Advice

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Working away from home base

Increasingly District Health Boards (DHBs) are collaborating on the design and delivery of health services. The resulting co-ordinated provision of health service may be on a national, regional or sub-regional basis.

These divisions can be described as:

National – high complexity, low volume small services.

Regional – the 20 DHBs are divided into four regions (Northern, Midland, Central and South Island) but these were established for administrative reasons and do not make a good 'clinical fit.'

Sub-regional – smaller groupings within the more 'crowded' regions, which are more practical for clinical service collaboration and cooperation. This is where most of the inter-DHB clinical collaboration is likely to occur.

In addition, DHBs that provide services from more than one hospital or site within their geographical region are adopting 'one-service, multiple-site services' which can have a major impact on how staff are employed and deployed. In some large or remote geographical areas, this model of health service delivery may also involve collaboration with primary health care providers.

Under the NZ Public Health and Disability Act, the Minister of Health can compel DHBs to co-operate with one another in certain circumstances. Although the Minister may use these powers sparingly, the Government effectively achieves the same result by requiring collaboration between DHBs through the Minister's Annual Letter of Expectations to DHBs. This may also be achieved by the Minister appointing the same person to chair or sit on more than one DHB board (sometimes described as "crossover").

Often it makes sense to encourage this kind of collaboration, which usually fits well with professional collegiality and the core ethics and values of senior medical and dental officers.

ASMS members and senior medical and dental officers ("SMOs") have a key role in the design, organisation and delivery of these services. However, for some it will also have a significant impact on their terms and conditions of employment, particularly if they are required to travel from one workplace to another, within a sub-region or region, or even nationally. Some will do this within their normal working hours but for others it will involve periodic "long days", long-distance travel and overnight stays away from home and families.

Some services have been sub-regional (or regional) for some time. Developments include;

- the merger of the Southland and Otago DHBs into Southern
- the 'Transalpine Plan' for the West Coast and Canterbury
- joint services in Whanganui and MidCentral
- the '3D' sub-regional relationship between Capital & Coast, Hutt Valley and Wairarapa
- the 'inner' or 'tight three' Midland DHBs (Waikato, Bay of Plenty and Lakes).

Designing and planning through distributive clinical leadership

Clinical service planning should be based on the engagement principles found in the MECA and have active involvement of health professionals from each of the sites and services covered in the collaboration.

MECA Clause 1 - Underlying Principles

1.1 The parties acknowledge the fundamental importance of the need to promote and establish clinical leadership within the workplace consistent with the principles of engagement in the Time for Quality agreement between the Association and all District Health Boards (refer Clause 2) and the associated need to establish effective employer-employee partnerships, based on good faith, mutual respect and constructive engagement.

1.2 Accordingly the parties will actively promote and encourage open discussion and collegial and collective responses to workplace challenges and issues.

MECA Clause 2 - Time For Quality

The parties note the Tripartite Process involving the Government, the DHBs and the Council of Trade Union affiliated unions which is based on the Health Sector Relationship Agreement and which includes the Time for Quality Document. Consistent with this relationship the principles of engagement are as follows:

- Employee/management partnership is founded on teamwork and respect.
- Managers will support employees to provide leadership in service design, configuration and best practice service delivery.
- Managers will support employees to ensure recognised competency and credentialing standards are met.
- Managers and employees affirm that quality care drives the system to optimise patient outcomes.
- Managers and employees will collaborate to meet both the "patient test" and the "whanau test" which means the patient experience is optimised for the patient and in a culturally appropriate way.
- Managers and employees explicitly agree that decision-making and responsibility will be devolved to the appropriate level.

- Managers and employees accept that there will be some services that can more appropriately be delivered regionally or nationally to effectively meet patient needs.
- Employees will support managers to operate services within the resources available.

Time and resourcing must be allocated for SMOs to be involved in clinical service planning. In the case of consistent or long-term commitments by an SMO to work on establishing or planning a clinical service, they should be relieved (at least temporarily) of some or all of their clinical duties, and their DHB position should be backfilled appropriately by locums or payment to colleagues.

The key to successful planning of national, regional, and sub-regional services is distributive clinical leadership as set out in the Government's policy advice on clinical leadership, In Good Hands (also available on the ASMS website).

This should include all SMOs from each of the DHBs involved in providing the service or projected service. It should be based on an objective and evidence-based assessment of the projected needs of the relevant population. This doesn't necessarily mean a large committee is needed but experience has shown that having all, or most, of the players in the room, at least initially, has the advantage of forging personal relationships and encouraging networking.

Frequently SMOs from different DHBs who have never met will find that they share clinical concerns that are able, when articulated, to rebut misguided notions on the part of managers and DHBs' back-room "planners and funders".

Some proposals may be driven by a desire to cut costs or meet immediate short term targets. It will often be up to the SMOs involved to ensure that the long term needs of the patient/population and the sustainability of the service over decades are kept in mind.

Clinical service plans will need to consider the level of medical skill needed on the ground including the level of skill available in primary care. SMOs from larger DHBs need to be cognisant of the different requirements of more generalist practice at smaller hospitals. The level of SMO cover (both accessibility and skill mix) required for the safe and effective delivery of quality services should be considered in determining regional staffing levels and arrangements.

It is important that SMOs at smaller hospitals do not feel that collaboration will mean that unreal expectations for the size of their hospital or service are being put in place by clinicians from a metropolitan hospital. Questions about skill levels and standards should be settled by recourse to appropriate SMOs who practice in hospitals of the same size to help ascertain the appropriate standard.

Transport options available to both patients and SMOs should be examined carefully. For example, it is sometimes easier to travel by air from a major city than to drive from an adjoining DHB. Travel time must be counted as workload (part of job size) and the effect on clinical services taken into account.

If agreement regarding the development and implementation of clinical service planning is not reached, mechanisms should be put in place to resolve disagreements.

Telehealth

DEFINITION

Telehealth is defined as the use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location New Zealand Telehealth Forum: ***http://ithealthboard.health.nz/health-it-groups/new-zealand-telehealth-forum***

Telehealth may be an option as long as the appropriate technology is available to you and the clinician who is working with the patient. Having confidence and trust in the technology, by you and any treating clinician, will probably be a prerequisite.

Clinical services plan

The outcome of this exercise will be a clinical services plan, clinical sevices model or similar document that should always be the first step when developing a new regional service. Temporary emergency arrangements may sometimes be necessary but experience has shown that a long-term focused discussion still needs to take place. It is important that these plans be articulated in an unambiguous way at the appropriate time. This is a necessary first step to moving forward to the clear statement of the responsibility that any SMO might carry with respect to services in another DHB.

Any new appointments covering both areas should await the clear articulation of such a plan. Planning should be sufficiently detailed for the roles of the SMOs involved to be clearly understood. The extent of regional/national duties should be clearly reflected in role descriptions. For example, duties may involve travel between locations, or may be relatively minor such as providing phone cover.

Existing responsibilities to patients need to be taken into account. The Health and Disability Commissioner has already ruled that being required by an employer to do a clinic out of town does not excuse obligations to existing patients. (Case 10HDC00855).

Unclear or ambiguous allocations of duties are potentially a medico–legal and industrial minefield.

Mutually agreed job descriptions

MECA Clause 13.1 - Hours of Work and Job Size

13.1 An employee's hours of work and job size shall be mutually agreed and shall objectively reflect the requirements of the service and the time reasonably required for the employee to complete their agreed duties and responsibilities, as set out in their job description.

MECA Clause 48.1 - Job Descriptions

48.1 All employees are entitled to mutually agreed job descriptions. The following is provided as the recommended guideline. For ease of reference and clarity, the job description should have several distinct sections: ...

Senior Medical Officers covered by the MECA are entitled to mutually agreed job descriptions. This means that no currently employed member may be required (in the absence of agreement) to change their job description to include additional national, regional or sub-regional duties and responsibilities. SMOs must take care before they agree to take on additional duties, particularly where out-of-town or overnight travel may be required. ASMS has now had the experience of numerous SMOs who thought that they were "helping out" on a temporary basis or were excited by a new initiative, only to discover they had taken on extra work indefinitely. For this reason we have developed the concept of the "parachute clause" which is explained below.

Even if you are happy to take on the new duties you should ensure that the following matters are addressed to your satisfaction.

Job sizing

Your job size, including clinical workload should be adjusted to accommodate any additional duties and travel required. This means that a job sizing exercise should be undertaken for your service either before (preferably) or very soon after the new duties are taken on. This may mean a change in the job size of the service and therefore a change to the job size of individual SMOs or the engagement of extra staff. There should also be an expectation that if the duties prove more time consuming or onerous than expected, a further job sizing exercise will be done (see ASMS Standpoint on Hours of Work and Job Sizing on asms.org.nz).

Health and safety

Your DHB must provide you with a safe and healthy workplace. This is a legal requirement and means you cannot be expected by your employer to travel when overly tired or take on excessive clinical responsibility over a large geographical area that may place your personal health and safety at risk. The health and safety of SMOs (for example, the impact of travelling long distances) and the impact of work arrangements on SMOs' lives (for example, flexibility for family commitments and leave requirements) must be considered in determining arrangements.

Accommodation

In Clause 53 of the MECA, your DHB has committed to provide "good quality, suitable and safe workplace conditions, resources and accommodation". If you are required to spend nights away from home 53.3 applies. Accommodation should be within reasonable walking distance, be quiet and fulfil the requirements in Clause 53.3 of the MECA.

MECA Clause 53 - Facilities and Equipment

53.1 Workplace Conditions, Resources and Accommodation

The employer recognises the importance of providing good quality, suitable and safe workplace conditions, resources and accommodation.

Each employer and the Association will work together through an agreed process in evaluating the extent to which these workplace conditions, resources and accommodation are provided and to develop an agreed plan for remedying any deficiencies.

53.2 An employer should provide sufficient good quality overnight accommodation for each employee who, as a result of the nature of their duties, requires accommodation in the hospital overnight.

53.3 This accommodation should be secure, private, quiet and self-contained. It should be within reasonable walking distance of the workplace, having regard to any emergency and other duties the employee may be required to attend to overnight.

The accommodation should include at least: a bedroom or bed-sitting room; private bathroom with toilet and shower facilities; access to basic kitchen facilities for cooking or heating food; a television set, a comfortable lounge chair and a work-station or desk with telephone, computer terminal and internet access.

The "parachute clause"

On occasion where SMOs have been involved in regionalisation initiatives, they have enthusiastically embraced a set of wider responsibilities only to discover that they cannot sustain the commitment required. The amount of travel may become too demanding and there may be reluctance by the DHB to properly job size the role, the promised support or resources may not be available or simply the mix between travel and clinical duties will not be sensible. Ideally the SMO should get management to agree to trial the new responsibilities for an agreed period of time (eg. six months, one year or even two years). In any case, you should ensure you have the option of returning to your original clinical role.

Almost always it should be possible to build in a review of the sustainability or utility of the arrangements. It is likely to be much easier to get management agreement on criteria for a review; and the right to revert to the status quo ante, while they are seeking your agreement to do new work rather than after you have been doing the new work for some time.

Secondments

Some SMOs may be approached to work for either the Ministry of Health or some other body (eg, Health Benefits Ltd or a DHB shared service agency) developing or planning clinical services. The MECA does not cover these positions. If the position is time or task limited, ASMS would normally advise you to arrange a secondment from your DHB position. This would require the agreement of your employing DHB and would mean that you would continue on your existing terms and conditions of employment and have the right of return to your existing position once the task or term of employment was over.

Should you be contemplating a more permanent move, you should seek the advice of the ASMS industrial team.

Travel

Positions requiring a lot of travel need not be regarded as a career long commitment. What is suitable to someone at the beginning of their career may not be suitable when they have young children or as they get older. For example, commitments by individuals may be time limited or rotated among a group. Crucially staffing must be set at a level which allows some flexibility for family commitments, leave and sabbaticals and allows for arrangements to ensure travel is not overly onerous for individuals over too long a period.

Travel between sites or to a site that is not the normal workplace must be incorporated within your job size as clinical time.

Negotiated enhancements

It is not unreasonable for an SMO taking on extra responsibilities to expect extra payment. We know that some such payments have been agreed with some individuals and groups. It is much easier to obtain agreement on these matters when the DHB is eager to persuade you to take on extra duties or responsibilities.

Quality initiatives, CME and non-clinical time

Regional, sub-regional and merged services provide the opportunity for SMOs from several sites to co-operate on education, quality initiatives and clinical audit. This should be part of the clinical services plan or model from the outset, partly to allow opportunities for SMOs to work together and align their practice, but also to monitor and evaluate the quality, standard and accessibility of the new service.

What happens if I do not wish to take on additional sub-regional or regional responsibilities?

In the first instance you may simply refuse to agree to a change in your job description. You are not required to give an explanation but if you have reasons such as health, family or private practice that makes it impossible for you to travel or to undertake additional responsibilities, then it would be helpful to state what they are. It's important that you do this in a considered manner as some of the reasons for not taking up the extra responsibilities may change over time. It may be that your colleagues will be willing and able to provide the service without you for a period of time.

If, after appropriate consultation with SMOs, the service that your DHB provides becomes sub-regional or regional, and you are unprepared or unable to participate in it beyond your current job description, then the redundancy provisions in the MECA may apply. If this situation is starting to develop, you should contact ASMS industrial staff immediately.

New appointments

In general DHBs agree that if it is possible to do so, an SMO who works across more than one DHB will have only one DHB employer. We would expect that DHB to be the DHB where the appointee does most of their work.

Individuals who are employed in services identified as future sub-regional or regional services should be told clearly that this is a possible future development and that they may be required to undertake more travel and greater responsibilities including call. In the case of applicants from overseas this may require careful and detailed discussion of the distance and terrain involved. This possibility of future changes should also be referred to in advertisements for the positions, at the time of interview and included in the formal letter offering employment.

The appointment process

Where SMO appointments are being made to regional/national services, SMOs from both/all participating DHBs should be appropriately involved in the appointment process.

The appointments clause in the MECA will apply to any new appointments to a new service. Care should be taken to ensure that all SMOs in the service at each of the DHBs involved have the opportunity to participate in the appointment initially with input into the nature of the role and the level of skill, experience and the qualities required. In the case of an appointment covering two or more DHBs, representatives of the Senior Medical Staff committees for each DHB (or equivalent organisation agreed by ASMS) will be entitled to sit on the appointment committee.

MECA Clauses 52 - Appointments

52.1 The parties agree that the appointment of senior medical and dental officers, including clinicians appointed to leadership roles, whether to permanent or temporary positions and whether as employees or contractors shall be impartial, fair and transparent.

The employer also agrees to adopt appointment processes that will ensure only suitably qualified persons are employed or otherwise engaged to provide or manage clinical services.

Accordingly, before reaching a decision to engage the services of a senior medical or dental officer the employer shall consult other affected employees, (i.e. those in the same service or on the same roster) as to the need for such an engagement; the nature of the role; the level of skills, qualities and experience appropriate for the role or appointment. Following this consultation, a new or revised job description, if required, shall be prepared.

52.2 The appointment committee shall be convened by the chief executive (or their nominee) who shall ensure that:

(a) The clinical director or delegated senior medical staff member of the relevant department is part of the appointments committee;

(b) The Senior Medical Staff Committee (or equivalent body agreed with the Association) is invited to appoint at least one member of the appointments committee who shall be from the same or similar discipline to the position advertised; and

(c) In appropriate circumstances, an independent external senior member from the relevant professional college or association may be invited to be part of the appointments committee.

Treating the new appointee fairly

One approach adopted when a service becomes part of a wider regional, sub-regional or national service is to allow the current SMOs to remain on their existing job descriptions while all new appointments are made to new positions with a new job description to cover the new work. While this may appeal to current staff, it has the potential to become a source of tension over time, particularly if the new appointments to the expanded service bear the brunt of the out-of-town travel and other more onerous duties indefinitely.

Onerous travel should be time limited or alleviated with changes in family circumstances. It is up to SMOs currently in employment to ensure that their new colleagues are treated fairly.