ANNUAL REPORT 2015

ASMS 27TH ANNUAL CONFERENCE 2015

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ASMS Annual Report 2015

The major events and challenges since the 26th Annual Conference in November 2014 have been a further visit by Professor Martin McKee, the election of a new Executive and new branch officers, the development of strategic choices for the Association in the upcoming MECA, expanding national office capability, responding to misguided decisions made by DHBs, Ministry and other agencies, and efforts to promote clinical leadership.

The National Executive comprises:

President	Hein Stander (Tairawhiti)
Vice President	Julian Fuller (Waitemata)
Region 1	Jeannette McFarlane (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)

Elections for the National Executive's new triennial term were held in 2015. Amendment to the Constitution adopted at the 2013 Annual Conference means the new term expires 31 March 2018. The Constitution was also amended to move to triennial terms for branch officers. Branch officer elections have been conducted and concluded for the new term commencing 1 July 2015.

Three candidates stood for the two Region 1 positions, with Carolyn Fowler and Jeannette McFarlane elected. The remaining positions were filled unopposed. The National Executive notes the longstanding committed service to the leadership of the Association by Region 1 representative Judy Bent, who was first elected in 1997. Formal recognition of her significant contribution was reported in the June issue of *The Specialist*.

The National Executive will have met on six occasions in Wellington since the last Annual Conference - 26 February (past Executive), 6 - 7 May (new Executive), 23 July, 13 August, 10 September and 18 November.

At the May meeting Jeff Brown was re-elected unopposed as National Secretary.

On 6-7 May, 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 the national DHB MECA negotiations.
- Extending the Association's direction in areas such as 'end-of-life' care. This was the subject of an article by Executive members Carolyn Fowler and Tim Frendin in the September issue of *The Specialist*.
- Promoting distributive clinical leadership.
- Progressing minimum standards in departments and services, including capital, workforce and information technology, following the session at last year's Annual Conference.

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

- Hon Jonathan Coleman, Minister of Health.
- Chai Chuah, Director-General of Health.

Following the Executive-only one-day meeting on 13 August, a dinner with the national office staff acknowledged the work carried out on behalf of members, and the position of the Association within the public health arena.

The national office comprises 15 permanent staff, three more than last year — Ian Powell (Executive Director), Angela Belich (Deputy Executive Director), Yvonne Desmond (Executive Officer), Cushla Managh (Director of Communications), Henry Stubbs (Senior Industrial Officer; part-time), Lyn Hughes (Senior Industrial Officer; part-time), Lloyd Woods (Industrial Officer), Steve Hurring (Industrial Officer), Sarah Dalton (Industrial Officer; commenced in May), Lyndon Keene (Director of Policy & Research; part-time), Charlotte Chambers (Principal Analyst Policy & Research; commenced in June), Lauren Keegan (Assistant Executive Officer), Kathy Eaden (Membership Support Officer; part-time), Shelley Strong (Administration Officer; commenced in January) and Maria Cordalis (Administration Officer – Membership; commenced in March). We engage additional accounting support on a weekly basis to assist with financial accounting and reporting.

It has been a year of significant change and expansion in the national staff – one each in industrial, policy and administration.

Lyndon Keene's position has been upgraded to 'Director of Policy & Research' in recognition of his outstanding research work for the Association, and his weekly hours have increased. After the Annual Conference he will be moving to Sydney for personal reasons but, owing to his immense value, will continue to work for the Association from his new home, with planned visits back to Wellington.

Dr Charlotte Chambers was appointed to the new position of Principal Analyst Policy and Research. Her previous experience includes time as a lecturer in human geography at Otago University. She has already made a significant impact with her well received Research Brief on social impact bonds and a survey (the magnitude of which the Association has not been able to undertake before) on presenteeism which will be reported to Conference, as well as a second survey underway on hours of work and burnout.

With these two changes, the Association now has a policy team led by Deputy Executive Director Angela Belich, who also leads the industrial team.

In order to 'future proof' the industrial team in light of increased workload pressures, the National Executive (on the advice of the Executive Director) agreed to increase its capacity, including the development of a limited career structure. Sarah Dalton, previously with the Post Primary Teachers Association, was appointed to an additional industrial officer position. Lyn Hughes was promoted to Senior Industrial Officer. This has led to changes in the geographic responsibilities for the team. Increased capacity (of six industrial officers) enables the team to react to members' issues and to DHB decisions, but does not allow the team to adopt a proactive role in membership representation.

Preparation for national DHB MECA negotiations

The current multi-employer collective agreement (MECA) expires on 30 June 2016, although it continues in force (including for new appointees) until a replacement is negotiated. Under the Employment Relations Act, collective bargaining cannot be initiated more than 60 days before the expiry date. Consequently, formal negotiations are expected to commence in May 2016.

Preparations for next year's MECA negotiations with the 20 DHBs began in 2014, including at Annual Conference, continued at Executive meetings throughout 2015, canvassed branch officers at their August gathering, considered members' feedback, explored recommendations from the Executive Director, and both formal and informal Executive deliberations.

MECA negotiation can be considered the most important activity the Association undertakes because it provides DHB members (the overwhelming majority) with their core terms and conditions of employment, is the most effective way of enhancing these conditions, and is of assistance for our members employed in the non-DHB sector.

There is also recognition that, despite the strong ratification vote in 2013, members expect the next settlement to provide more than the last one.

At the May meeting the National Executive decided:

- that a broader range of claims be developed, including around remunerative and reimbursement entitlements
- to extend the membership of the negotiating team beyond the National Executive, also including medical officers.

At the July meeting, the Executive adopted the theme *achieving patient centred care,* focusing on the role of senior medical and dental staff as critical to this objective. Underpinning sub-themes include:

- unmet need
- entrenched shortages
- capacity (to give the time to achieve distributive clinical leadership)
- fatigue.

A programme of activities was ratified, including publication of issues papers relevant to these sub-themes, to be collated into a comprehensive document.

At the September meeting the Executive decided:

- the ratification process of a proposed settlement of the MECA would rest with the National Executive after taking into account the result of a postal and electronic ballot of affected members.
- the individual members who would be invited to make up the expanded Association negotiating team. Invitations have been sent to these members.

The MECA negotiations are a major subject for discussion at the Annual Conference.

Trans Pacific Partnership Agreement (TPPA)

At the 2014 Annual Conference the following two resolutions were adopted without dissent:

1. that Annual Conference support the request for a formal independent health impact assessment of the Trans-Pacific Partnership Agreement based on the draft text prior to signing
2. that the Association opposes the TPPA on the grounds that health care will suffer from the loss of national autonomy that may result.

On 23 March the Association received a request from Dr Eric Monasterio (a member who addressed last year's Annual Conference on the TPPA and has been interviewed many times in the media) for

public endorsement and financial support to challenge the Government's refusal to release negotiating documents for the TPPA. On 3 May the Association received a further approach from the organiser of the initiative, Professor Jane Kelsey, adding a further request - litigant status, to assist credibility in court and in the media.

The aim was not only to secure greater disclosure in relation to these negotiations, but also to obtain a definitive legal interpretation of the relevant provisions of the Act for the future (for example, the multi-party Trade in Services Agreement negotiations currently taking place on the margins of the World Trade Organisation).

The case was taken by Matthew Palmer QC, with support from Professor Kelsey and useful research conducted by some Auckland University law students, in the name of Professor Kelsey with other parties, which included Consumer NZ, Ngati Kahungunu, Oxfam NZ, Greenpeace NZ, Tertiary Education Union, and NZ Nurses Organisation. The Association joined these supportive parties.

The pivot for the case was Professor Kelsey's request to the Minister of Trade (25 January) for a number of New Zealand documents, which were aligned to documents released by the European Commission, following the European Union Ombudsman's report on transparency in the similar trans-Atlantic negotiations involving the EU and United States. The Minister provided a blanket refusal to release any of the documents (27 February).

Litigant status was new territory for the Association, but the National Executive considered the request was comfortably within the remit of the Conference resolutions. The TPPA has important implications for health policy in New Zealand and also for the employment of our members.

Consequently the National Executive voted to endorse the initiative, to accept the offer of litigant status, and approve a donation of $5,000 to the initiative. This was reported fully to members in an *Executive Direct*.

The Official Information Act requires the Ombudsman to review the Minister's decision before any judicial review can be taken. After much delay the request was declined by the Ombudsman, which led to the judicial review. The case was heard by the High Court in September and our application was successful. Particularly significant was the firmness of the decision criticising ministerial use of blanket rather than specific refusal.

The greatest risk for the Association, if the case had been lost, was the awarding of costs, although this is considered unlikely. Awarding costs depends on the extent to which the action was seen by the Court as a genuine public interest.

Although the success of the case was mitigated by the prior signing (subject to ratification) of the TPPA, nevertheless it will provide information and insights into the background of the negotiations and also sets an important standard for considering future requests for information under the Act.

The National Executive also recommended that branch officers consider hosting Dr Monasterio at local meetings on the TPPA. Meetings were held in Rotorua, Masterton and Blenheim.

Disclosure of personal information under Official Information Act

At its July meeting, the National Executive discussed requests for personal information of DHB employees under the Official Information Act. This related to employment entitlements (eg, CME expenses) and individual clinical 'performance' data (eg, surgical procedures). The former involved the targeting of public health specialists by undisclosed industry lobbyists. The latter involved journalists whose enquiries, if successful, would have had the effect of naming, shaming and blaming individual specialists, mainly surgeons.

The Association has taken a two-pronged approach to the latter issue.

First, we have focused on why disclosing this information is not in the public interest, especially in a quality and relevance context, where patient care is by teams, and completely dependent on the way those teams function, rather than on a specific individual. Data on the performance of departments or institutions may reflect clinical performance, but data on outcomes assigned to an individual clinician is neither achievable nor accurate. A draft discussion statement from the Health Quality & Safety Commission on this aspect has been invaluable. The Association also made a positive submission to the Commission on this document.

Second, we sought the advice of a barrister specialising in privacy law with particular reference to the application of the Privacy Act. In summary, the advice states that personal information held by an organisation can only be used for the purpose for which it was gathered and cannot be publicly disclosed without the individual's permission.

This legal advice has been forwarded to the Medical Council and DHBs. It was also sent to members as an attachment to the national *ASMS Direct*. We have been raising this subject at our Joint Consultation Committees (JCCs) in each of the DHBs, where we have been pleased by the high level of agreement with our position.

Director-General reviews of capability & capacity and funding

In April, the Minister of Health announced his decision to establish a group to review the New Zealand Health Strategy (December 2000).

Subsequently the Director-General of Health announced two further reviews reporting directly to him. The first was on capability and capacity (run by Sue Suckling) and the second on funding (run by Murray Horn, along with Des Gorman). Both had the highly restrictive deadline of 30 June 2015. Consultation was limited. Sector workshops were held but limited by their construction and the tight timeframe. The National Secretary and Deputy Executive Director participated in the Health Strategy review, the National President and Director of Policy & Research contributed to the Capacity and Capability review, though the Association was not invited to engage with the funding review.

The Director-General of Health released the recommendations of his two reviews to a small select group of people (primarily DHB Chief Executives and Chairs, along with senior Ministry officials) but they were not given the reports that provided the rationale for the recommendations. Inevitably the recommendations were leaked (to Radio New Zealand) and attracted much public controversy.

Both the reviews' recommendations lacked sufficient detail to allow sensible debate. Concerns were largely about the funding recommendations centred on a more market approach which would be likely lead to:

- opening up DHB services to competitive tendering
- short-term funding
- short-term planning
- fragmentation of services and clinical teams
- uncertainty for DHB staff and patients
- lack of transparency due to commercial sensitivities.

The capability and capacity recommendations were less dramatic than those of the funding review but did suggest a more centralised 'command and control' approach. They also failed to acknowledge the need for senior medical staff to have sufficient time to engage in distributive clinical leadership and to address the poor state of information technology in DHBs.

In discussion with the Executive Director, the Director-General recommended that the Association make a written representation to him expressing our concern about the thrust of the reviews' recommendations. This was sent on 20 August.

Unmet need project

The National Executive received a request at its May meeting from prominent general surgeon Associate Professor Phil Bagshaw (Canterbury and Charity Hospital) for a contribution toward a proposed research project to comprehensively measure unmet need for secondary health care.

The project aims to:

- develop a questionnaire to identify unmet need for secondary health care services in New Zealand's adult population
- develop and introduce a modification of computerised records so general practitioners can register cases of unmet secondary healthcare needs among their patients
- pilot three methods of administration of the questionnaire, namely: face-to-face interviews; telephone interviews; and web-based reporting
- determine which of the four methods of data collection, or combinations of these, would be most accurate and cost-effective for subsequent use in a regular national survey programme for New Zealand.

It is intended that in a second phase of the research the selected methodology will be used to assess the extent of unmet health care need in New Zealand.

The project recognises that the current limited information – mostly anecdotal – suggests a significant level of unmet health need. While discussion has usually focused on access to primary care and elective surgery, it is now widely accepted that there are other areas of unmet need across secondary health care services including dental health, mental health, sexual health, and disability, as well as medical and surgical specialties.

The Ministry of Health is currently working on a way to measure unmet need that will include only those patients that have been referred to a specialist but are then sent back to their GPs for ongoing monitoring. This will overlook many others with unmet need, including:

- patients who are deterred by the cost of GP visits
- GP exclusion of patients who do not meet DHB thresholds
- GP referrals that are not accepted by DHBs
- those affected by diminishing public expectations for elective health care provision.

The Executive agreed that an effective and regular measure of unmet need will help to inform policy makers and governments – and the public – on the performance of the public health system and the effects of government policy. It would also help to identify and highlight areas where public hospital specialist services lack capacity to meet patient needs.

Further, it may be valuable for our industrial work (such as job sizing) and DHB MECA negotiations.

Consequently the National Executive approved funding of $10,000 toward the cost of this project.

The project hopes to publicise its results before the Ministry of Health reports its more limited survey in the middle of 2016.

Clinical leadership – distributive and formal

Clinical leadership was a priority for the National Executive in the past year. There have been four main activities:

1. Conducting an electronic survey of DHB employed members, which revealed a disappointing situation with no overall improvement since the poor results in late 2013, and confirming no significant improvement since the publication of *In Good Hands* in 2009. These results have been extensively reported in *The Specialist* and *ASMS Direct*.
2. Publication of an *ASMS Advice* to members focussing on distributive clinical leadership as an employment right for members and a responsibility for DHBs.
3. Distributive clinical leadership as a regular agenda item at Joint Consultation Committees.
4. A forthcoming publication supporting and advising those in, or considering taking up, formal clinical leadership positions. This is being developed by the National President, Vice President, National Secretary and Deputy Executive Director.

Activity in the non-DHB sector

This is a growing area of membership, with 204 members. There is enormous scope for recruitment across the sector. We are confident that we currently look after these members well and are responsive to their needs. We are, however, concerned that with increased workloads in the DHB sector (95% of membership) it will become difficult to maintain, let alone increase, services in the non-DHB sector.

This year has been busy for the industrial team, with all bar one involved at some level in negotiating non-DHB agreements. Negotiations have continued to be difficult in most, mainly due to the continued funding squeeze. Members are very supportive but also pragmatic, meaning in some cases a 'rollover' of conditions and no salary increase. This has increased the gap for non-DHB members compared with those in the DHBs. Despite this, or possibly because of it, our membership continues to increase.

There is risk to some of the very high needs practices, with two of our union health centres in serious financial trouble.

General practice

We include union health centres in this category and have a very mixed situation. We successfully negotiated a collective employment agreement (CEA) at Golden Bay for our six new members, with a very good result, including near-DHB conditions in many areas (this is the only Primary Health Organisation to directly employ general practitioners). At the other end of the scale we have Otara Union Health which has just announced that it is technically insolvent. There, and at other such practices, we will have to roll over the current agreement. Our biggest grouping (Wellington Doctors MECA – 22 members) was negotiated late last year, gaining four members as a result. Our biggest standalone practice is Te Runanga O Ngati Toa Hauora, where we have once again increased membership (now at 15).

Hospices

The hospice MECA was negotiated last year with the addition of two extra employer parties, and membership has increased to 45 covered by the MECA and five covered separately (including a CEA at Otago). Long term, we plan for a true nationwide MECA covering every hospice. Notably (and unusually) we have had serious employer relationship issues at one hospice, where shoddy management and governance has created havoc.

Rural hospital medicine

Most rural hospital medical specialists in New Zealand are Association members either through their DHB at smaller hospitals such as Greymouth, Ashburton, Thames, Taupo and Queenstown or in non-DHB sites such as Dunstan, Oamaru and Hokianga. The DHBs continue to look for 'generalist' cover at these smaller sites, and membership continues to increase, although we have seen redundancies at Ashburton.

ACC

The ACC CEA is under negotiation and as usual these talks are difficult and complex. Membership is up to 28, meaning this is our second largest non-DHB group. Members at ACC are employed very differently to other SMOs, increasing the difficulty in maintaining some form of parity. A stopwork telephone call was held in late October, with further negotiations expected to be protracted. Members are very supportive and we have a very good negotiating team representing their ACC colleagues.

Family Planning Association

This is our biggest non-DHB group under one CEA, with 40 members. Planning for negotiations is well underway with teleconference meetings and negotiations due in November. We expect these will see an increased membership, although membership density is already very high.

Iwi authorities

We have negotiated both of our Iwi Authority employment agreements this year. Te Runanga O Ngati Toa Hauora is our biggest membership in an Iwi Authority (or across our GP practices overall) with 15 members. We successfully concluded negotiations in good time. Ngati Porou Hauora has a reduced membership but we are maintaining their collective and have initiated bargaining for talks later this year.

Agreements at other health services

We have other collective agreements at Queen Elizabeth Hospital, New Zealand Blood Service, and Compass Health, with all due for negotiation in 2016. Given sufficient industrial officer time we will be actively recruiting to increase membership in these (and all of our other non-DHB sites).

Industrial team activities

The industrial team now has six staff, led by Deputy Executive Director Angela Belich, and includes Senior Industrial Officers Henry Stubbs and Lyn Hughes and Industrial Officers Lloyd Woods, Steve Hurring and Sarah Dalton. Despite the increase in staff, the team is more stretched and finding more demands on their expertise.

Lyn Hughes and Sarah Dalton have 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 is our resident expert on medico-legal issues, and takes referrals from other members of the team, particularly on cases that require rapid intense interaction.

The team is Wellington-based and meets formally at least monthly. Additional informal meetings have been introduced to provide support and peer review.

There has been a shift in the approach of management in DHBs to a range of issues, which is discernible even in those DHBs where we have had very good relationships with management and

human resources departments. Some DHBs have moved to “zero tolerance” approaches even for quite minor alleged misdemeanours and are more inclined to take formal disciplinary action than at any time in the Association’s history. This has meant additional travel and additional demands on the team as these processes cannot usually be dealt with entirely by phone or email. For the members involved this is an extremely stressful time, they need Association help, and they require prompt, reliable and knowledgeable support.

In addition to a hard-line attitude to personal cases, some DHBs have exhibited a reluctance to take an appropriately consultative approach to other issues such as job sizing. This has required the industrial staff to take an active and time consuming role in even the minutiae of the process.

Shift work

Earlier this year the Association was contacted by Waitemata DHB management and informed that they were considering requiring their Emergency Department FACEM SMOs to work night shifts due to severe staffing shortages of medical officers. This DHB has historically employed medical officers to work night shifts in the department. To ensure MECA compliance, the Association has been supporting members to develop a shift work agreement. This has involved a research project undertaken by Principal Analyst Charlotte Chambers, which resulted in a discussion paper to support and facilitate an agreement. It is anticipated that a shift work agreement will be completed in readiness for negotiations with WDHB sometime in November.

Know your MECA

‘Know your MECA’ workshops have been held throughout the South Island and lower North Island, and have been well received by members.

Job sizing

Job sizing continues to deliver benefits, even in the current constrained environment. In most DHBs the process has been collaborative and resulted in agreement on further positions, increased FTE and the inclusion of non-clinical time in job sizes. However, the process is not inevitably smooth. The team has noted two additional trends this year, with Waikato DHB management trying to minimise both the Association’s involvement and the collegial approach which works best. In addition, management at Whanganui DHB has the clear belief that the process will deliver savings to the DHB at the expense of SMO remuneration. This has required more involvement from industrial officers.

Bullying and harrassment

As a consequence of the spotlight on the behaviour of SMOs, we are finding that some DHBs are overzealous with regards to these types of complaints, are taking a more formal approach, and increasingly involving external lawyers in investigations. The issue is likely to grow in terms of the work of the industrial team.

Service reviews and changes to working arrangements

Constrained funding has led to a constant stream of reviews at DHBs as they attempt to find savings.

Redundancies

Although redundancies within DHBs do occasionally happen, they are still unusual. However, this year we have had to negotiate several. Privatisation of Fertility Services in Otago and Capital & Coast DHB laboratories led to job losses, and elsewhere we saw losses in Ashburton, Auckland and Palmerston North. The MECA has a very robust process that serves members well, but being made redundant is almost always a painful process with an even more painful outcome that we try to avoid.

We fear an increase in redundancies as DHBs look at ways to save money, including through the reduction or cessation of some services. Changes in expectations have also made some medical officer roles less tenable.

Advice to new appointees

This service is provided to prospective members who have received a job offer from an employer, on the understanding they will join the Association when they accept the offer and start work with the employer. It is received very positively. In the past 12 months, the team advised 88 doctors.

Long-term illness and 'return to work' plans

There has been an increase in cases of more lengthy periods of ill health (in excess of four weeks) and, in particular, cases involving stress and burnout.

'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 cases

One major case has been referred to the Employment Court during the past 12 months. In previous years, most cases were settled before mediation took place. A different pattern is emerging, with more unsuccessful mediations and fewer settlements before mediation.

There have been several cases this year where members have been subject to repeated attempts by the employer to either discipline or performance manage individuals. The underlying reason in our view may be because of age and/or because of a belief by management that they are no longer 'fit'.

Research team activities

The research team now has two staff: Director of Policy and Research Lyndon Keene, and Principal Analyst Dr Charlotte Chambers. Since November 2014, the Association's work in this area has focused on a range of professional, industrial and political matters, including the report *Proposed privatisation of hospital laboratories: weighing the risks of unintended consequences*, about the privatisation of hospital laboratories in the Capital & Coast and Hutt Valley DHBs.

This year has seen a surge of government activity in health, including a number of reviews, consultations and proposed legislative changes. The research team has accordingly worked on a number of Association submissions, including to the Ministry of Health's Capability and Capacity Review, and the Review of Health Funding Arrangements; the Productivity Commission's inquiry on 'Enhancing Productivity and Value in Public Services'; and on the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill.

The team has also drafted Association responses to the Medical Council of New Zealand's discussion paper 'Better data – the benefits to the profession and the public' and the subsequent and related Health Quality & Safety Commission's discussion document on the release of surgeon-specific performance data.

Lyndon Keene has co-written an analysis on the 2015 Vote Health Budget with Council of Trade Union economist Bill Rosenberg. Charlotte Chambers has produced a Research Brief (a new Association publication) on social impact bonds, a report on the annual SMO salary survey, and a discussion paper on shift work scheduling and risk factors in emergency departments, which is the subject of ongoing work.

Other research topics include health and safety specific to the medical workforce, health funding, patient centred care, and medical specialist workforce capacity.

The health and safety work has included a major study by Charlotte Chambers on 'presenteeism' in the senior medical workforce, including a national survey of Association members. The study has been published as an Association *Health Dialogue* and a version is going to external peer review journals for consideration. This is being followed up by another national survey of members on hours of work and burnout.

Health Sector Relationship Agreement steering group

Six meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group have been scheduled this year (the Association was able to attend four meetings). 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. This body is the primary means by which the Government, through the Ministry of Health, DHBs and health unions, engages on a national level. SFWU has recently amalgamated with the Engineering, Printing & Manufacturing Union under the new name of E tū.

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 start of each meeting.

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

- a presentation from WorkSafe New Zealand on its preparation for the pending legislation (effective next April)
- the discrepancy between the language of the Agreement and the conduct of individual DHBs, specifically referring to poor engagement processes over food services
- the DHBs-owned Health Partnerships Ltd replacing the crown agency Health Benefits Ltd
- evaluation of care capacity demand management
- regular reports from the national director of the National Health Board (NHB).

National Joint Consultation Committee (NJCC)

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. Although required to have at least four meetings each calendar year, this year it met three times, with the DHBs withdrawing from the fourth meeting and attempts to reschedule proving impossible.

There is some dissatisfaction among the National Executive over DHBs' commitment to the NJCC. However, there have been useful discussions on Official Information Act enquiries for personal employee information; consideration over a single consent form, insurance for death or injury for infectious diseases contracted through employment, transition from Health Benefits Ltd to Health Partnerships Ltd, clinical engagement before procurement and outsourcing decisions rather than after, Minister and Ministry of Health reviews, and common issues arising out of JCCs.

Joint Consultation Committees (JCCs)

In their 10th year of operation, JCCs are a vital part of the Association's work. Three JCCs have been, or will be, held in each DHB this year. Overall, attendances have been encouraging.

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

- 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 Association publication ASMS Advice on distributive clinical leadership. Responses ranged from non-committal to interest.
- DHBs' approaches to staff flu vaccinations with a particular emphasis on face masks for 'non-compliant' staff. The Waikato approach has been confirmed as an outlier.
- Association advice on enquiries under the Official Information Act for DHBs to provide personal staff information (principally around clinical outcome data but also employment entitlements – CME expenses). It appears all DHBs agree with the Association's approach.
- The recommendations of the reviews established by the Director-General of Health on (a) funding and (b) capability and capacity. These discussions have been useful but DHBs have necessarily had to be discrete. Nevertheless there is a high level of consistency with the Association's concerns.
- The Association's publication ASMS Research Brief on social impact bonds. Lack of information subsequent to its Budget announcement has limited discussion.
- Medical Council's e-portfolio for PGY1s.
- Importance of better supporting international medical graduates.
- Application of Population Based Funding formula.
- Updated SMO staffing, which occasionally leads to some interesting discussion.
- 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.
- Unintended consequences of official government health targets have led to interesting discussions in some JCCs.
- Sabbatical use. This, along with other Association promotions of sabbaticals, appears to be leading to more use of this entitlement by members. Applications are increasing and rejections are few. The JCC was also used to reverse the retrenchment by Auckland DHB reported to the 2014 Conference.
- 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

Car parking for SMOs when on after-hours call; acute admission pressures; masterplan for the public hospital sites; need to replace Patient Administration System; sexual health service; involvement of clinical heads of departments in employment agreement offers to new appointees; and replacement of local GPs with DHB rural hospital doctors at Dargaville Hospital.

Waitemata
Pressures on services with population growth occurring faster than expected as a result of immigration pressures; hospital redevelopment; a new institute for innovation and improvement; better support for the hospital at night; training for clinical directors; further co-sponsoring arrangements with the Association following the successful Professor Martin McKee visit; continuing development of nurse endoscopists in 2016; bullying; and Waitakere Hospital pressures.

Auckland
Surgeons' letter to chief executive outlining serious concerns over new clinical decision-making structure; adequacy of time allowance for new clinical director roles; concerns over new leave recording system extending into hours of work; application of the DHB's new 'values statement'; decision to contract out kitchen services; process of reimbursement of travel expenses; workforce capacity to achieve oral health target; internet access at workplaces; and CME guidelines.

Counties Manukau
Environmental sustainability initiative; rationing in context of addressing unmet need and improving end-of-life care; CMO survey of heads of departments over administrative support; pressures on emergency department; difficulties with DHB's research office; radiologists' difficulties with remote IT access; ongoing patient and visitor smoking; and possibility of fixed expenses (eg, APC and College fees) being invoiced (and paid directly by the DHB) and Kiosk developments.

Waikato
Management initiated 'medical efficiency review' involving job sizing (contentious); CME leave balances (contentious); SMOs working when on annual leave (welfare concern); new draft policy from CMO on SMO responsibilities; and tightening of processes for new and replacement positions.

Bay of Plenty
Improving administrative support; rigidity of minimum FTE appointments in anaesthesia; roll-out of Microster system (in conjunction with Bay of Plenty); management interest in 'partnering' with the Association over membership surveys; bullying; and violence against clinicians.

Lakes
Difficulties in getting locums processed under the new Vulnerable Children Act; concerns over functioning of internal clinical governance structure; rigid of relationship between funding & planning and provision functions; and a project on responding to workplace violence.

Tairawhiti
Delays in police checking under Vulnerable Children Act (police vetting); facilities review; increasing integration between DHB and Ngati Porou Hauora; bypassing head of department in critical stage of an SMO appointment (general surgery); and dress policy.

Taranaki
Performance appraisal review document (contentious); concerns over resourcing and organisation of retrieval teams; delays in police checking under Vulnerable Children Act; and return to public provision of privatised radiology service.

Hawke's Bay
DHB's Transform & Sustain programme to improve health and wellbeing; insufficient dedicated SMO car parks; inadequacies in provision of 'back office' support; and vulnerable services due to chronic understaffing.

Whanganui
CMO appointment process; and dissatisfaction with management's responsiveness to SMOs enquiries and requests; and sub-regional collaboration with MidCentral DHB.

MidCentral
Threatened disciplinary action against a specialist clinical diabetes nurse over a presentation to a national forum; sub-regional collaboration with Whanganui DHB; concerns over extent of 'mixed warding'; O&G external review; and cashing up accumulated annual leave.

Wairarapa
Unacceptability of workload pressures when rosters fall to 1:2 (unsafe environment created for SMOs and patients); appointment process for new chief executive; lower North Island sub-regional collaboration; concerns over accuracy of reported data relevant to six hour target; recognition of time for non-clinical duties in emergency department; process for employment of locums; value of a radiologist on-site; RMO numbers on weekends; and moves to strengthen permanent positions and weaken locum reliance.

Hutt Valley
Lower North Island sub-regional collaboration; increasing distance between funding and planning and service provision in lower North Island DHBs; deficiencies in management's transition planning for clinical leadership of emergency department; hospital laboratory privatisation; CMO appointment process; use of non-clinical time; and harassment and bullying.

Capital & Coast
Lower North Island sub-regional collaboration; hospital laboratory privatisation; consultation failures in mental health including letter of concern from psychiatrists; CMO initiative to move toward fixed term employment for formal clinical leadership positions; clarifying right of SMOs not to use DHB's preferred travel agency for CME travel; professional reviews and professional development plans; engagement of external consultants to look at theatre capacity; and CMO-initiated forums to discuss DHB's poor showing in the Association distributive clinical leadership survey.

Nelson Marlborough
Clinical prioritisation budget process; health needs analysis work; SMO involvement in Marlborough-based Deputy CMO appointment process; application of 'Top of the South' review process; strategic workforce planning; ICU improvements; what to do about clinical risk; pressures on smaller departments; planned redevelopment of Nelson Hospital (including consideration of digitalising the system); earthquake strengthening at Wairau hospital; cashing up of excess annual leave; an audit on SMO allowances (eg, call back, availability, and ad hoc historical arrangements); use of doctors' and nurses' images without their permission on social media and online; concerns over reimbursement processes and complexity of the current system; and SMOs putting in money as voluntary contributions toward a shared CME fund (from the MECA entitlement).

West Coast
Redevelopment of Grey Hospital and the Buller site; Trans Alpine collaboration; chief medical officer position and functions; elder care in Buller; GP shortages and effects on emergency department; tensions with Ministry of Health over building development planning; concerns over rebuild of a new ward and ATR facilities; and communication issues between surgical team managers and anaesthetists.

Canterbury
New 'Realign' project on patient flow and patient journey; tensions between DHB and Ministry of Health; severe workload pressures on mental health service (post-earthquake); Microster; and SMO appointment process.

South Canterbury
Results of distributive clinical leadership survey with particular reference to senior management; payment of expenses reimbursement; methodology for deduction of time-in-lieu days relevant to annual leave; SMO recruitment processes in respect of engagement; site development; review of emergency department; pressures on small services; appointment process for clinical director positions; and incorrect calculation of leave entitlements for part-timers.

Southern
Cuts to rural hospitals; planned building work at Dunedin Hospital; urology shortages in Southland; strategic plan; allegations of higher medical costs; loss of ICU accreditation; joint appointments with Otago University; asbestos; introduction of a leadership training programme; appointment process for CMO position; paying for PWC to cover the absent CFO position; emergency department staffing at Southland Hospital; and bullying.

Joint Association-DHB engagement workshops

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

Since the last Conference there have been workshops at:

- Northland (exploring SMO values and organisational culture)
- Waitemata (Chief Executive update on developments within the DHB; facilities and masterplan; patient experience; and service quality indicators)
- Counties Manukau (experiences of SMOs leading development of clinical services; and bullying)
- Lakes (distributive clinical leadership in light of the Association's electronic survey results)
- Canterbury (research initiatives; updates on post–earthquake community; and IT)
- South Canterbury (distributive clinical leadership; meeting targets; continuing to provide an ENT service; acute pathway; and meeting the demand for echocardiographs).

National branch officers' workshop

National branch officer (presidents and vice presidents) workshops have been held since 2011, two in each of 2012 and 2013 and one in each of 2014 and 2015.

This year the 14 August workshop programme included:

- direction of and preparation for the national DHB MECA negotiations and distributive clinical leadership – Executive Director Ian Powell
- duty of good faith and the Association Constitution - Senior Industrial Officer Henry Stubbs
- being a Branch Officer: your role/our role - Senior Industrial Officer Lyn Hughes
- "Know your MECA" - workshops to empower members - Industrial Officer Lloyd Woods
- workshops on:
  - fatigue, consultants and night work

- speaking out for better patient care
- taking up formal clinical leadership roles

- Medicine stories project - National Secretary Jeff Brown.

Medical Students Association

In 2014 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 helped fund NZMSA to send observers to our 2014 Annual Conference.

In February the Executive Director met NZMSA President Elizabeth Berryman and other representatives about further development, including the joint holding of an event to discuss the sort of specialists New Zealand should be training for 2025. NZMSA subsequently forwarded their written thoughts on how the relationship might develop. Further discussions have postponed this event until March 2016, but it is still tentative.

The National President and Deputy Executive Director attended the NZMSA annual conference in May (Auckland) and the Association made a financial grant of $5,000 towards its cost.

The Association continues to support NZMSA attendance at our 2015 Annual Conference.

Sexual harassment, bullying and inappropriate behaviour

On 22 July, the Resident Doctors Association (RDA) initiated a meeting to discuss the medical profession's response to the results of their survey on sexual harassment, bullying and other inappropriate behaviour toward resident medical officers (which attracted much media coverage). While there are legitimate criticisms over the robustness of the survey, it nevertheless confirmed the prevalence of this unacceptable and serious problem behaviour.

The Association was represented at this meeting by Senior Industrial Officer Lyn Hughes and Principal Analyst Charlotte Chambers. Other participants included Medical Council, Council of Medical Colleges, DHB Chief Medical Officers and Human Resource Managers, Ministry of Health and WorkSafe New Zealand. Unwisely, both NZ Medical Association and NZ Medical Students Association were not invited. The meeting agreed that the reported behaviour required action. It was agreed that a further meeting should be held on core principles and strategies for addressing them.

Partly because the Medical Students Association was unaware of this process, they conducted their own membership survey, which led to further media coverage, including some harrowing personal stories.

A second meeting was held on 24 September. The Association was represented by the National President and Lyn Hughes. On this occasion both the NZ Medical Association and NZ Medical Students Association attended. An agreed media statement was made on behalf of the group, confirming their commitment to "creating awareness and ensuring there are effective strategies and mechanisms in place to address issues". The group's next task is to develop an agreed action plan.

Subsequently the RACS has publicised a survey of surgical trainees, and issued statements from their President acknowledging bullying and harassment from supervisors, and committing to addressing this behaviour and changing the culture in the workplace.

National Bipartite Action Group

The Association is an observer on the National Bipartite Action Group (National BAG) which was established in 2010 as part of the settlement between the 20 DHBs and three health unions (Public Service Association, Nurses Organisation and Service and Food Workers Union). Subsequently the Resident Doctors' Association, APEX and the Medical Laboratory Workers Union have joined the National BAG. It meets every two months face-to-face and by teleconference in the intervening month. The Deputy Executive Director attended five meetings this year and Industrial Officer Lloyd Woods attended one.

The National BAG developed useful vaccination guidelines, which were followed by all but one DHB, and is now working on guidelines to protect staff from violence. It has also proved a useful venue for following other unions' bargaining and issues in DHBs as well as engaging in a different way with the State Services Commission, the Ministry of Health, WorkSafe and other national bodies.

Staffing and base salaries

This survey has been running since 1993. The original aim was to compare DHB (or their predecessors) salary levels for the purposes of single employer collective bargaining. During the years when Tony Ryall was Minister of Health, it provided useful data on the head count of senior doctors and dentists, and their spread over the salary scale.

The most recent survey collates base full time equivalent salaries as at 1 July 2015, and shows:

- 4307 specialists and 485 medical and dental officers (a 2% increase in specialist numbers and an 8% decrease in medical and dental officer numbers compared with 2014)
- an increase in the average specialist salary of 3% and a decrease in the average medical and dental officer salary of 6% from 2014
- the highest average salary for specialists at the Wairarapa DHB ($208,692) and the lowest at Waitemata DHB ($189,384)
- the highest average salary for medical and dental officers is shared between Tairawhiti, Wairarapa and South Canterbury DHBs ($166,000), with the lowest average salary found at Auckland DHB ($137,923)
- 57% of female specialists are on step one of the salary scale compared with 43% of male specialists. 23% of female specialists are on step 13 (top step) compared with 77% of male specialists
- for medical and dental officers, 40% of females are on step one compared with 60% of males. 46% of females are on step 12 (top step) compared with 54% of males
- most specialists were on step 13 (1629 specialists in total), with the next highest number on step 4 (515 specialists in total)
- for medical and dental officers, most were on step 12, with the next largest number (60) on step one.

Health Sector Directions Forum

This forum 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 and Principal Analyst Charlotte Chambers represented the Association.

This forum had presentations by:

- Chai Chuah (Acting Director–General of Health), with opening observations
- Treasury officials on the Budget and overall government spending
- Ministry of Health on the Budget effects in respect of health
- CTU Economist Bill Rosenberg on the Budget, with specific reference to health. He noted that New Zealand's cash deficit is well below increases in GDP and that, as a consequence, the country can afford more debt. Thus, the fixation of the Government on attaining a surplus is misleading and that cutting expenditure was more to do with a political programme rather than concerns with debt levels. Expenditure cuts included successive years of funding shortfalls for health since 2009/10. The CTU-ASMS analysis of the health budget estimated an accumulated shortfall of more than $1 billion by 2016.

There was also discussion that attempted to develop a shared understanding of the definition of productivity, which was inconclusive.

Medical Workforce Taskforce Governance Group

In 2013 Health Workforce New Zealand (HWNZ) 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. Its brief has since widened to the whole medical workforce career, and its membership expanded. The Group is convened by HWNZ Chair Professor Des Gorman and included representatives of DHBs (Chief Executives and Chief Medical Officers), medical schools, Ministry of Health, Medical Council, Council of Medical Colleges, Association of Salaried Medical Specialists (represented by the Executive Director), Resident Doctors' Association, NZ Medical Association (including its Doctors-in-Training Council), and NZ Medical Students Association. A drawback of the meetings is that they have been by teleconference, which seriously affects our ability to engage effectively, although the first 'face-to-face' meeting was held on 12 August.

Six meetings are scheduled this year (the Association has attended four to date). Features of the meetings have been:

- compilation of data on the profile of the senior and resident medical officer workforce
- funding of post-graduate medical training (currently $21 million) with the Chair of HWNZ proposing a shift from what he describes as funding for service provision to funding for 'future need'. This is expected to become a prominent issue next year.
- the Budget and workforce training
- community-based placements
- Medical Council training workshops for supervisors of interns
- Medical Council initiative on establishing a prevocational training baseline, involving reporting back on its survey of progress to date
- a presentation on job sizing by the Executive Director.

Lower North Island hospital laboratories

Much work by the national office has been dedicated to representing members' opposition to the privatising outsourcing of the Capital & Coast and Hutt Valley DHBs' hospital laboratories. The significance of the outcome and the commitment of Association resources justify a substantial report to Annual Conference.

These laboratories have historically been integrated into the services of their hospital. Community services for both the areas of the Hutt Valley DHB and Capital & Coast DHB were provided by Aotea Laboratories (45% Sonic owned). This contract came up for renewal in 2014 and was renewed for a further year until October 2015.

In 2013 the Laboratory Services Strategy was produced (guided by the combined planning and funding service for the three Wellington region DHBs, SIDU – Service Integration & Development Unit) assessing the region's laboratories. The DHBs' pathologists were excluded from being involved in the leadership of the development of this strategy.

The report concluded that the laboratories were working well and that the major requirement for an integrated service between the hospital laboratories and the community laboratories was a shared data depository. It included a number of references to serious shortages of capital and outlined a series of options for a more integrated service. These ranged from DHB hospitals doing all community and hospital testing, to the full outsourcing of all services.

- The head of SIDU advised the Executive Director, when asked, that outsourcing would not occur.
- A commercial process was then used, where expressions of interest were sought, then shortlisted and engaged in a request for proposal process. Members, the public, the Association and the pathologists at the two DHBs were frozen out of this process because of 'commercial sensitivity'. A saving of 8% was mooted. Explanation as to how this figure was arrived at has never been made available publicly, despite requests under the Official Information Act and follow up requests with DHB management.
- The three DHBs released a proposal in September 2014 ('the Integrated Laboratory Services Proposal and Consultation document') which had only two options, both of which proposed potential privatisation. Two weeks were available for feedback.
- Toward the end of the process, a group was convened by a Hutt Valley plastic surgeon to work on the specifications. This was the only stage in the RFP process that our pathologist members were actively engaged.
- On 30 January 2015, the DHBs delayed reaching a recommendation but finally made a provisional recommendation on 6 March. This provisional recommendation was confirmed on 24 April. Despite a request under the Official Information Act, the Board resolutions making the decision were not been made available to us or to the public.
- On 2 February Abano Healthcare announced that its subsidiary, Aotea Pathology, one of the two proposers in the RFP process, had pulled out because of concerns about the clinical and financial viability of what the DHBs were proposing. In April, Aotea Pathology was sold to Southern Community Laboratories for $1.
- Throughout the last weeks of the process we were hopeful that the Minister of Health would refuse permission for the DHBs to proceed with the outsourcing. In part, this was based on the implied message to Annual Conference by the Minister in response to a specific question on this subject that the DHBs' should take the advice of the pathologists. The Minister received a letter signed by all affected pathologists urging him not to support the privatisation, along with a similar letter from the Society of Pathologists.
- In part this was also based on concern in the Minister of Health's office and the Ministry of Health about the risks of unintended consequences and lack of confidence in the DHBs' competence over this matter.
- We learned at a meeting for unions held on 24 April that the Minister had given permission for the privatisation of the hospital laboratories.

- This approval threw into serious doubt his previously expressed commitment to clinical leadership and engagement. The DHBs are also now losing their most critical expertise for evaluating the performance of SCL.
- Subsequently Healthscope, the owner of SCL and now the majority player in the New Zealand laboratory market, has sold its Australian laboratory business to an American company. It appears that Healthscope has used this process to win a tender on an initial loss leader basis in order to boost the value of shares for a sale.
- This led to members' responses ranging from disbelief to outrage.

The Association has issued six media releases on the topic, written two submissions during the process, met with local management on the issue, attempted to lobby Board members, and discussed our concerns with the Ministry of Health and Health Minister's office. Interaction with Board members by the Association was severely restricted. Board members were warned that because the issue is 'commercially sensitive' they could not comment publicly without opening the Board and themselves to legal action. Every interaction by any individual on the subject had to be reported to the Board.

We have also published a *Health Dialogue* on the subject and kept members informed through seven *ASMS Directs* to Wellington region members, and three *DHB News*.

The final phase of this activity has been industrial support for the 15 members who are to be transferred to the private provider.

Health and Safety at Work Act 2015

The tragic death of 29 men in Pike River mine in 2010, and the subsequent Royal Commission and an Independent Taskforce on Workplace Health and Safety led the Government to promise to pass a new, improved health and safety law by the end of 2014. The draft legislation reflected that promise and received multi-party support in Parliament as well as from the Council of Trade Unions and Business New Zealand.

However, due to lobbying by a number of smaller employers and the farming community with allies in the government caucus, this consensus unexpectedly disintegrated. The Health and Safety Reform Bill that was eventually introduced to Parliament was different in many critical respects to the draft. The effect was to create a new Health and Safety at Work Act, replacing the Health and Safety in Employment Act 1992.

The proposed reforms include some positive aspects of Australian health and safety law and strengthen the role of worker representatives. Key among the proposed changes are initiatives such as employees' rights to a health and safety representative and that employers must provide information, pay, training and provide time and resources to undertake their role. The proposals further state that health and safety representatives will be able to stop unsafe work and issue notices to employers requiring them to address health and safety concerns.

These changes reflect admissions by the Government that New Zealand's health and safety record for serious injury and death at work is poor. It follows concerted efforts by the CTU after the Pike River tragedy to highlight the high death rates in forestry and the need for stronger health and safety legislation. The Association has supported these initiatives, including making a donation to the families of those killed at Pike River.

But the eventual Bill and subsequent new Act has been considerably weakened in three main areas:

- the removal of the requirement for worker representation on health and safety committees for businesses employing fewer than 20 employees
- the inclusion of the concepts of 'workgroups' (across employers) to limit the coverage and number of workplace representatives
- the addition of a provision that will enable employers to opt out of providing personal protective equipment in lieu of an allowance.

This led the CTU to embark on a public campaign to oppose the weakening of the proposed Act, which included the employment of a short-term project manager, written resources, advertising and the production of a short film for advertising purposes. The ASMS National Executive, at its July meeting, donated $4,500 toward the CTU's campaign.

Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill

The Government has introduced the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, which is currently with the Health Select Committee. This is an omnibus Bill amending seven statutes to increase the range of functions that can be performed by health practitioners under those statutes. The amendments will allow health practitioners to lawfully perform functions which could previously only be performed by medical practitioners.

The current legislation sets out functions to be carried out by medical practitioners. The original intent of these statutory measures was to protect public safety by ensuring that only medical practitioners with the required knowledge and skills were permitted to perform certain tasks. However, over time, the training of health practitioners has changed and it is argued that many health professional groups are now capable of performing tasks that were previously solely the domain of medical practitioners.

The stated intention is that the amended Acts will enable health practitioners with the required competencies and knowledge to lawfully perform certain statutory responsibilities such as participating in claimants' individual rehabilitation plans, issuing certificates of proof of illness or injury, providing ongoing health care, arranging medical examinations of children or young people, and taking blood specimens from road users. However, on closer examination it became clear that an underlying reason for some of the proposed changes was a shortage of general practitioners. The Association made a submission to the Health Select Committee raising concerns about proposed changes to the Burial and Cremation Act 1964; the Children, Young Persons, and Their Families Act 1989; the Mental Health (Compulsory Assessment and Treatment) Act 1992; and the Misuse of Drugs Act 1975. The submission is available in the 'Publications' section of the ASMS website.

Medicine stories project

At its February meeting the National Executive received a report from the National Secretary proposing financial support for a project initiated by Dr Glenn Colquhoun (GP and poet). This project arose from discussions between Glenn Colquhoun, David Galler, and Jeff Brown about the possibility for a collaborative effort involving Ko Awatea (Counties Manukau DHB) and the Association to develop an archive of doctors' writings. The Executive agreed in principle that the Association would make a seeding donation of up to $12,000 to the project.

There was hesitancy about the place of such a project, whether it aligned with Association objectives and whether it would be viewed positively by our members.

At its July meeting the Executive considered a further report from the National Secretary, debated the value of the project, including possible risks to individuals and for the Association. After robust discussion the Executive voted to confirm seeding funding of up to $12,000 for development of a website and the mechanisms for doctors to submit their stories, and to engage Glenn Colquhoun to review and curate the submitted stories. The project and funding would be reviewed after the first six months.

APAC Forum

Executive Director Ian Powell, Director of Policy & Research Lyndon Keene, Industrial Officer Lloyd Woods, and Director of Communications Cushla Managh reported positively on their attendance at the APAC Forum in Auckland in early September and organised by Ko Awatea (Counties Manukau DHB). A number of Association members, chief medical officers, some DHB chief executives and managers also attended. Earlier in the year the Association reached agreement with Ko Awatea over a discount rate for members. The Executive Director expects to have discussions about future collaboration for the 2016 Forum in Sydney, including possible involvement in the programme.

Visit of Professor Martin McKee

Last August the Association organised a successful visit to New Zealand by Professor Martin McKee (London School of Hygiene & Tropical Medicine and the European Observatory of Health Policies & Systems), including participation in the Association's 25th anniversary celebrations. Immediately afterward he addressed the APAC Forum in Melbourne in a session chaired by the Executive Director. In the audience was Waitemata DHB Chief Executive Dale Bramley, who was impressed and approached the Executive Director about co-sponsoring a second visit by Professor McKee. After further discussion and agreement, Professor McKee visited New Zealand between 11-17 April.

Most of his time was in Auckland but the Association used the opportunity to organise additional, well attended presentations and meetings in Whangarei and Palmerston North.

The Auckland meetings were:

- one to one meeting with the Waitemata Chief Executive
- an informal meeting facilitated by the Chief Executive and including clinical leaders, senior medical staff and Association representatives, and senior management
- the formal Chief Executive's lecture on international perspectives on integrated care, with a particular focus on chronic illnesses
- a grand round at North Shore Hospital on the sustainability of public health systems
- a session with Auckland region public health specialists in which he advised them to use their statistical and epidemiological skills to challenge the prevailing acquiescence to doctrines such as austerity and alleged unsustainability of public health systems.
- a meeting with Professor Max Abbott, Dean and Pro Vice-Chancellor of the Auckland University of Technology (AUT)
- a seminar at AUT.

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 this affiliation at both a national office level and with the affiliates. CTU work on analysing health spending and Vote Health in the Budget continues to be very valuable (Director of Policy and Research Lyndon Keene provides critical assistance for this work).

CTU President Helen Kelly has concluded her second four-year term and, due to illness, did not stand for re-election. She has proven to be an articulate, courageous and outstanding leader with an ability to effectively communicate to a wide audience. CTU Secretary Peter Conway stood down from his position after three years in his second term (previously he had been employed as the CTU economist for eight years). His dedicated service is acknowledged and the Association was saddened to learn of his tragic death earlier this year. Sam Huggard replaced him for the remainder of the term.

Richard Wagstaff (Public Service Association) was elected unopposed as the fourth CTU President and Sam Huggard was re-elected Secretary. Rachel Mackintosh (EPMU; now E tū) is the Vice President.

The Executive Director usually attends the CTU's quarterly National Affiliate Council. Issues considered by the Council included:

- the development of a new strategic direction for the CTU, doing fewer activities better, especially where resources are involved, and with a particular focus on union membership growth
- the regrettably revised health and safety reform bill
- the introduction of a 'campaign levy' for strategic campaigns to replace the current ad hoc method of seeking additional funding from affiliates. This has an explicit governance arrangement and was endorsed by the National Executive at its September meeting.
- Trans Pacific Partnership Agreement
- the implications of the successful Terranova equal pay case
- climate change
- the Employment Standards Legislation Bill
- migration policy, with particular reference to the rights of migrant workers vulnerable to exploitation and the impact on working conditions (for New Zealanders and migrants).

Meetings with Director-General of Health

The Executive Director has six regularly scheduled meetings with the 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. Following his confirmation into the position earlier this year, the Association issued a media release welcoming the appointment.

Topics included:

- his commissioned reviews on funding and capability & performance
- the controversial hospital laboratory privatisation in Capital & Coast and Hutt Valley DHBs
- difficulties in specific DHBs including Whanganui, Hutt Valley, Capital & Coast, Whanganui and Southern.

International travel

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

- The Executive Director attended the first of the two Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation, in Canberra in April. Issues discussed included the employment of senior doctors in Queensland public hospitals following the surprise defeat of the one-term government responsible for punitive employment legislation; clinical engagement agreement in New South Wales; bullying of resident doctors in Victoria; sexual harassment in the medical workforce; 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.
- Senior Industrial Officer Lyn Hughes and Industrial Officer Lloyd Woods attended the Australasian Doctors Health Conference in Melbourne in October. This led to some useful contacts being established with presenters.
- The Executive Director visited Europe in May. The main purpose was to attend the General Assembly of Marburger Bund, the union representing salaried doctors in Germany, in Frankfurt, which also enabled him to attend part of the German Medical Association Annual Conference. He also met with OECD health officials in Paris; the European Observatory on Health Policies and Systems in Brussels; attended the British Medical Association-led Local Medical Committees (general practitioners) in London; met academics and union representatives in London; had meetings with the Irish Medical Organisation and Irish Hospital Consultants Association in Dublin; and attended the Irish National Healthcare Conference in Dublin

Association communications

The Association's communications activity in the past year has focused on maintaining a solid media profile on issues that matter to members, developing an effective online presence through the use of social media, producing high quality publications that enhance the Association's reputation for analysis and relevance, and providing professional communications support by way of writing, editing and advice.

Media

Nearly 50 Association media releases have been issued to date on a wide range of topics including unmet health need, DHB funding, distributive clinical leadership, workforce shortages, rural hospitals, the right to 'speak out', government investment in the medical workforce, laboratory privatisation, and the Trans Pacific Partnership Agreement (TPPA). The Executive Director and individual members have been interviewed on these and other issues arising. Media advice and support has been provided to members acting as spokespeople, as needed.

The media continues to be interested in the work of our members and the health sector in general, and approaches us regularly for comment. It is worth noting the growing emphasis on online news platforms, which are changing the way journalists work in terms of timeliness, priorities and possibilities for coverage of issues.

Publications

The Association's quarterly magazine, *The Specialist*, has continued to develop in the past year, with the introduction of several new features to build on the existing content. We have also refreshed the

look and feel of the magazine with the aim of providing both a good read and a professional, contemporary looking publication for members. New features include profiles of members, photos and letters from the archives, cartoons, publication of individual MECA clauses to draw attention to them, and stories about specific workforce issues where these have not already garnered media coverage. These new features complement the existing analysis of significant issues provided by the President and Executive Director, and others within the Association.

Other publications sent to members during the year included the regular *National Direct* and *Executive Direct* e-newsletters, a *DHB News* tailored to each region following local Joint Consultative Committee (JCC) meetings with chief executives and senior managers, and *Regional Directs* notifying members of specific issues that have arisen.

In addition, a wide range of other publications have been produced during the year, including the establishment of a Research Brief Series to report on significant pieces of work by the Association's policy and research team, advisory publications such as a pamphlet on distributive clinical leadership, and flyers and other materials to support events (for example, Professor Martin McKee's return visit to New Zealand).

Executive Director Ian Powell continues to write a regular column for *New Zealand Doctor* magazine. In March 2015 he and Professor Martin McKee from the London School of Hygiene & Tropical Medicine jointly published an article in the British Medical Journal on New Zealand's approach to tackling unpopular health care legislation: http://www.bmj.com/content/350/bmj.h1502-0

Earlier this year the National Executive approved a recommendation to begin using QR codes on ASMS publications, and these have been appearing in *The Specialist* and elsewhere. QR codes are a type of sophisticated barcode that can take smart-phone users directly to a website article or online video or other material. They are a useful addition to the suite of communications tools.

Social media

The Association's presence online has continued to develop in the past year.

- Association website – this is updated regularly to ensure it is topical, timely and relevant. The redesigned website has continued to be very successful, attracting more than 2,500 unique visitors each month. New features have been introduced such as the 'Did you know?' carousel of items about individual MECA clauses (these are also reprinted in each issue of *The Specialist* magazine), as well as videos, historic photos and documents, profiles of Association members, and a fledgling new 'blog' section which will provide a platform for expert commentary (in the form of short articles) from members and others. The website is intended as the 'go-to' source of good quality information for members about the relevant collective employment agreements, job vacancies and for interesting, reliable news.
- Facebook, Twitter, LinkedIn and YouTube – these are all useful communication channels to have, although their value to the Association's day-to-day work varies. Facebook, in particular, is proving to be a good way to communicate with members and others. While the Association does not have a large number of followers, we regularly gather significantly more viewers when we report on issues that people find particularly topical or relevant. Likewise with Twitter, when someone with a good number of connections decides to repost one of the Association's 'Tweets', the post can reach many thousands of people within minutes.

The Association's use of social media is still in the early stages and will mature further in the coming year.

Membership

Once again the Association has had a record membership year (the 15th in succession). Membership as of 31 March 2015 was 4,271 compared with 4,167 at 31 March 2014, representing an overall increase of 104 (2.5%).

It represents a 196% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 163 senior medical and dental staff this year; to date 257 bargaining fee payers have converted to full financial members.

The annual membership increases since 1998-99 (the last year where we had a membership decrease) are: 1999-2000 (105 – 6%), 2000-01 (118 – 6.4%), 2001-02 (98 – 5%), 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%), 2013-14 (266 – 6.8%) and 2014-15 (104 – 2.5%), an overall increase of 130% over this period.

The average annual increase since our formation is 109 (7.6%). 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 164 (8.3%).

Currently membership is 4,307, an increase of 36 since 31 March 2015. Although membership growth in the latter part of the year is generally offset by factors such as retirements, we expect the 31 March 2016 membership to exceed current numbers. The combination of actively recruiting new members and strong membership loyalty continues to be key to our effective representation in both collective and individual matters.

Close to 90% of our members pay their subscription by automatic salary deduction (about 75% of new members employed during the past year opted for fortnightly payments). In April this year we added PayStation facilities to our website, allowing members to pay annual subscription fees online or over the phone with their credit cards. 30% of the members who pay their subscription annually opted to do so by credit card.

10% of Association members are also members of the NZMA. 18% of members who joined the Association in 2015 were also members of the NZMA, compared with 22% in 1996.

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).

Quarterly advisory consultancy meetings between the Executive Director, Executive Officer and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Mike Davy) continue. MAS have also generously increased the funding for this consultancy.

Discussions at these quarterly meetings have included our preparation for next year's national DHB MECA negotiations; our approach to inquiries to DHBs under the Official Information Act for personal senior medical staff information; the leaked documents on the two Director-General of Health reviews' recommendations; settling outstanding Christchurch earthquake claims; national office staffing expansion; our *Research Brief* on social impact bonds; the lower North Island laboratories dispute; MPS counselling service; the presenteeism survey; and particular DHBs.

Association finances

The Association's financial position remains healthy following another successful year with income and overall expenditure coming in close to budget. The 2015 budget had projected a surplus of $24,000. However, the very successful 25th commemorative conference, which was funded through reserves, resulted in a net operating deficit of $113,734 for the financial year ending 31 March 2015. The result has depleted our cash reserves to $3,477,199 (from $3,585,000 in 2014) but these still exceed the reserves policy target of $3,200,000 (set in 2013).

Administration

The administration team comprises Yvonne Desmond (Executive Officer), Lauren Keegan (Assistant Executive Officer), Kathy Eaden (Membership Support Officer), Maria Cordalis (Administration Officer Membership) and Administration Officer (Communications) - currently a temporary appointment until we find a permanent replacement for Shelley Strong, who recently resigned.

Reviewing and improving internal systems and processes has been a strong focus for the Administration team throughout the past year. The development of our new contacts database has allowed us to better manage communications and mailing lists and also incorporates a new feature that enables us to send a reminder text to members before a JCC or important meeting. We have added a conference registration feature to our database which integrates with our new online conference registration form, allowing us to process all registrations electronically. Recently we have moved our internal email system to a more secure cloud-based service offering us increased protection from viruses and spam. Ongoing projects include the migration of our membership database to a more robust software server and integration of our database with accounting and mail campaign software.

An increase in staff numbers during the year provided an opportunity to review the layout of the office and create new workspaces. Two extra offices and a small meeting room were built and we also completed a refurbishment of our resource and record room, allowing for increased storage and space.

Job vacancies online (jobs.asms.nz)

The vacancies section of the website advertises a comprehensive listing of senior hospital doctor and dentist job vacancies in New Zealand. Average listings on the site at any one time is 30 and the vacancies section has over 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.

Other matters

HQSC discussion paper: quality and patient safety framework

The Association formally responded positively to the Health Quality & Safety Commission's discussion paper: *A framework for quality improvement and patient safety capability and leadership building for the New Zealand health system*. We welcomed the direction of the paper and highlighted the link between entrenched shortages and failure to achieve substantive distributive clinical leadership. The Association recommended that the proposed framework be extended to include a focus on the need for adequate clinical staffing levels.

Medical Council recertification statement

At its September meeting the National Executive considered the recent proposed recertification statement of the Medical Council and was concerned with the restrictive timeframe, lack of problem definition and the limited nature of the questions. It was agreed to recommend to the Council of Medical Colleges (CMC) that it convene a meeting of relevant professional medical bodies with a view to developing a shared understanding and position. The CMC, however, declined the request, noted the level of earlier consultation on this issue, and provided a copy of its response to the Medical Council which may address the Executive's concerns.

Council of Medical Colleges

On 24 June the National President and Deputy Executive Director met the Council of Medical Colleges, including Chair Dr Derek Sherwood and Executive member Dr Julia Peters. The purpose was to discuss their best practice guideline and toolkit for use when "developing and reviewing systems that enable medical specialists in New Zealand to demonstrate their ongoing professional competence." Discussion was constructive and wide-ranging, including regular practice visits and changes to the Health Practitioners Competence Assurance Act proposed by Health Workforce New Zealand.

Minister of Health's annual letter of expectations to DHBs

Each year the Minister of Health sends all DHB chairs a 'Letter of Expectations'. The letter for the 2015-16 year focused on the clinical leadership, fiscal discipline, targets evolution, DHBs and primary care, and refreshing the New Zealand Health Strategy .

Australian Border Defence Act

At its July meeting the National Executive endorsed the call from the World Medical Association to allow doctors to speak out about the health of asylum seekers held in Australian detention centres.

Southern DHB chief medical officer position

Upon being informed by members of concerns over the appointment process for the vacant Chief Medical Officer, the Executive Director was involved in protracted advocacy over ensuring that the process complied with the requirements of the appointment clause of the national DHB MECA. The substantive issue was the involvement of the two senior medical staff bodies at Dunedin and Southland Hospitals. Eventually compliance was achieved, with agreement reached over a satisfactory process.

Association's responsibilities under new health & safety legislation

At its February meeting the National Executive considered its responsibilities under the then Health and Safety in Employment Bill, which required organisations (including unions) to have a governance structure to monitor operations. It was agreed to assign this role to the National Secretary.

Medical officer representation on National Executive

At its May meeting the National Executive received a request from a member for medical officer representation on the National Executive as an additional position to the current 10 members. This led to a wider discussion on the composition of the Executive including, for example, representation from smaller specialties, smaller DHBs and from members employed outside the DHB sector. This matter is being further considered by the Executive.

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. The Executive Director met with the Chief Executive of MPS while in London in May. MPS has also agreed to continue (and increase) its sponsorship of the Conference dinner.

Surveying DHB senior medical staff superannuation entitlements

The Association has been surveying the uptake of superannuation at DHBs for some years. The origins of this survey go back to the campaign for an employer superannuation subsidy during the 1990s. This campaign culminated in a provision for a 6% employer contribution in the first MECA being made available to all members working at DHBs

As at 1 July 2015 DHBs reported 98% of senior medical and dental officers were receiving some form of superannuation, with 278 enrolled under the NPF or GSF scheme (down from 323 last year), 4431 receiving the 6% employer contribution under the MECA and only 8 individuals receiving an employer contribution in some other way.

NZMA Specialist Council

For over a year, until the completion of her term on the National Executive, Judy Bent represented the Association as an observer on the New Zealand Medical Association's Specialist Council (the NZMA also has two other councils for general practitioners and doctors-in-training). It has proven difficult to confirm a replacement (no Executive member is also an NZMA member and none are Wellington-based where the meetings are held). Carolyn Fowler has agreed to represent the Association from the next meeting scheduled for 1 December.

Employment Exit Survey

Over the past year the Employment Exit Survey questionnaire has been reviewed and updated. We have also compiled and analysed all survey data dating back to when the survey began in 2010. Reports are provided to the National Executive twice a year, including the results of our historical analysis. We have looked at trends in members' movement overseas and also compared the reasons why members resign from employment over the past five years.

We continue to send the survey to members who resign, usually because they are retiring, moving overseas or because they are moving to another DHB. The response rate is around 36% (increased from 30% last year).

2016 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 2016 the Conference should be held in Wellington on 17-18 November (Thursday-Friday).

Jeff Brown
ASSOCIATION NATIONAL SECRETARY 11 November 2015