreement, but is difficult to renegotiate because of high doctor turnover.
- Wellington Southern Community Laboratories – we are making progress on these negotiations for our ex-Hutt Valley and Capital & Coast DHB members who transferred across when their hospital laboratories were privatised. We expect to have a new collective agreement in place before the end of 2017. This has been a very slow but ultimately worthwhile process
- Otara Union Health –The practice appeared likely to be closed or sold by its union owners before the end of 2017. We are now in discussion with the potential new owners in order to protect our three longstanding members

Collective agreements negotiated and settled:

- Wellington Primary Health
- Waitaki Health Services (Oamaru)
- Te Runanga o Toa Rangatira
- Golden Bay Health
- Hospice MECA

Other negotiations due this year:

- Hokianga Health
- ACC
- Central Otago Health Services
- Christchurch Union and Community Health
- Ashburn Clinic
- Compass Health
- Family Planning.

We plan expiry dates to avoid such a big load in any year but, as noted above, due to the DHB MECA moving into 2017, they have accumulated.

"I believe flexibility of hours and part-time work is vital for the future of our workforce and especially those with children. Valuing our staff and appreciating the high rate of burnout and taking steps to address this is essential."

POLICY AND RESEARCH

The Association's policy and research team is led by Deputy Executive Director Angela Belich and has two staff – Director of Policy and Research Lyndon Keene and Principal Analyst (Policy and Research) Charlotte Chambers.

This year's work continues and builds on the work of previous years with the aims of collecting greater intelligence on the SMO workforce and working conditions, and monitoring workforce trends. This provides an evidence base for advocating for better health policy as well as better workforce policy, and has become a valuable resource for supporting DHB MECA claims.

Study on SMO workforce intentions

A major study on SMO workforce intentions was completed this year and first published online in July 2017 as a *Health Dialogue*, with printed copies distributed with the September *Specialist*. The study, led by Principal Analyst Dr Charlotte Chambers, involved a national survey of ASMS members on their future career intentions. The core aim of this research was to assess how SMOs may change their levels of involvement in DHB-based employment over the next five years and to understand their reasons. The study found almost a quarter of SMO respondents indicated they were unlikely or extremely unlikely to continue in DHB-based employment. While age was a major factor, feelings of disillusionment, exhaustion and low morale were driving senior doctors to consider leaving earlier than they would otherwise.

The findings sit alongside those from the ASMS study on 'presenteeism' (2015), which indicated 88% of SMO respondents had gone to work while unwell over a 24-month period, and the ASMS study on burnout (2016), in which half of the respondents reported symptoms of burnouts (high levels of fatigue and exhaustion).

Workforce intentions https://www.asms.org.nz/wp-content/uploads/2017/07/Future-intentions-of-the-New-Zealand-DHB-based-senior-medical-workforce_168309.4.pdf

Presenteeism study https://www.asms.org.nz/wp-content/uploads/2015/11/Presenteeism_A5-Final-for-Print_164753.pdf

Burnout study https://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf

Surveys of heads of department on SMO staffing needs

Complementing this body of work, surveys of clinical leaders (Heads of Department) are being undertaken in selected DHBs to ascertain current SMO staffing levels and required SMO staffing needs as assessed by respondents, taking into account the SMO staffing capacity needed for patient centred care, clinical leadership, appropriate leaving-taking and attending to unmet need.

The first two surveys (Hawke's Bay and MidCentral Health DHBs [2016]), indicated substantial staffing shortfalls in both DHBs. This year further surveys were reported for Capital and Coast, Nelson Marlborough and Counties Manukau DHBs. According to the HoD assessments, SMO full-time equivalent (FTE) staffing levels in these DHBs needed to be increased by approximately 27%, 17% and 18% respectively in order to provide safe, quality and timely care. At the time of going to print a survey of Canterbury DHB HoDs is underway. More surveys are planned.

Research Briefs detailing the results of each staffing survey can be found on the ASMS website at https://www.asms.org.nz/publications/researchbrief/.

Study on bullying in the workplace

A further national survey of ASMS members was undertaken in May and June 2017 to provide ASMS with more insight into SMO working conditions, including the prevalence of bullying. The study also sought information on SMOs' perceptions of workloads and relationships with management and colleagues. Early findings, presented at the annual Branch Officers' workshop in August, indicate that peer-to-peer bullying is prevalent in the ASMS membership with over a third of respondents self-reporting as bullied to some extent and over two thirds reporting witnessing bullying behaviour. Strong associations between the prevalence of bullying and increasing workplace demands, low peer and managerial support, suggest that bullying is yet another symptom of a stretched and strained public health system. The results of this study are planned for publication in late 2017.

Follow-up to the SMO burnout study

As a follow-up to the burnout study in 2016, Dr Chambers has initiated a qualitative study involving face-to-face semi-structured interviews with female ASMS members aged between 30-39. The focus of this research is understanding the lived experiences of these women in the DHB system and why women in this age group have on average the highest burnout scores. Preliminary findings were presented at the Australasian Doctors' Health Conference in Sydney in September.

"I love working in my lab. My work is interesting and my colleagues are on the whole fantastic."

Analysis of workforce demographic trends

An analysis of New Zealand specialist workforce demographic trends was released at the end of 2016. It highlights three concurrent trends in the specialist workforce which will impact on the capacity to meet New Zealand's growing health needs and will require a rethink in the way immediate specialist workforce planning is approached. They are: the growing proportion of females in the specialist workforce, attitudinal changes about the importance of work-life balance, and the aging of the specialist workforce.

International medical migration

A *Research Brief* on international medical migration discusses New Zealand's high expatriation rate of doctors coupled with a relatively low number of locally trained medical graduates (despite recent increases), which has led to our heavy dependence on international medical graduates (IMGs) - currently 43% of the specialist workforce. Monitoring the trends in the movement, supply and retention of IMGs is therefore especially important for New Zealand to develop and sustain a medical workforce capacity that will meet our growing health needs. Two key issues have emerged: increasing competition to attract IMGs, and continuing poor retention rates of IMGs in New Zealand.

IMG research brief is at https://www.asms.org.nz/wp-content/uploads/2017/02/IMG-Research-Brief_167359.5.pdf

Analyses of the 2017 Health Budget

As in previous years, pre- and post-Budget analyses of Vote Health were undertaken in partnership with the Council of Trade Unions (CTU). The post-Budget analysis shows DHB budgets for 2017/18 are approximately $107 million short of what is needed to maintain services and provide new initiatives announced in the Budget. The overall operational funding shortfall for Vote Health is estimated at approximately $215 million compared to last year, and $1.4 billion compared to 2010. This year a special CTU-ASMS post-Budget analysis on mental health funding shows that despite the Budget-day announcement of a $124 million 'boost' for mental health services over four years, mental health funding is taking a real cut in 2017/18.

ASMS media release with links to report https://www.asms.org.nz/news/asms-news/2017/06/07/called-budget-mental-health-funding-boost-cut-real-terms/

ASMS 'Snapshots'

ASMS is examining the views of members on topical issues at specific DHBs through a new publication, ASMS Snapshot. These are designed to gain a better understanding of issues of relevance to our members. The first 'Snapshot' survey was done of Waikato members regarding the proposed Waikato medical school and found, among other things, that 93% of respondents had not been consulted on the proposal.

Patient Centred Care

A *Health Dialogue* on patient centred care is planned for publication later this year, which will include updated discussion papers published in 2016 and additional chapters on health literacy (including the role SMOs have in supporting patients and their families to make sense of the system, as well as personal health matters), engagement with Maori, and the use of telemedicine, with discussion on what is needed to make genuine patient centred care happen.

Salary Survey

The analysis of the 2017 ASMS salary survey of senior medical and dental officers has been completed. It reports on the salary scales of the MECA for DHB-employed members which came into effect on 1 July 2015, not the salary scales of the new MECA which took effect on 3 July 2017. As at 1 July 2017, there were 4691 specialists and 503 medical and dental officers employed across New Zealand's DHBs. This represents a 2.9% increase in specialist numbers and a 3.9% increase in medical and dental officer numbers compared with the previous year. The survey found an increase in the average specialist salary of 0.3% and a decrease in the average medical and dental officer salary of 0.4% compared with the previous year.

Submissions

Submissions to government agencies this year include those to:

- The Ministry of Business, Innovation and Employment on the draft Employment (Pay Equity and Equal Pay) Bill: https://www.asms.org.nz/wp-content/uploads/2017/05/pay-equity-submission-May-2017_167945.2.pdf
- HWNZ on a proposal to introduce competition for vocational training funds: https://www.asms.org.nz/wp-content/uploads/2017/05/Submission-on-HWNZs-medical-training-paper-final_167986.2.pdf
- HWNZ on the Voluntary Bonding Scheme for 2018: https://www.asms.org.nz/wp-content/uploads/2016/06/Submission-to-the-Ministry-of-Health-on-Voluntary-Bonding-Scheme.pdf

Research team activities have also included presentations and attendances at various national and international conferences and workshops related to specialist workforce issues.

Employment exit survey

In 2010, we started conducting interviews/surveys with members as they departed from their employers to find out where they have gone and to improve our services to our members.

The redesigned ASMS exit survey was sent to 123 people and 44 responses were received.
Ten reported intending to take up employment with another DHB and a further 10 intended to cease medical/dental practice completely. Seven were leaving New Zealand to take up overseas-based employment and eight intended to start or increase private practice in New Zealand. The remainder intended to take up some other form of employment in New Zealand.

"New Zealand should be a world class medical workforce. We have a skilled and dedicated team of doctors across all specialties…but the Government is creating a disenchanted and cynical workforce."

COMMUNICATIONS

The Association's communications work is carried out by Director of Communications Cushla Managh and Communications Advisor Lydia Schumacher.

The Association uses a range of channels to communicate with members, health policy-makers, hospital managers, other organisations, and the public. These include our website, media releases and interviews, social media (two Facebook groups, Twitter, YouTube), publications, videos and photographs, and events.

The purpose of the Association's communications is to support and inform members, amplify the voice of senior doctors in the wider discussions about public health provision, workforce and resourcing, and to support the organising and advocacy work of the industrial team.

Key areas of work in the past year have included:

Media

In the past year, the Association has sent out approximately 50 media releases on a wide range of topics, including the Government's Vote Health allocation, SMOs shortages across the senior medical workforce as well as in specific DHBs and/or specialties, flawed funding proposals for the development of new facilities, issues to do with bullying and the ongoing crisis caused by unmet health need. We have also written about the need for greater physician advocacy, adequate time for doctors to see patients, and whether changes are needed to better regular the accountability of senior health bosses. We have responded whenever possible to any threats to members, specialties or services.

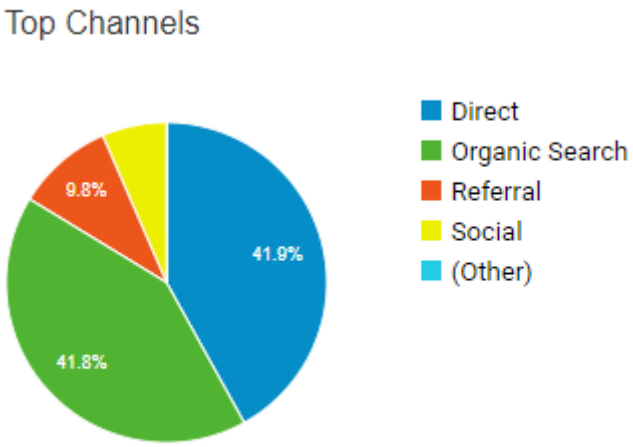
We have worked on joint communications on occasion (for example, with the Council of Trade Unions around the Vote Health Budget announcements).

The Executive Director has done numerous interviews on these topics with newspapers, radio stations and TV. The Association's communications team also supports the National President, and ASMS members speaking to the media about matters within their clinical expertise. We monitor the news media and provide a daily news digest to the Executive. The Executive Director writes a regular column for *New Zealand Doctor* magazine.

"Although I enjoy the work I do, I feel like I am drowning in the amount."

Website

The ASMS website (www.asms.nz) is updated several times each day with relevant media clippings, media releases and other items of interest. Between January and September 2017, the website recorded 20,281 homepage visits and a total of 29,938 unique visits. People found the website by directly typing in the web address, googling it, clicking on a link to the website while on another site, or via social media such as Twitter or Facebook. The proportions of each are illustrated below.



The website's homepage is viewed the most, followed by publications, agreement and salary information, the MECA Bargaining Bulletins, contact details, employment advice and information on joining ASMS.

Social media

The Association continues to maintain an active presence on social media, including the following:

- ASMS Facebook page – we have 363 followers, up 64 from the start of 2017. Items of particular interest generate up to 2000 views (and occasionally more). Most items posted on the ASMS website are also placed on Facebook to broaden coverage. Most of our followers are from New Zealand, with a smattering of loyal fans also from Australia, the United States and the United Kingdom.
- Women in Medicine (WIM) Facebook group – this has been a highly successful initiative for the Association. Formed as a result of a meeting of women senior doctors at last year's Annual Conference, it is a closed Facebook group open only to women doctors working in New Zealand or about to, or who have recently left (ie, with a strong connection to New Zealand medicine). ASMS established the group in the expectation that it would take on a life of its own as a valuable network for women doctors, and that has happened. A small team of moderators, including Association staff, SMOs, GPs and a medical student, manage the group and resolve any issues arising. As at October 2017, the group had 4216 members. WIM provides another channel for the Association to communicate with female doctors at all stages of the medical career life-cycle, and to better understand the issues of concern and interest.

- Twitter – we have 266 followers, and we use Twitter to re-post the Association's website items.
- YouTube – the Association's videos are hosted on YouTube and can also be accessed via our website.
- Live streaming – we will be live streaming the 'open' presentations from the Annual Conference for the first time this year. This gives media outlets and the Association's members who are unable to attend the Conference an opportunity to view presentations as they happen.

Publications and documents

The communications team handles nearly 400 publications and documents of various types over the course of a typical year. Some of these require intense work interviewing, writing, editing, sourcing images, liaising with contributors, designers and printers, while others are more straightforward but still require formatting, quality control, sign off and distribution.

Publications in the past year have included *Health Dialogues* (including a new design for these), quarterly issues of *The Specialist* magazine, *Research Briefs*, *ASMS Directs*, *Executive Directs*, *Bargaining Bulletins*, DHB-specific *Directs* (including advisories to members about upcoming JCC and engagement meetings), *DHB News'*, discussion papers on patient-centred care, submissions, internal staff newsletters, and the preparation of papers for National Executive meetings. In addition, we also edit and format other specific documents as these arise, including the Association's 'Q&A' documents, letters, speeches and presentations by our staff.

The Association now distributes most of its publications electronically and also puts these on the website. However, our key publications – including *The Specialist* and the *Health Dialogues* – are also distributed in hard copy.

Events

The communications team provides support for events organised by the Association; ie, the Annual Conference and the Branch Officers workshop. At the Annual Conference (for example), we liaise with contractors to provide photographs, videos and live-streaming of the presentations. We promote these on our website during the event itself, as well as writing media releases and liaising with journalists as the Conference unfolds.

Reputation and brand

The communications team maintains a watching brief on the Association's reputation externally so that we can respond as needed. We also ensure that our templates for publications and other documents are refreshed as needed to maintain a professional, contemporary look and feel.

Strategic planning

The communications team provides advice and other input into the Association's internal planning to implement the strategic direction set by the National Executive.

"An even reasonable standard of management within the health sector would make a massive difference to doctors' job satisfaction and happiness."

ASMS NATIONAL OFFICE

Staffing and organisational matters

The national office is led by Executive Director Ian Powell and Deputy Executive Director Angela Belich, and comprises 18 staff (including two vacancies) providing industrial, policy and research, communications and administration support. We engage additional support on a weekly basis to assist with financial accounting and reporting.

Longstanding Executive Officer Yvonne Desmond resigned from Association employment effective 18 October this year. During her more than 21 years of employment she provided high quality service leading a well performing administration team and, as part of the national office leadership, organising significant Association events including Annual Conferences. The Association wishes her the best for the future.

Last year there was an employment relations matter which was resolved following dialogue at the end of the year. The National Executive is confident that the issues were appropriately dealt with.

Association finances

The 2017 budget had projected a deficit of $635,600. However, the result for the year was a net operating deficit of $720,642.

In response to a continued challenging and demanding employment environment, our budgeted increased capability to support members (industrial, research, communications) has been both effective and valued.

The expiry of the MECA and the delayed settlement of the new agreement resulted in a lack of bargaining fee revenue ($90k budgeted), though this was offset by improved subscription income (boosted by membership growth and increased subscription level).

In conjunction with Grant Thornton NZ, we have undertaken a review of our expenditure classification to more easily measure the Association's spending on various activities and objectives. The purpose is to enhance our financial reporting by grouping expenditure into more distinguishable headings (activities) that will more easily enable tracking activity and team spending. In turn, this will add value to the information provided to members in the financial statements.

The change involved a complete review of the chart of accounts which will mean that the 2016/17 financial statement headings and expenditure allocation will require some rearranging before presenting to the 2018 Annual Conference, to provide meaningful spending comparisons (on previous year).

Administration

The Association's administration team comprises Assistant Executive Officer Sharlene Lawrence, Membership Support Officer Kathy Eaden, Support Services Coordinator Maria Cordalis, Membership Administrator Saasha Everiss and Project and Support Coordinator Angela Randall. Until 18 October the team was led by Executive Officer Yvonne Desmond.

The administration team provides membership and organisational support for the Association, and is often the first point of contact for our members. It manages our membership database, ensures the day-to-day smooth running of the national office and provides support for the industrial, policy and research, and communication teams.

Specific projects in the past year have included:

- Organising the 2017 Annual Conference and 2017 Branch Officers' workshop
- Organising the Association's MECA ratification ballot and subsequent bargaining fee process
- Managing the administrative processes around recruiting new members
- Ongoing development of the membership database to simplify the data matching process
- Assisting the industrial team to develop membership mapping to support recruitment
- Supporting the Association's communications work by managing distribution of our printed publications
- Work on restructuring the online membership form which will ultimately lead to developing a membership portal
- Working across the Association to develop a new way of reporting financial information (making it more activity-based).

Job vacancies online

The vacancies section of the website advertises a comprehensive listing of senior hospital doctor and dentist job vacancies in New Zealand. The listings on the site at any one time is around 40 and the vacancies section has on average 1,000 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.

"We have very little say or influence in the direction of the DHB."

LOOKING AHEAD

The priorities for 2018 will include a focus on implementation of the new DHB MECA, negotiating and renewing collective agreements for our members who do not work in DHBs, continuing to break new ground in our policy and research work, and ensuring that the voices of senior doctors are heard in the ongoing debates about public health, resourcing, priorities, workforce development and patient care.