ASMS
TOI MATA HAUORA

25th Annual Conference

ANNUAL REPORT

2013

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Annual Report 2013

The major events and challenges since the 24th Annual Conference in November 2012 have been the adoption of *Toi Mata Hauora* as the Association's Maori name; concluding the national DHB multi-employer collective agreement (MECA) negotiations; developing a strategic direction for the Association following the settlement of the MECA; the Employment Relations Amendment Bill; examining the work of Health Benefits Ltd; publishing *The Public Hospital Specialist Workforce*, Constitutional amendments, lower North Island general practitioner MECA, branch officers national workshops, and life membership process and criteria.

In the biennial elections for the National Executive, concluded in March, the following were elected:

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

Elections were contested for Vice President and representatives in Regions 1, 2 and 4. Hein Stander was elected the Association's seventh National President. 31 March 2013 marked the end of the five term national presidency of Jeff Brown who did not stand for re-election but who was elected as one of the Region 2 representatives. Jeff Brown was subsequently elected National Secretary by the National Executive at its 9 May meeting in accordance with the Constitution.

The standing down of two long serving Executive members who have made outstanding contributions to the leadership of the Association deserves to be acknowledged. Brian Craig was elected as Region 4 representative in 1995 and served as National Secretary from 1997. John MacDonald was elected to the Executive as Region 4 representative in 2000 in a by-election. This represents a considerable loss of quality experience for the Executive. One other member of the previous Executive also did not stand for re-election – Andrew Darby (Region 2). The National Executive is appreciative of his constructive contribution to the Association. There are now three new members on the National Executive – Jeff Hoskins (Region 2), Murray Barclay (Region 4) and Seton Henderson (Region 4).

Over May-June the second biennial elections were also conducted for the positions of branch presidents and vice presidents. The successful candidates took office on 1 July.

The National Executive has met on four occasions in Wellington since the last Annual Conference, with a fifth meeting to be held immediately preceding this Conference.

On 8-9 May the National Executive held its annual two day meeting to discuss strategic directions, the first day being informal. The informal day included:

- A 'direction and scope' analysis led by the new National President that focussed on the situation we were in, our core competencies, obstacles, prospects and expectations.
- Advancing the Association's profile (which included the participation of media consultants Cabix).
- The direction of the national DHB MECA negotiations.

Arising out of the informal meeting the National Executive agreed on the following action points:

1. Exploring how international medical graduates, in particular, and others could be better welcomed, including the role of the Association branches.
2. The use of the recently developed online membership application form for international medical graduates.
3. Developing possible linkages with the Association website including mobile applications and social media.
4. Trialling membership electronic surveys on social media and clinical leadership time.

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

- Kevin Hague MP, Greens health spokesperson.
- Dr Kevin Woods, Director-General of Health.
- Dr Johan Morreau, Chair, Health Benefits Ltd Clinical Council.

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

The national office comprises 12 permanent staff — Ian Powell (Executive Director), Angela Belich (Deputy Executive Director), Henry Stubbs (Senior Industrial Officer; four days/32 hours per week), Yvonne Desmond (Executive Officer), Lyn Hughes (Industrial Officer; four days/32 hours per week), Lloyd Woods (Industrial Officer), Steve Hurring (Industrial Officer), Lyndon Keene (researcher; 24 hours per week), Lauren Keegan (Assistant Executive Officer), Kathy Eaden (Membership Support Officer; four days/32 hours per week), Terry Creighton (Administration Officer) and Ebony Lamb (Administration Assistant; 5 days/31 hours per week). We also engage additional accounting support on a weekly basis to assist with financial accounting and reporting. In addition, Angeline Tuscher has been employed on a temporary basis until the end of this year to catch up with administrative backlog work.

Since the last Conference the following changes have occurred:

1. The employment of Steve Hurring as our third industrial officer commencing in January. The decision to create this additional position was reported to the last Annual Conference.
2. The employment of Lauren Keegan into the new position of Assistant Executive Officer commencing in September. The decision to create this additional position was reported to the last Conference.

3. Recognising the success of the position of researcher, including the publications *The Public Hospital Specialist Workforce* and the *Health Dialogue* (*Waitemata District Health Board's 'Package of Care' Elective Surgery Model: A costly experiment?*) along with ongoing analyses of specialist workforce claims, including by the Minister of Health, and supporting the work of the industrial team, the Executive agreed at its September meeting to increase Lyndon Keene's hours per week by four to 24 and make the position permanent.
4. The Assistant Executive Director position held by Angela Belich was renamed Deputy Executive Director. This decision brought the name into line with its role and functions rather than being a change in position.

At its meeting immediately before Conference the Executive will also be considering a proposal to establish a new full-time Communications Director position.

In the 2012 Annual Report we advised that because of our need for additional accommodation the Executive Officer had entered into negotiations with the building owner to take over the full space of the 11th floor in the Bayleys Building where the national office has been located since 2006. These negotiations were complicated but successful and we took over the expanded premises on 1 July after signing a new, nine-year lease. A substantial refit has significantly improved the accommodation of national office staff.

Bruce Corkill QC, barrister, continued to provide valuable counsel and support. Due to his position as Chair of the Health Practitioners Disciplinary Tribunal we also use Bartlett Partners for back up employment law and medico-legal advice.

Toi Mata Hauora

Last year we reported to Conference an important development initiated by then National President Jeff Brown, with the support of the National Executive, investigating a possible Maori name for the Association. At its meeting on 28 February 2013 the National Executive adopted the following resolution:

> *That the Association adopt the name Toi Mata Hauora in conjunction with the name Association of Salaried Medical Specialists as our identity.*

An appropriate ceremony gifting our new name occurred at the national branch officers' workshop held on 26 March with the Association accepting the gift of *Toi Mata Hauora* from Dr Te Huirangi Waikerepuru.

In appreciation of the gifting by Te Huirangi Waikerepuru of *Toi Mata Hauora* as the Association's Maori name, National Secretary Jeff Brown and Deputy Executive Director Angela Belich went to New Plymouth. We gave our koha to a kohanga reo (Te Kopae Tamariki Kia U Te Reo) which had been nominated by Dr Waikerepuru (who had also given the kohanga its name). In acknowledgement of the amount of time and effort involved by Te Huirangi Waikerepuru in making his gift and attending our branch officers' workshop in March we settled on $7,000 for the koha. At the kohanga reo the Association was treated to some delightful singing by a lively group of pre-schoolers. An article on the adoption of *Toi Mata Hauora* was published in the September issue of *The Specialist*.

The National President also wrote to Colin Feslier (Angela Belich's husband), who is fluent in te reo and was taught by Dr Waikerepuru, expressing the Association's appreciation for his support at both the branch officers' workshop and the visit to New Plymouth.

Strategic Direction for the Association

Following a report from the Executive Director, the National Executive spent significant time at its July meeting discussing the future direction of the Association following the settlement of the national DHB MECA. Arising out of this discussion the Executive endorsed a direction based on achieving greater visibility and effectiveness through:

- Greater use of Joint Consultation Committees in pursuing issues of concern and relevance.
- Shaping the narrative on issues of importance to members and the public health system including through the use of Association publications.
- Enforcement of the national DHB MECA including job sizing and hours of work, professional development and education, appointment processes, and recovery time. This would include more *ASMS Standpoints* providing advice on employment relations subjects.
- Joint forums with the Medical Protection Society on subjects of mutual interest not necessarily confined to medical-legal matters.
- Possible holding of 'events' such as special conferences or seminars on subjects of significance and relevance, perhaps in partnership with other organisations.
- Surveying members on relevant and important issues in part to stimulate conversations and debate.

This direction was introduced by National President Hein Stander at the branch officers' workshop on 29 August and also will be the subject of a special session at the Annual Conference.

Constitutional Amendments

The National Executive has considered extending the two year terms for both the Executive and branch officers to three years. Consequently on 11 July it adopted the following resolutions:

> *That the National Executive propose a remit to the Annual Conference that the Constitution be amended to extend the term of the National Executive from two to three years*.
>
> *That the National Executive propose a remit to the Annual Conference that the Constitution be amended to extend the term of the Branch Officers from two to three years.*

Background information has been forwarded to members and branch officers. If adopted by Annual Conference it would take effect for the next electoral term commencing 2015.

Life Membership

A priority for the National Executive was the development of a formal process and criteria for determining life membership. In our 24-year history the Association has confirmed four life members – John Hawke (third National President, deceased), James Judson, George Downward (first National President) and Allen Fraser (second National President). Aside from their involvement in the leadership of the Association, what characterised all four was their central role in our formation.

However, there is no formal process or criteria for regularly reviewing worthy candidates for life membership. The Constitution (6.2) states that the National Executive, branches or individual members can nominate and that the Annual Conference determines life membership. Unless an individual member decides to nominate, nothing happens, and there are no guiding criteria as to what might be sufficient grounds to award life membership.

Following discussions at the first two National Executive meetings of the year the three national officers (President, Vice President and Secretary) were tasked with considering the issue and asked to bring a proposal to the Executive. They sought advice from the Executive Director, met to consider the issue, and then made recommendations regarding process, criteria, and a candidate for life membership. This was considered by the Executive at its 12 September meeting. In respect of process it was resolved that:

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

In respect of criteria the Executive resolved two measures:

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

Based on the recommendation of the national officers the Executive agreed that it would be most appropriate to nominate Dr Peter Roberts as the next Association life member. Dr Roberts has an extensive background in the leadership of the Association which includes:

- National Executive Region 3 representative, 1991-1993.
- Vice President, 1993-1997.
- National President, 1997-2003.

In addition Dr Roberts:

- Was the Association's first Wellington branch president.
- Received the Prime Minister's prize for being top in the Master of Public Policy course in 2002.
- Received the Sir Frank and Lady Holmes Prize in 2003 for his MPP thesis which was subsequently published as part of the prize as *Snakes and Ladders-- the Pursuit of a Safety Culture in New Zealand Public Hospitals*.
- Has continued to be a source of advice on professional issues to the Association, including most recently the Medical Council's work on increasing prevocational training requirements.

National DHB MECA Negotiations and Settlement

At the time of the last Annual Conference negotiations for the next national DHB MECA had yet to commence but the Association and DHBs had just concluded a process of 'technical discussions' largely on non-fiscal issues which served to 'clear the deck' of a number of potential issues for inclusion in our claim. It also resolved the 'bargaining process agreement' required by the Employment Relations Act.

Process

The Association's negotiating team comprised the National Executive along with the Executive Director as advocate and the Deputy Executive Director. Formal negotiations commenced on 7-8 February (the existing MECA expired on 28 February) and concluded on 7 May when provisional agreement was reached subject to ratification. At the Executive's meeting on 9 May the following resolution was adopted:

> *That the National Executive approves the without prejudice settlement of the national DHB MECA negotiations reached on 7 May, subject to ratification by the DHBs and recommend its acceptance by members in an indicative postal ballot.*

The indicative postal ballot of DHB members was then conducted over the month of June. In summary:

1. 85% of respondents voted to accept the proposed settlement. This compared with 93% in 2011 and 88% in 2008.
2. The response rate was 58% compared with 63% in 2011 and 74% in 2008.
3. The highest 'no' vote was South Canterbury (26%) followed by Hutt Valley (23%) and Waitemata (22%).
4. The highest 'yes' vote was West Coast (94%) followed by Canterbury (94%) and Lakes (93%).

This was the first time that we provided an electronic voting option which we actively encouraged in numerous *ASMS Directs* and other electronic reminders. The percentage of respondents who voted electronically was 53% (at the time we had email addresses for 90% of our DHB employed members.

At its meeting on 11 July the National Executive adopted the following resolution with one abstention:

> *That the National Executive, after consideration of the results of the indicative membership ballot, approves the ratification of the proposed national DHB MECA settlement.*

Settlement

Although the National Executive recommended to DHB employed members that they vote in favour of ratification, it also advised members that it was under no illusion that this was a very modest and rather limited settlement and it had no desire to oversell it. But it was also the best the Executive believed could be achieved in the current difficult environment. Factors behind the Executive's assessment were:

- The government had done a 'flip-flop' on the issue of the vulnerability of the specialist workforce in DHBs. When in opposition and in the first two years of being in office their position was that there was a crisis in hospital specialist staffing levels and it was the Health Minister's top priority to address this. Since then, however, there has been a U-turn with misleading claims of increased hospital doctor numbers.
- The DHBs adopted very restrictive financial parameters for the negotiations. This has been in two different ways – the cost of the settlement during the term of the new MECA and the ongoing annual cost of the settlement by the end of the term of the settlement. The practical effect of these parameters is that if all the increased cost was spread equally across each of the salary steps the offered increased salary would be not more than 0.7% per annum.
- There were possible approaches to overcome this. One approach was limited industrial action at the level of electives and non-acutes. However, the assessment of the Executive, reinforced by discussion among Annual Conference delegates and also at national

meetings of Association branch presidents and vice presidents, was that there was, at most, limited support for this form of action. A second approach was to wear the DHBs down by attrition over time but the Executive's assessment was that, while in some circumstances this can bring results, this would not be the case on this occasion. A long drawn out negotiation would run the risk of a long period of uncertainty with the possibility of the same or very similar outcome.

- The Association's priority in these negotiations was to improve the competitiveness of the salary scales, especially the specialist scale.
- There are two main points of vulnerability in the specialist workforce. One is newly trained specialists and the other is those on the top of the scale (or close to it) who are less likely to have dependent family members and are therefore open to opportunities for overseas job offers mid to later career. In the previous MECA settlement the Association had focussed on new specialists by achieving removal of the bottom three steps (the old Step 4 became the new Step 1). Anecdotal reports suggest that this was useful in recruiting more domestically trained new specialists. In these negotiations the National Executive focussed on the upper end of the scale. Some members on the top step have not had an increase for several years whereas others have had annual increases (through salary step progression) locked in by previous MECAs.

Consequently the approach to reaching the settlement was two-fold:

1. Focussing on the upper end of the specialist scale (including the introduction of a new 13th step) and to a lesser extent the non-specialist medical/dental officer scale. Note that an estimated 47% of specialists are on the top three steps of the current scale.
2. Obtaining what small increases we could for the rest of the scale.

The settlement is for a three year term commencing on 1 July 2013 and expiring on 30 June 2016 although it covers a period of 40 months as the current MECA expired on 28 February 2013.

In summary, the main elements of the changes to salary scales were:

1. The introduction of a new 13th specialist step effective on 1 October. Those who were on Step 12 for at least 12 months on 1 October would transfer to the new Step 13 (others will advance on their normal annual advancement date). Over the three year period the margin between Steps 12 and 13 increases from $3,000 to $8,500.
2. There were very small increases to all of the salary steps on 1 October 2013 (except Step 12), 1 September 2014 (except Steps 10, 11 and 12) and 1 July 2015 (except Step 2 which stayed the same). The increase is a little higher for those on specialist Step 13.
3. There was a slightly higher increase to the top step of the non-specialist medical/dental officer scale in the third year compared with the other steps.

The other elements of the settlement were few, minor and non-financial, (there were no losses of existing conditions), the main ones being:

- The wording on placement of new appointees on the salary scales progression was tidied up and made more explicit. Although not necessary it should ensure that the misapplication of placement by the three Auckland DHBs in 2012 (subsequently corrected) will not be repeated.
- A provision in the parental leave clause, enabling a member returning from parental leave to apply to vary the proportion of full-time employment from that which applied before the leave was taken, has been relocated.

- The sabbatical entitlement wording was tidied up by removing some duplication that should make the application of the clause easier to understand.
- A few other small wording changes for greater clarity and to correct minor errors.

Aside from the overall small size of the gains of the settlement there were three main specific criticisms:

1. The length of the term of the new MECA (three years). The National Executive opted for this length because it had been in almost continuous negotiations with the DHBs since 2010 and there was no indication that the political or financial environment would be substantially different in one or two years. Further, we would be likely to be negotiating with the same personnel.
2. The small increases for those members on the lower and middle steps. This was an inevitable consequence of the approach taken by the Association to the scale (discussed above).
3. No 13th step for the medical and dental officer scale in contrast with the specialist scale. This was the last issue the Association's negotiating team pulled back on in the final stages of the formal negotiations. The retention argument used to achieve the 13th specialist step was much less applicable for this scale and also it posed a potential relativity issue with the specialist scale. We did, however, further widen the margin between the ultimate and penultimate step to the benefit of those on both steps.

Bargaining Fee

Part of the settlement was the continuation of the bargaining fee provision which required ballots to be held of both members and potential members employed in each of the 20 DHBs. The ballots were organised, in consultation with the Association, by human resource general managers with branch officers or other Association representatives acting as scrutineers. In total 1,542 members and non-members voted with overwhelming majorities in favour in all DHBs (91% nationally) meaning that those who wish to benefit from the MECA conditions must pay a bargaining fee to ASMS equivalent to an annual subscription.

Employment Relations Amendment Bill

In the 2012 Annual Report we advised that anticipated changes to the Employment Relations Act were expected to pass through Parliament before Christmas despite doubts over a tight time frame. However, the Employment Relations Act did not have its first reading until June. The Bill is currently being considered by the parliamentary select committee.

The thrust of the Bill is retrograde in that it seeks to reduce existing rights of collective bargaining and increase the vulnerability of already vulnerable employees. The Council of Trade Unions submitted an impressive and particularly comprehensive submission to the select committee. Recognising and appreciating this, the Association's submission was narrower in scope; it focused, in particular, on the Bill's provisions that would:

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

Oral submissions in support of our written submission were made by the Executive Director, Deputy Executive Director and Senior Industrial Officer to the select committee. In addition, four *Parliamentary Briefings* focussing on our concerns with the Bill were sent to all MPs.

State Sector and Public Finance Bill

Late November last year the government introduced the State Sector and Public Finance Reform Bill into Parliament for its first reading before referral to the Finance and Expenditure Select Committee. The Bill provided that:

- The State Services Commissioner may, without union consultation, issue wide-ranging binding workforce policy orders relating to principles of pay and conditions or workforce strategy. This provision had potential to impact very negatively on our national DHB MECA negotiations.
- Ministers and departmental chief executives may delegate public sector functions or powers to contractors or companies outside of the public service without needing legislative (or even cabinet) approval.
- Redundancy compensation for employees in the state sector may be denied where they are offered another job elsewhere in the state sector (including where the employee elects not to accept the role in some cases).
- State Owned Enterprises and crown entities (DHBs are crown entities) may be partially privatised by order in cabinet (placing them in new schedule 4A of the Public Finance Act) without requiring additional legislation. This was an obscure provision which could have been potentially very serious.
- The State Services Commissioner may vary or disapply the state sector code of conduct for individuals or groups of individuals.

The Association made a submission on the Bill based on a draft prepared by the Deputy Executive Director. For a number of matters we deferred to a comprehensive submission from the Council of Trade Unions. Further, both the NZ Educational Institute and Public Service Association were having separate discussions with government over some key provisions of the Bill which were in our interests for them to succeed (and where it appears good progress has been made). Our submission specifically focussed on:

- Redundancy and transfer of employment provisions.
- Workforce policy orders.
- Consultation and the State Services Commission with particular reference to the health sector.
- 'Whole of government directions' for crown entities (eg. DHBs) including the implications for collective bargaining and Health Benefits Ltd recommendations.

Activity in the Non-DHB Sector

It has been a busy year for negotiations. Angela Belich, Lyn Hughes, Steve Hurring and Lloyd Woods were all involved as advocates. These collective agreements can be quite difficult and involved. Association members sometimes face considerable employer opposition to their attempts to negotiate collectively. As advocates we are very dependent on a group of active members. Their input and assistance is the key to continued successful bargaining. The National Executive appreciates these members who joined or assisted negotiating teams. Non-DHB membership is small in comparison to DHB membership but continues to slowly grow. Within

the next twelve months we expect to increase to 200 non-DHB members. We have included 'union friendly' clauses in our non–DHB claims that should encourage membership growth.

General Practice

Following considerable interest last year as a result of initiatives for general practitioner trainees we expect that the number of employed general practitioners will be increasing over time. Whilst we have agreements for some general practitioners we expect demand for membership from this group to increase. Typically when a GP is initially employed he or she might negotiate what seems to be an attractive package but over time this tends to fall away. In some cases it appears that in order to recruit the employer will offer very good enticements but once 'caught' the bait diminishes considerably. Without attention to annual improvements (as negotiated for our members on collective agreements) these arrangements soon fall behind.

The biggest GP group that the Association represents comprises 22 GPs in the Wellington region union health centres. After considerable difficulty we negotiated a new 'Doctors Collective' that covers Association members only across the four union health centres. This new collective agreement is our first exclusively general practice MECA (and our third MECA alongside those covering DHBs and hospices).

Te Runanga O Ngati Toa Hauora is our biggest stand-alone GP practice with 12 members. The collective agreement was renegotiated after some tense discussions due mainly to some employer 'claw-backs'. Other collective agreements are very small and employers are struggling to recruit - Te Oranganui (Whanganui); Christchurch union health centre; Waitakere/Otara union health centre; and Hokianga Health have long standing collectives. All have been renegotiated or are in the process of renegotiation. Settlements have been around 2% to date.

Rural Hospital Medicine

The Faculty of Rural Hospital Medicine is part of the College of General Practitioners and nearly all of these graduates will be covered by our DHB MECA at smaller hospitals such as Greymouth, Buller, Taupo, Thames, and Queenstown or by our separate non-DHB collective agreements at Hokianga, Oamaru and Dunstan. The demand for 'generalists' at small hospitals is increasing and we are also seeing some changes in demand for rural specialism. We are watching this closely. Most rural hospital specialists will spend much of their working lives employed under the DHB MECA. Oamaru and Dunstan Hospitals have collective agreements that are set to match the DHB MECA.

Hospices

The Hospices MECA increased to 11 hospices for negotiations this year. We continued lining up hospice conditions with the DHB MECA with some success. Members were very happy with the outcome. The Association also negotiates the collective agreement for members employed by the Otago Hospice which we hope to eventually incorporate in the Hospice MECA. We continue to recruit members at other hospices and aim to eventually bring them under the Hospice MECA. The Employment Relations Act (currently) is advantageous in allowing us to bring a one member site into the MECA whereas to negotiate an ordinary collective agreement we need two.

ACC

As reported in earlier years the negotiation of a collective agreement for our members employed as Branch Medical Advisors at ACC was ambitious and created a lot of work but was eventually achieved. Renegotiation of the collective agreement includes many of the challenges in gaining the original collective and this year has been no exception. ACC are pushing very hard for a very strict 'performance management and reward' system.

ACC is our biggest non-DHB site with a growing membership (currently 24). Members are engaged in the process and we have a very busy negotiating team. We held our first formal non-DHB stopwork meeting as part of the negotiation process. We expect negotiations to conclude this December.

Other Health Services

The Family Planning Association collective agreement will be renegotiated later this year. The Queen Elizabeth Hospital collective agreement covering rheumatologists has been renegotiated but not finalised as yet due to the loss of membership through redundancy and resignation leaving us with only one member on site. The New Zealand Blood Service collective agreement has been settled with the same remuneration as the DHB MECA and with a similar three year term. The Compass Health collective agreement was successfully renegotiated also moving towards parity with the DHB MECA.

Industrial Team Activities

The industrial team now comprises Deputy Executive Director Angela Belich, Senior Industrial Officer Henry Stubbs and Industrial Officers Lyn Hughes, Steve Hurring and Lloyd Woods.

Lyn Hughes has responsibility for Northland, Waitemata, Auckland and Counties Manukau DHBs; Steve Hurring for Waikato, Lakes, Bay of Plenty, Hawkes Bay, Tairawhiti, Taranaki, Whanganui and MidCentral DHBs; and Lloyd Woods for Wairarapa, Hutt Valley, Capital & Coast, Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs. Henry Stubbs has responsibility for medico-legal issues, mentoring, developing and codifying advice to members and also takes referrals from the rest of the team. This highly competent, productive and experienced team is led by Deputy Executive Director Angela Belich.

Much of the work of the team is offering advice by telephone or email to members about their entitlements, the application and interpretation of their employment agreements and advising, representing and otherwise supporting them as they respond to complaints arising from their employment. The team is based in Wellington but travels frequently to meet with members and management. The team meets together at least monthly to ensure advice is consistent, to discuss more challenging issues and to develop resources for members.

'Know Your MECA'

The approach that the Executive has agreed on, following the MECA settlement, comes under the rubric of 'know your MECA'. For the industrial team much of this is business as usual. In addition, a programme of proactive resources and promotion has been embarked on. In the period covered by this report this activity includes a session at the second branch officers national workshop by the Senior Industrial Officer on the appointments clause in the MECA (this issue has also become part of JCC discussions), the *Working Away from Home Base* advice for members and the '*Parental Leave Q and A*' in the September 'Specialist' and on the website. Further resources for members are planned for next year.

Job Sizing/Back Pay

Job sizing takes time and the process varies considerably between and within DHBs. Back pay has become more difficult to access although prior agreements have delivered some very significant back pay for members.

Bullying in the Workplace

The Association's *ASMS Standpoint* on *Bullying in the Workplace* was finalised early in the year and has been well received by our members and DHBs. The production of the Standpoint followed a period when the Industrial Officers identified an increase in cases of bullying against, and by, our members, some of which were dealt with inappropriately by DHBs.

Service Reviews and Changes to Working Arrangements

The Association has been insisting on good consultation and clinical engagement and DHBs now understand the advantages of this engagement. We receive a constant stream of review documents. Almost all will have some effect on members' work. In some cases these reviews are very important and demand full consultation resulting in a high workload for both the Association industrial team members and our activists within the DHB. It is very important that we have good membership input.

As the DHB sector has come under financial strain, reviews have tended to have even more impact. Of particular note in the last 12 months have been the clinical leaders, radiology and fertility service reviews in Southern DHB, and the 'Top of the South' review of Nelson Marlborough DHB.

Redundancy is now more commonly an outcome of service reviews. Obviously this creates major issues for those affected and when there are possibilities relating to redundancy even more stringent consultation is required.

Advice to New Appointees

One of the most useful services the Association offers is the advice provided to new appointees on the understanding that they will join the Association when they take up the job offer. This year has seen an increase in the proportion of New Zealand applicants using the service. Since last conference the team has offered advice to 89 applicants of whom 55 were New Zealand trained. The Association website provides a useful resource for applicants.

Two problem areas often identified by the industrial team when advising on job offers are inappropriate fixed term appointments for international medical graduates, and deteriorating relocation packages. DHBs should only be able to offer a fixed term contract if needed for a genuine reason such as covering a temporary staff absence. We see many doctors from overseas agreeing to fixed term contracts where the vacancy is in fact a permanent post. It appears that some doctors are under the misapprehension that agreeing to a fixed term gives them the freedom to leave, when in fact under New Zealand law they can leave the job at any time subject to three month's notice. We have also seen a number of cases where adverse clinical events have left IMGs in the unfortunate position of being unemployed on the expiry of their fixed term contract, and at the same time not being able to practice here or elsewhere while under review.

Financial pressures have seen some DHBs offering lesser relocation packages than previously. Relocation expenses should cover all reasonable costs of the relocation and some new appointees have found that the offer does not cover all their expenses. As per the provisions of the MECA we regularly advise members to re-negotiate a more appropriate package prior to accepting an offer.

International Medical Graduates

The health system still relies heavily on International Medical Graduates (IMGs) moving to New Zealand to fill our vacancies. We have noted that there have been issues arising as a result of poor orientation or mentoring of these doctors when they first arrive. It seems in the past there was more time given for a 'settling period' but now the new IMG is expected to 'hit the ground running'. The industrial team is contemplating devising a formal process of orientation for new IMGs to assist them in their transition to the new culture and the New Zealand way of clinical practice. This will require DHB and possibly Medical Council 'buy in'.

Complaints by or about Members

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

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

The industrial team has seen an increase in complaints against members involving inappropriate behaviour towards colleagues and this remains a major part of our work.

Long-term Illness and 'Return to Work' Plans

We have supported around 15 members in returning to work following a period of long term sickness, and have had fewer cases of illness resulting in termination of employment. The DHBs are becoming more aware of the health review provisions of the MECA (Clause 27.5) which has resulted in us achieving a smoother less fractious process for our members.

Suspensions and Clinical Competence Reviews

We have supported several members facing reviews that might result in restrictions on their clinical practice. Clause 42 of the MECA (Investigations of Clinical Practice) is now commonly invoked even for quite minor concerns. In most cases the employer's initial reaction was to impose clinical restrictions. The industrial officers, or more usually the Senior Industrial Officer, will carefully monitor use of Clause 42 especially in terms of the protections offered.

Generally Medical Protection Society or other medico-legal support is encouraged with the Association taking responsibility for the correct application of the clause. This requires a partnership approach and has worked well.

These cases are usually urgent and are given priority. The process is taxing for all involved and of great concern given the members career and reputation may well be on the line.

Withdrawal of Supervisory Support

Occasionally assistance is sought by members as a result of a supervisor withdrawing their support. This may well trigger or be part of a Clause 42 investigation. Withdrawal of support is taken as a very serious indicator of concern and hopefully members will only have to withdraw such support for very good clinical reasons. If there are reasons due to the supervisor's own workload or even a personality clash it is important that in withdrawing support the supervisor notes it is not due to clinical concerns.

'Involuntary' Termination of Employment

Involuntary terminations include: dismissals, resignations or retirements in anticipation of dismissal (usually to avoid a disciplinary process or investigation of some kind) and redundancy. This year the team has dealt with several involuntary terminations, which included one dismissal, two redundancies, two resignations and two retirements due to clinical issues.

Salary Overpayments

We continue to support members who have been called upon to repay significant sums received as salary overpayments. Most DHBs are going through salary audits and this is highlighting these issues. Human error in human resources or payroll is generally the cause. Our experience is that where there has been one error there may well be another and in the majority of cases the amount notified will be reduced. It is very important to access our assistance if a member is notified of an overpayment as every case tends to be different and a forensic analysis of the pay history will be required.

Mediation and Legal Costs

There are two matters in the pipeline for the Employment Relations Authority (ERA). One relates to unlawful dismissal and the other to the refusal to pay back payments in respect of job sizing. Eight matters were referred to mediation, including:

- A member who had not been paid correctly as per a previous management agreement. Mediation achieved suitable back payment
- Members being treated unfairly as a result of a job sizing error. This was resolved to the satisfaction of both parties.
- A refusal to pay for duties that had been agreed verbally. This was resolved in the member's favour.
- The denial of an equitable retention allowance on appointment. This was resolved in the member's favour.
- A back pay refusal in respect of job sizing in accordance with the job sizing agreement. The DHB representatives attended mediation without authority to settle and the matter is now proceeding to the ERA.

In one case a DHB has refused to attend mediation contrary to the employment problem resolution procedures in the MECA. This matter may proceed to the Authority.

As in earlier years the industrial team resolved most issues including mediations themselves and thus payment of possibly large legal fees remained at a minimum. Legal fees amounted to approximately $17,000 including major assistance through a MECA Clause 42 process and opinions relating to payment of superannuation, privacy matters and unlawful dismissal.

Parental Leave

The Association maintains our fight for decent parental leave conditions for all members. The DHB conditions are relatively good but often not well understood. We have posted advice on frequently asked questions on the Association website www.asms.org.nz and published these also in the September issue of *The Specialist*.

While the DHB conditions are relatively good our non-DHB members generally do not share these practice conditions. We continue to claim for parental leave improvements and this year our negotiating teams have won improvements in several non-DHB agreements.

Regionalisation and Sub-Regionalisation of Services

We continue to see closer ties between DHBs with increasing drives to regionalise or sub-regionalise services.

Of specific note is the merger of the senior management of the Hutt Valley and Wairarapa DHBs (known as '2D') in tandem with closer ties with Capital & Coast ('3D'). These three DHBs have been tasked with acting as a sub-region including dealing with their various deficits as a group. Many members and the industrial team have been involved in a great deal of effort as a consequence.

Also of note the ex-Otago and Southland DHBs continue to lurch towards working jointly between their sites albeit legally they have been one DHB for three years.

Publications

The industrial team have produced two publications over the year, the *Bullying in the Workplace ASMS Standpoint* and the employment advisory document *Advice on Working away from home base*. These have been well received by the members and act as helpful guides when encountering these issues.

Health Sector Relationship Agreement Steering Group

Four meetings of the tripartite Health Sector Relationship Agreement (HSRA) Steering Group have been held this year with a fifth scheduled prior to Annual Conference. The participants are the Ministry of Health (through the National Health Board), all 20 DHBs, and each of the CTU

affiliated four main health unions (NZ Nurses Organisation, Public Service Association, Service and Food Workers Union, and the Association). All are signatories to the HSRA. The significance of this body is that it is the primary means by which the government through the Ministry of Health, DHBs and health unions engage on a national level.

Participation in the Steering Group is proving to be a valuable opportunity for the Association to engage with key players and organisations at a high national level. A regular feature is the opportunity to raise current issues at the beginning of each meeting – examples this year include concerns of the Service and Food Workers Union over residential care standards and the Association's concern over the application of the government's national health targets.

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

- Regular reports from the National Director of the National Health Board on NHB issues.
- Update from the Health Quality and Safety Commission.
- Victoria University study on workplace dynamics in New Zealand public services in 2013.
- Ministry of Health officials presenting on a new social bonds project initiative where payments for services provided by non-government organisations are only made if outcomes are achieved.
- Amendments to the Employment Relations Act.
- Update on Health Benefits Ltd processes.
- Aged care workforce qualifications.

National Joint Consultation Committee

The National Joint Consultation Committee set up under the national DHB MECA met three times this year. The Committee has developed slightly more traction as the result of the recent attendance of a second Chief Executive. Issues discussed included the Gravatt High Court decision (release of doctors' names by the coroner's court), older SMOs and the aging workforce, and a conclusion to the discussion of aid programmes and continuing medical education. The principal value of the NJCC appears to be regular updates from Health Workforce New Zealand, Health Benefits Ltd and, more recently Pharmac.

Joint Consultation Committees

In their eighth year of operation JCCs have become a vital part of the Associations work. Three JCCs have been held in each DHB this year, in Wairarapa the third JCC was held jointly with the Hutt Valley DHB JCC.

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

- Minister of Health's annual 'Letter of Expectations' to DHBs.
- National travel contract (Ministry of Business Innovation and Employment). This has been useful in establishing that where DHBs sign up to this contract the right of members to choose how they book their CME travel is preserved. All DHBs who have signed the contract have also accepted the continuation of this membership right except for Hawke's Bay whose position is unclear (there was initial uncertainty over Southern's position). A minority of DHBs have declined to sign (Auckland have still not decided whether to sign).
- SMO staffing reports (mixed quality and detail varying from worthless payroll data to good well-presented useful information).

- Sabbatical usage (indications that these conversations are generating some increased interest and applications).
- Health Benefits Ltd (occasionally a useful exchange of information). More recently an emphasis on the transfer of accounts payable and receivable to the northern shared services agency Health Alliance.
- The *ASMS Standpoint* on bullying which has generated some good constructive discussion. The publication has been well received by DHBs.
- The Association publication *The Public Hospital Specialist Workforce: Entrenched shortages or workforce investment?* Managers have avoided this subject like the plague although there were brief positive observations from Counties Manukau and Bay of Plenty chief executives.
- Application of placement of new appointees on the MECA salary scales (double-checking that the resolution achieved late last year is being adhered to; no problems to date).
- In some JCCs there are regular updates on information technology developments.
- Concerns about the High Court Gravatt case decision on name suppression in two JCCs (Waikato and Tairawhiti) although it was also discussed in our preparation meetings at a number of other JCCs.
- The second engagement principle of Clause 2 of the MECA – ('Time for Quality': *managers to support SMOs to provide leadership in service design, configuration, and best practice service delivery*). This has led to some useful discussions including lack of SMO time (workforce capacity), internal DHB culture, external pressures (regional, sub-regional and national), and its application to SMO involvement in non-SMO appointment processes. This has become a regular agenda item and we are looking to develop it into a basic checklist.
- In some JCCs either the planning for or evaluation of joint SMO engagement workshops.
- We began providing members through *ASMS Direct* six weeks notification of the forthcoming JCC. This arose out of discussion among our Counties Manukau JCC delegates over improving notification to members given the usual length of time between one JCC and the next (and the difficulties of changing clinical arrangements where this was not done earlier). We are also using this to enhance the relevance and profile of JCCs to members, in part to improve participation.
- Unintended consequences of the Government's national health targets are now an on-going JCC agenda item. In the main there is increasing membership frustration with the application of the targets (insofar as our delegates are indicators) and management empathy with our concerns (it is too politically sensitive to expect more than this).
- The Association employment advisory publication *Working away from home base*. We are encouraging management at the JCCs to advise us of any significant concerns they may have with the content.
- Mid Staffordshire in the context of whether it could happen in New Zealand. While no-one is saying that there is a Mid Staffordshire on the horizon, no-one is prepared to say that it could not happen here.
- The application of the national contract based on 'alliance contracting' between the DHBs and PHOs to specific DHBs.

- Monitoring the MECA appointment clause in respect of DHBs' compliance with the different elements of the clause.
- Planning failures between Health Workforce New Zealand and DHBs over placement of easily predicted increased numbers of PGY1s.
- Staffing and resource implications of the Medical Council's increased requirements for prevocational training.

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

Northland—Processing of CME claims and car parking.

Waitemata—CME claims being held up by lower level managers; merger of funding and planning (Waitemata and Auckland) with all staff becoming Waitemata employees; and emergency medicine department staffing.

Auckland—Six week threshold for approving annual leave applications with an inflexible high level decision-making process; poor consultation over the merging of funding and planning with Waitemata; monitoring the MECA provision for overnight accommodation at Auckland City Hospital and a 'Staff Agreement' regarding patient confidentiality,

Counties Manukau—Quality of food and lack of healthy and gluten free options; travel time for CME leave when taken in conjunction with annual leave; change in practice with the new laundry provider which is now requiring staff to wash their own scrubs if they are named and blue coloured; and car parking safety and security.

Waikato—Deficient job sizing process policy document based on increased managerial control.

Bay of Plenty—Criticism of Tauranga Hospital emergency department by the Chief Executive over six hour target performance; patient tests going to the incorrect senior doctor.

Lakes—Continued concern over information technology resources including for non-clinical and educational activities; use of CME expenses for Koru Club membership, cost of members participating in regional and sub-regional activities; challenges faced by secondary hospitals coping with complex cases arising from limited capacity at tertiary centres; and challenges arising out of the requirement to adopt Concerto as part of the Midland region.

Tairawhiti—new clinical leadership structure; data plans for mobile devices and the network's ability to support many staff online at once and funding and support for supervision and peer review outside the DHB.

Hawke's Bay—Car parking at the hospital; employee vaccination policy; the ethics of waiting lists; low take up of sabbaticals, and use of CME expenses for lunch at 'grand rounds'.

Taranaki—New SMO annual review process (part of Midlands DHB initiative); GP electronic referral system replaced by an inferior regionally endorsed system which was slower and provided less clinical information; effective challenge to a seriously deficient proposed new sabbatical policy in Taranaki.

Whanganui—Management restrictions on annual leave for orthopaedic surgeons in response to the pressure to comply with the five month maximum waiting time for electives; slow development of information technology infrastructure; decision of Chief Executive to impose restrictions on business class travel without consultation with the Association. Underpinning

much of the discussions is a widely divergent assessment of the extent of genuine clinical engagement and clinical leadership between the Chief Executive and Association members.

MidCentral—Changes in nursing leadership and the extent of unmet clinical need in the population.

Wairarapa—Implications of a political decision forced on Hutt Valley to takeover Wairarapa (two DHBs; one chief executive and senior management team); serious failure of DHB to engage with members on a range of issues including changes in clinical and sub-regional processes; and employment of an additional SMO position in the emergency department. Only two JCCs were held because of scheduling difficulties due to the disruptive impact of management restructuring.

Hutt Valley—Dramatic decline in morale, including lack of trust in management; the decision of the College of Anaesthesia to give notice of the removal of training accreditation (subsequently reinstated on interim basis); lack of SMO engagement and leadership in the sub-regional laboratory review; and failure of the DHB to comply with the appointments clause of the MECA with particular reference to SMO involvement in interview panels.

Capital & Coast—Difficulties in getting clarity from senior management on the sub-regional laboratories review; lack of a sufficiently clear framework for clinical leaders in the wider sub-regional collaboration; progress on developing an annual leave process guideline; and dissatisfaction from both management and SMOs with the performance of HWNZ.

Nelson Marlborough—Serious overall financial situation; lack of information technology support, (hardware, office space and desks); poor state of the library, offers to new SMO appointments overly prescriptive with regard to time that should be spent on site for non-clinical activities; review of nursing; review of clinical governance structures; and 'Top of the South' reviews of orthopaedics, general surgery and general medicine.

West Coast—Privacy breaches (wrt Jessie Ryder); significant serious events relating to a "catastrophic equipment failure"; employment of short term locums; lack of a simple patient tracking system; and systematic decline over a long period at Grey Hospital.

Canterbury—Environmental sustainability activity; serious misgivings over HBL; and paperless systems.

South Canterbury—Upgrading of hospital facilities; joint management-Association group agreement to provide tablets and cell phones as 'tools of trade'; and failure to confirm an agreement over physician job sizing.

Southern

Serious frustrations over clinical director (heads of department) positions and the appointment process; DHB's document *Performance Excellence and Quality Improvement Strategy* developed by Professor Mike Hunter; formation of a new 'Strategic Health Alliance' leadership team for leading many hospital-community integrative and alignment programmes; and radiologist shortages.

Joint Association-DHB Engagement Workshops

For about five years the Association and individual DHBs have been holding joint SMO engagement workshops. Almost always they are a half-day and have involved the rescheduling of elective activity.

In the year December 2012 to November 2013 there have been workshops at:

- Waitemata (Elective Surgery Centre, Mid Staffordshire and Health Quality & Safety Commission; second workshop to be held later in November).
- Counties Manukau (the first at this DHB - financial constraints and budgets, localities, capital planning and sustainability).
- Waikato (information technology).
- Capital & Coast (Mid Staffordshire, patient flow in acute care, and Health Quality & Safety Commission).
- Nelson Marlborough (the first at this DHB which saw a frank discussion on the lack of faith SMOs had in management, the 'Top of the South' review and concurrent sessions on advanced care planning, information technology and 'what are we doing that we shouldn't be doing').
- West Coast (facilities and the lack of non-clinical time).
- Canterbury (facilities planning).

The only DHB where no workshops has been held at all is Auckland though it has now been at least a year since a workshop was held at Hawke's Bay, Taranaki, Wairarapa, Bay of Plenty and Southern.

National Branch Officers' Workshops

In 2011, following the first nationally coordinated elections for the newly established branch officer positions of president and vice president, the National Executive trialled a national branch officers' workshop as a form of orientation. The next year two workshops were held largely on the national DHB MECA negotiations.

They have proved to be a success and become a regular feature of the Association's work. The first for 2013 was held on 26 March with the two main features being the acceptance of the gift of *Toi Mata Hauora* from Dr Te Huirangi Waikerepuru and the DHB MECA negotiations.

The second this year was held on 29 August which focussed on identifying the three top issues for Association members in the branches; the national DHB MECA settlement; the role of branch officers and the industrial team; changes to the Employment Relations Act; and the appointment processes and supporting new appointees.

In respect of the top issues concerning members the following emerged under broad headings:

- Managerialism and SMO engagement.
- Understanding the MECA in order to empower its implementation (eg, job sizing) and the importance of the Association as the 'guardian' of the MECA.
- Erosion or undermining of MECA entitlements and provisions in their application.
- Workforce development, planning and resourcing (time).
- Information technology.

Arising out of this discussion the Association has begun to raise the application of the MECA appointment clause in the JCCs. At its subsequent meeting the National Executive resolved to have a focus around the theme of 'Know Your MECA.'

Membership Electronic Surveys

The National Executive resolved to trial the use of electronic surveys of members. The first was to guide the Association's approach to the use of social media. In addition to the subject matter, the purpose was to also trial the utility of future surveys and lessons that might arise out of it.

The survey took place over a week, (3-10 July) and focussed on the extent to which Association members use online social networking and media sites. It was sent to all members for whom we currently have email addresses (3,730). Members were actively encouraged to participate in the survey via *ASMS Direct* and using Mailchimp's tracking software. This allowed us to re-send targeted emails to those who had not yet opened the email and participated in the survey.

In summary:

1. A total of 546 members (15.6%) completed the survey.
2. Facebook and LinkedIn were the two most popular social media sites with 284 respondents using Facebook and 218 using LinkedIn. Just over 200 respondents were not using any type of social networking sites.
3. 51% of respondents did not use social media sites in a typical week.
4. Facebook is the most used social media site in a typical week.
5. 137 respondents were using social media sites for less than 30 minutes each week.
6. Despite its profile only 10% of respondents use Twitter.

After discussing these results the Executive concluded that at this stage there was no basis to pursue social media such as Facebook and Twitter.

The survey was seen as a useful informative exercise but it was noted that the tight time frame and the use of an additional step (*ASMS Direct* link) were likely to have affected the response rate. Consequently future surveys will be conducted over a longer timeframe to allow more members time to respond. Further, the survey should be sent electronically directly to members rather than through an *ASMS Direct*.

This led to a second survey, this time of DHB-employed members only, on time for involvement in distributive clinical leadership. It was conducted between 26 August and 27 September. With a response rate of 43% (1,503 members), 63% of respondents said they did not have enough time for non-clinical duties in order to engage in distributive clinical leadership. Further:

- In only three DHBs did more than 50% of respondents believe that they had enough time (Lakes, Tairawhiti and Nelson Marlborough).
- In 12 DHBs less that 40% of respondents believed that they had enough time.
- The poorest performers were Hawke's Bay (26%) and Whanganui (21%).

The survey also asked for information on the number of hours for non-clinical duties although the usefulness of the responses is limited because of the confusion caused among some members employed part-time with their DHB.

National Bipartite Action Group

The Association has been an active observer on the National Bipartite Action Group (NBAG) since its establishment in 2010. This body was established as the result of a joint settlement between the 20 DHBs and the three other main health unions affiliated to the Council of Trade Unions (Public Service Association, Nurses Organisation and Service and Food Workers Union). Until this year, although they were not affiliated to the CTU, the Resident Doctors' Association, APEX and the Medical Laboratory Workers Union (the unions served by Deborah Powell's

Contract Services Ltd) were also observers. This year the terms of reference for the NBAG were amended so that observer status was no longer available. APEX, the RDA and the Medical Laboratory Workers have signed up to the terms of reference and are now full members of the NBAG.

At its meeting on 11 July the National Executive decided that the Association would not join the NBAG as a full member at this point but would seek to continue as an observer. At its meeting on 2 October the NBAG agreed to grandparent the Association as an observer but admit no further unions without them signing up to the terms of reference as a full member.

NBAG meet two monthly on a face-to-face basis with a one hour teleconference in the intervening month. The Executive Director attended two full meetings this year with the Deputy Executive Director attending a further two. The NBAG seems to be getting more traction and made good progress on reformulating some over-the-top DHB policies into much more pragmatic guidelines. Examples are the smokefree and drug and alcohol guidelines. Other issues seem to move at a glacial pace (for instance a putative adverse weather policy) as groups like the DHB human resources general managers test their power.

Surveying Full-Time DHB Senior Medical Staff Base Salaries

Since 1993 the Association has been asking DHBs for data on the base salary of the SMOs they employ. During the 1990s this provided vital data for bargaining though the information was bedevilled by DHBs reluctant to provide the information. Since 2000, covered by four national MECAs, the survey has continued to measure changes to the scales and progression through the scales.

In the course of assembling this data we have inadvertently developed a consistent head count of SMO numbers that has served to give a longitudinal picture of the work force. The data has been used to monitor senior medical officer staffing levels. This data is also pointing to trends such as a slight decrease in the number of Medical Officers and a majority of female specialists on the first two steps of the scale.

The survey is of mean full-time equivalent base salaries and does not take into account hours worked in excess of 40 hours per week (which are recognised through job sizing), the availability allowance or other special enhancements

The 20th salary survey shows as at 1 July 2013 (this is before the changes to the salary scale consequent on the MECA settlement took effect):

- There was an increase from 3,826 specialist to 4,022 specialists employed at New Zealand DHBs. There has been a decrease in medical officers for two years which may be the beginning of trend (520 this year, from 540 in 2012 and 565 in 2011).
- The average base salary for specialists between 1 July 2012 and 1 July 2013 went up by 0.7% from $184,271 to $185,529.
- The average base salary for medical and dental officers went up by 0.4% from $144,488 to $145,117.
- The average annual salary for specialists was highest in Wairarapa DHB ($200,854) and lowest in Counties Manukau ($179,896). The average annual salary for medical and dental officers was highest in Lakes ($162,250) and lowest in Auckland ($133, 864).
- The average annual salary for female specialists was $178,342 and the average salary for males was $189,119. For medical officers the figures are $144,610 for females and $145,559 for males. A third of specialists are female while 47% of medical and dental officers are female.

- As at 1 July 1,219 male specialists and 320 female specialists were on the then top step (step 12). Numbers on the other steps were more evenly spread with the next most populous step being step two with 241 females and 224 males. This suggests that a significant number of SMOs have been appointed within the last four years, and that within 10 years the specialist workforce at DHBs might have a majority of females.

Health Benefits Ltd

Health Benefits Ltd is the crown entity charged with making $700 million cumulative savings (initially over five years but now extended to 2016). This expectation has continued to be a major issue for the Association at Executive meetings, National Joint Consultation Committee, National Bipartite Action Group and Joint Consultation Committees. The process, issues and concerns have been regularly updated to members in *ASMS DHB News*.

After much delay HBL's Clinical Council was formed early this year. The Association had an influential role in the background in shaping its composition. This is a critical organisation as part of the HBL processes and we were pleased with the composition including Dr Johan Morreau as Chair (Lakes paediatrician and former chief medical officer), Andrew Bowers (Southern physician) as Deputy Chair and Judy Bent (National Executive but appointed on an individual basis).

One of the most critical parts of HBL's work is the Finance, Procurement and Supply Chain business case. The Deputy Executive Director and Executive member Judy Bent represented the Association on a union advisory group which met early this year. It considered a draft of the proposed operating model for DHB finance services, procurement and supply chain.

Essentially it is proposed that HBL act as the 'integrator' for these services which suggests an on-going role for HBL. Finance services would be delivered by Health Alliance (the northern DHBs shared services agency) with some functions needing physical proximity still delivered at DHBs.

Procurement would be by Pharmac for medical devices, Ministry of Business Innovation and Employment for all whole of government procurement (this appeared to include travel) and by Health Alliance for any residual categories. Pharmac will also provide localised support, a substantive change in Pharmac's role.

The supply function would be through a contracted third party logistics provider with three delivery locations in Auckland, the lower North Island and the South Island. Much of this function is already done by the private sector for DHBs but the impact is hard to gauge as it is not immediately clear where the "supply" will be delivered and it may differ DHB by DHB.

The area that appears to have most potential impact on our members is procurement. Discussion reveals that the definition of medical devices is very wide (including, for instance, gloves). We are concerned that this could easily limit innovation and trials of new devices by our members as DHBs were likely to have much more limited funds to react quickly to new ideas with funding possibly limited to catalogue items.

Consequently on 28 February the National Executive adopted the following resolution:

> *That the Association make a brief submission to Pharmac indicating the need for some funding to remain at the DHBs to make innovation possible, the need to make sure that the right clinicians were in the room when decisions were made about which medical devices to fund, the need for a more robust exceptions policy than was presently the case for pharmaceuticals; and the need to address senior medical officers shortages and backfill positions as the demands of clinical leadership fell on already stretched senior medical officers*.

The Association subsequently forwarded the submission prepared by the Deputy Executive Director.

The Finance, Procurement and Supply Chain business case has now been released and, in summary, involves disestablishing many roles and functions in these areas from the DHBs south of the four northern DHBs and centralising them in the northern DHBs shared service agency Health Alliance which will become a much larger bureaucracy.

There are concerns over the pending size of Health Alliance as a new organisation, and the loss (due to the inevitable destabilisation arising from this restructuring and the lead-up period of uncertainty) of intellectual capital in procurement but also of expertise in the supply chain. There is also a high level of nervousness over whether Health Alliance could achieve these new greatly expanded tasks.

Further projects in the pipeline are the rationalising of laundry and food services and data storage. A project on Human Resources Information systems is in process.

Health Practitioners Competence Assurance Act Review

Health Workforce New Zealand, apparently as the result of submissions which were very strongly of the view that the Act was working well, drastically cut back their plans for reviewing the Act. Instead of the planned discussion paper that was to have been released in the middle of 2013 HWNZ held focus groups to discuss four proposals to change the Act:

1. Change the Act to give guidance to the regulatory authorities as to what information they should provide relating to complaints and disciplinary outcomes
2. Require the authorities to develop a shared code of practice for all health professionals
3. Require the authorities to develop a shared set of standards for team work and communications between health professionals
4. Audit all authorities every three years against a set of indicators.

The Deputy Executive Director attended one of the focus groups. The 22 recommendations that came out of the 2007-2009 operational review still remain to be actioned. The next step was to be for recommendations to be made to the Minister of Health. However these may have been overshadowed by what appears now to be proposals for the merging of the regulatory authorities including the Medical Council.

Medical Council: Changes to Prevocational Training

The Medical Council's work on pre-vocational training requirements was an emerging issue throughout the year for the National Executive. The first stage of the process which concluded in December 2011 resulted in a decision to keep the run length at three months and that a general scope would be achieved after 12 months. A second consultation paper was issued in February this year. This paper proposed the setting of learning outcomes in a curriculum framework, changes to clinical attachments and the use of a professional development plan (PDP) in PGY2.

The consultation process on the second paper included a national road show in March and April this year and the establishment of a Prevocational Training Advisory Group of which the Association is a participant although unfortunately its first meeting coincided with our Annual Conference last November. Vice President Julian Fuller attended the second meeting in June.

The conclusion of the process was reached at a Medical Council meeting in July where the Council resolved;

- to implement their proposed curriculum framework (November 2014);
- to develop standards for accreditation of clinical attachments (implemented November 2015);

- to proceed with the decision to have a professional development plan to be completed in PGY2 which is expected to replace the Health Workforce New Zealand (HWNZ) career plan (an immediate priority);
- to implement what is described as a 'high trust' model of assessment for the intern years (PGY1 and PGY2);
- to record learning in an e-portfolio (implemented in November 2014 for PGY1) and use multisource feedback as an educational tool (a working group is to decide how to do this) with implementation by November 2015;
- to review the current supervision report;
- to introduce a framework for the training of supervisors (both intern supervisors and supervisors of clinical attachments) which is to be followed by a review of the responsibilities of intern supervisors. The development of a framework is an immediate priority with the expectation that it will be implemented by November 2014; and
- to introduce a requirement to spend at least 12.5% of time in community settings; this will not be mandatory until the last stage of implementation but will be available as an option before then.

The requirements for general scope of practice will be:

1. Satisfactory completion of four accredited clinical attachments.
2. Attaining the learning outcomes in the Curriculum Framework.
3. Completion of 10 weeks in each attachment.
4. A recommendation for a general scope by a panel which will include the intern supervisors and an acceptable PDP for PGY2.

Unfortunately, however, there is no explicit recommendation that will ensure there are sufficient numbers of SMOs to deliver on the additional teaching requirements. The closest it gets is some discussion in the context of the PDP and PGY2 of the additional resource requirements of appointing specific supervisors to PGY2 or considering the use of mentors. A working group is expected to engage further with relevant stakeholders on the options for the provision of oversight for PGY2.

HWNZ is expected to provide the funding for the training but the provision of sufficient SMO time is to be pursued by the Medical Council in discussion with DHB chief executives and chief medical officers. Mention is made of ensuring supervisory responsibilities and accountabilities are included in SMO job descriptions and are 'viewed as a fundamental aspect of employment with time available for supervisors to undertake the role.'

At its meeting on 12 September the Executive adopted the following two resolutions:

> *That the Association notes with concern the apparent lack of consideration being given by the Medical Council and other stakeholders as to how SMOs will be practically resourced in their workplaces to provide prevocational training and that the Association write to the Medical Council and the DHBs, through the CMO group, to express our concerns and seeking discussions with those groups to address them.*
>
> *The Association draw up guidelines and advice to members about the need to ensure their employers and the Medical Council provide proper workplace resourcing, including through job size and remuneration, for PGY1s, PGY2s and others undertaking prevocational training in their workplaces.*

To date we have yet to receive a reply from the Medical Council but, in response to our letter to the Chair of the Chief Medical Officers national group there has been a useful discussion between the Chair of the CMOs and the Deputy Executive Director.

It was also agreed that this issue should start to be raised in our Joint Consultation Committees in each of the 20 DHBs. This activity is currently underway with the issue raised in most JCCs prior to Conference.

Council of Trade Unions

The Association first affiliated to the Council of Trade Unions (CTU) in 1990. As in previous years the Association continues to benefit from our affiliation at both a national office level and with the affiliates. This was evident this year by the CTU's comprehensive submission on the Employment Relations Amendment Bill along with its submission on the State Sector and Public Finance Reform Bill and its advocacy over the Trans Pacific Partnership Agreement. Its work on analysing health spending and Vote Health in the Budget continues to be very valuable. The Executive Director (or in his absence the Deputy Executive Director) usually attends the CTU's quarterly National Affiliate Council although clashing commitments have made this difficult.

National Affiliate Council

There have been three National Affiliate Council meetings to date but the Association has only been able to attend two of them (the fourth conflicts with Annual Conference). Issues considered by the Council included:

- The Employment Relations Amendment Bill.
- The establishment of the new workplace health and safety crown regulator statutory body arising out of the report of the Royal Commission on the Pike River Coal Mine Tragedy. The CTU had a significant influence on the shaping of the implementation of the Commission's recommendations and all but one was adopted by government.
- Trans Pacific Partnership Agreement.
- Ports of Auckland dispute.

Biennial Conference

Deputy Executive Director Angela Belich and Industrial Officer Lloyd Woods represented the Association at the CTU's well attended Biennial Conference on 9-10 October which commenced with a stirring address by President Helen Kelly. It was an uncontroversial conference with the highlights being a panel discussion on industrial relations from some of the political parties and an address by freelance journalist and researcher Nicky Hager on what he argued was a loss of democracy in New Zealand.

Meetings with Director-General of Health

The Executive Director continued his regular informal meetings, usually monthly, with the Director-General of Health, Dr Kevin Woods, with five held to date. These meetings are very useful to the Association. These informal meetings are an opportunity to raise issues, perspectives and differences that might not otherwise be brought to the Director-General's attention. Topics for discussion included:

- The negotiation and settlement of the national DHB MECA negotiations.
- His advocacy of the importance of focussing on relationships rather than structural change.
- Application of the government's national health targets.
- Patient safety and the Jessie Ryder case.

- The Association's relationship with DHBs nationally.
- Health Workforce New Zealand.
- North Shore elective surgical centre.
- Health Benefits Ltd activities.
- Review of the Health Practitioners Competence Assurance Act.
- Experience of the difficulties of PGY1 placements.
- King's Fund report on the Canterbury Initiative.
- Difficulties in specific DHBs.

Dr Woods' contract ended in November and he opted not to seek renewal for family reasons. The Executive Director had a number of interactions and discussions with him and was impressed with his commitment, professionalism and insightfulness. The National Executive also appreciated the opportunity to meet him on two occasions for constructive discussions.

International Travel

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

- On 8 March the Executive Director attended an interesting and pertinent conference in Sydney on *Serving the Community: Training Generalists and Extending Specialists* organised by the Australian and New Zealand Colleges of Physicians and Surgeons and the Canadian College of Physicians and Surgeons. Sessions included: what is a generalist, delivering safe effective and timely specialty medical care to widely and unevenly distributed populations, what does the future hold, education and career transitions, and what success in addressing a generalist agenda would look like (and what needs to change to achieve success).
- The Executive Director attended both of the twice yearly Industrial Coordination Meetings organised by the Australian Medical Association, in conjunction with the Australian Salaried Medical Officers Federation. The first was in Canberra in April. Issues discussed included proposed radical changes to the employment of senior doctors in Queensland, representation of resident medical officers in New South Wales, cost cutting initiatives in New South Wales, collective agreement negotiations in Western Australia, GP registrars national minimum terms and conditions of employment, Australian Nursing Federation's application for 'low paid bargaining authorisation' for practice nurses, intern placement of medical graduates, and Health Workforce Australia's 2025 report.
- In May-June the Executive Director visited the United States, Germany, Belgium, England and Wales for three weeks. The prime purpose was to accept an invitation to attend for the second time the Assembly of Marburger Bund, the German doctors union, in Hannover (where he gave a brief address) as well as a King's Fund conference on leadership in the National Health Service in London. The Association and Marburger Bund have developed good relations in recent years with the latter attending our Annual Conference in 2011. He also had the opportunity to attend the General Assembly of Bundesärztekammer (German Medical Association), also in Hannover. In the United States he met the American Physicians and Dentists Union in Los Angeles and Doctors Council (another physicians union) and Physicians for a National Health Programme in Chicago. In England he had meetings at the British Medical Association, Rand Europe,

King's Fund, Hospital Consultants and Specialists Association and other unions, academics and researchers, and Medical Protection Society. In Wales he met the BMA.

- In September the Executive Director attended the second Industrial Coordination Meeting held in Perth. Some of the issues he reported on were the threats to senior doctor employment in Queensland, expected federal industrial law changes following the change of government, the new federal government's health policy, specialist salary setting in New South Wales, surgical trainee hours, Western Australian collective agreement negotiations, intern placement of medical graduates in 2014, Health Workforce Australia, and working with children checks in New South Wales.
- Industrial Officers Lloyd Woods and Lyn Hughes attended the thought provoking 2013 Health Practitioners Health Conference titled *Caring for you, Caring for others* in Brisbane on 3-5 October, organised by the Queensland branch of the Australasian Doctors Health Network. From an Association perspective it was very useful dealing predominantly with ways to keep members safe in terms of health and stress but also in how we can support members when they are already suffering.

Association Publications

The *Specialist*, the Association's quarterly newsletter (generously sponsored by MAS) is a cornerstone of our advocacy and communications work. Since the last Annual Conference the precarious state of the specialist workforce in light of vocational registration and retention rates, the flight of international medical migrants, the impact of changing demographics on the specialist workforce, and threatening industrial laws have been the feature of all four issues from December to September.

Other feature articles were on the following subjects:

- 'Object in the mirror' (former National President Jeff Brown's Presidential address).
- The state of palliative care.
- Sustainable healthcare – it's a clinical issue.
- Why the *Living Wage* matters to our health.
- *Toi Mata Hauora*.
- Shorter stays in emergency departments – four years on.

In addition, other issues covered included:

- 2012 DHB salary survey.
- Review of the Health Practitioners Competence Assurance Act.
- Strengthening central control: amending the State Sector Act.
- Misleading claims on public hospital doctor numbers.
- Parental leave Q & A.
- Big changes for Kiwi house insurance.

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

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

We have continued our email publication, *ASMS Direct*, which is produced on an as-needed basis. It is increasingly being used by journalists as a resource and source of information and comment. *ASMS Direct* also links with news items on the website homepage. The membership circulation list is over 3,700. Four issues were produced between the last Annual Conference and the end of last year with a further 18 issues to date this year. Much has focussed on the national MECA negotiations and settlement, misleading government claims of increased hospital doctor numbers, Health Benefits Ltd including Clinical Council, review of the Health Practitioners Competence Assurance Act, Medical Council review of prevocational training.

Other subjects covered included:

- NZ Nurses Organisation's highly critical 'open letter' on Health Workforce New Zealand leadership.
- Medical Council and BPAC programme for general registrants.
- Association national meeting with Chief Medical Officers.
- Waitemata elective surgical centre controversy.
- Association publication on state of specialist workforce in DHBs.
- Threat of disciplinary action against Dr John Chambers.
- National Executive and branch elections.
- *ASMS Standpoint* on bullying.
- 'Living Wage' campaign.
- KiwiSaver changes (contributions).
- Gravatt High Court decision.
- 'What killed Ken Callow' forestry safety video.
- Sabbatical usage.
- Medical Council activities – *Good Medical Practice* update; medical certification consultation; evaluating effectiveness of 'regular practice review'; consultation over standards and processes for recognition and accreditation of New Zealand colleges; outcome of consultation on proposed amendments to *active clinical practice requirement for the comparable health system* and *locum tenens* pathways; and renaming of branch advisory bodies.
- PSA survey on impact of the government policy cap on the number of DHB staff employed as 'management' or 'administration.'
- Resident Doctors' Association appreciation for SMO support on placement of PGY1s.
- Results of DHB bargaining fee ballots.
- Results of survey of members on DHBs support for distributive clinical leadership.
- Warning about advertised specialist positions in Queensland.

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

Four issues of our electronic publication, *Executive Direct*, have been sent reporting on the February, May, June and September Executive meetings.

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

Membership

Once again the Association has had a record membership year (the fourteenth in succession). Membership, as of 31 March 2013 was 3,901, compared with 3,878 at 31 March 2012, representing an overall increase of 23 (0.6%). It represents a 171% increase over the 1,440 members in our first year of existence (1989-90). The bargaining fee, introduced in 2008, attracted payments from 320 senior medical and dental staff this year; to date 155 bargaining fee payers have converted to full financial members.

It is interesting to note the annual membership pattern increase since 1998-99 (the last year where we had a membership decrease) – 1999-2000 (105 – 6%), 2000-01 (118 – 6.4%), 2001-02 (98 – 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%) and 2012-13 (23 - 0.6%) an overall increase of 123% over this period. Since our formation in 1989 there have been three years of membership losses – 26 (1.8%) in 1991-92, 47 (3%) in 1993-94, and 15 (0.8%) in 1998-99, and quite wide variations year to year (16% in 2009 to 0.6% last year).

The annual average increase since our formation is 107 (7.4%). Under the period of the Employment Contracts Act (1991-92 – 2000-01) the average annual increase was 61 (4.3%). Under the period of the Employment Relations Act, since 2000-01, to date the annual average increase has been 160 (8.1%).

Currently membership is 4,130, an increase of 229 since 31 March 2013. Although membership growth in the latter part of the year is generally offset by subsequent resignation factors such as retirements that arise at the end of our financial year, we expect the 31 March 2014 membership to exceed current numbers. The combination of actively recruiting new members and strong membership loyalty continues to be the key to our effective representation in both collective and individual matters.

About 90% of our members pay their subscription by automatic salary deduction (about 85% of new members employed during the past year opted for fortnightly payments).

Despite incomplete information, it remains the case that few Association members are also members of the NZMA. Those who were NZMA members at the time of joining the Association represent an estimated 10% of our current members. Just 2.5% of members who joined the Association in 2013 were also members of the NZMA compared with 22% in 1996.

Medical Protection Society

The Association has continued our close working relationship with the Medical Protection Society, including working together on several cases where our respective roles overlap or intersect. Much of this involves the Senior Industrial Officer and other industrial staff working with the MPS representatives and lawyers on specific cases.

The relationship was tested late last year when the MPS made significant changes to its legal representation in New Zealand which was a surprise to the Association. We expressed our forthright views through the Executive Director and Senior Industrial Officer to the MPS both in the United Kingdom and New Zealand. We have had the opportunity to further engage with the MPS on these matters and are much more comfortable with their position, including the upgrading of the role of their New Zealand office.

The Executive Director visited the MPS in their London office in June which was an opportunity to meet again meet Chief Executive Simon Kayll along with Dan Bown (Executive Director Operations) and Dr Rob Hendry (Medical Director). The MPS provides a regular column for *The Specialist*. We are grateful for the generous decision of MPS to again sponsor the Conference

dinner. Dan Bown and Rob Hendry (who has specific responsibility for New Zealand) will both attend Annual Conference as observers with the latter also speaking.

MAS

The Association's collaborative 'preferred provider' relationship with MAS continues to strengthen. This includes the Society's generous sponsorship of *The Specialist*. The Society has also generously agreed to continue to sponsor the pre-Conference function this year (this sponsorship has been provided for several years).

The quarterly advisory consultancy meetings between the Executive Director (and Executive Officer) and Society Chief Executive Martin Stokes (and Sales and Marketing Manager Glenys Powell) continue. Three meetings have been held to date with the fourth after Annual Conference.

Discussions at these quarterly meetings have included the national DHB MECA negotiations and settlement, next year's general elections; stability of the specialist workforce in DHBs, the Association's new strategic direction, the MAS decision to continue with full house replacement insurance, MAS-MPS relationship, our meeting with Medicus, calibre of DHB senior management when under financial and external pressures, and the Association's use of electronic membership surveys.

Association Finances

A combination of higher than anticipated income levels and under-budget expenditure has resulted in an after tax surplus of $523,729 ($497,529 above budget) for the financial year ending 31 March 2013. This surplus is due largely to a combination of membership subscription (FTEs), interest earnings and bargaining fees exceeding expectations and total expenditure coming in well under budget. The main area of under spending was collective bargaining for which the budget contained a precautionary buffer.

The Association's Investment Committee comprising Executive member Paul Wilson, Executive Officer and MAS' Investment Products Manager (Daniel Callaghan) reviewed the investment strategy and agreed to continue the conservative approach, placing reserves on reasonably short term deposits with staggered maturity dates. As at 31 March these reserves totalled $3,190,535 over varying terms of between 3 to 12 months.

Administration

The administration team, led by Executive Officer Yvonne Desmond, is an experienced and dedicated team ensuring that the office runs smoothly and the industrial team is well supported.

The online membership application form launched earlier this year, has been embraced by members and payroll departments alike; it greatly simplifies the administration of the steadily rising membership.

The adoption of our Maori name *Toi Mata Hauora* allowed us to review and refresh ASMS branding. This timely and important project was not undertaken lightly, and involved significant work for office and advisory staff. We are very pleased with the resulting image overhaul - the pinnacles representing both the peaks and facets of health leadership.

When taking on the lease of the whole of 11th floor in July we elected to undertake the refurbishment work in stages which has enabled a reasonably seamless incorporation of the additional floor space with minimum disruption. Though not yet complete the expanded premises are taking shape and are a rewarding venture; the new logo and image will be incorporated into the final design.

Strong focus continues on communicating with members in a timely and efficient manner, striving for efficiencies in all areas along with maintaining the professional standard of the Association's publications (including *The Specialist, Standpoint, Health Dialogue* and employment advisory documents). In addition to the annual DHB salary survey we conduct regular membership exit surveys as well as surveying members on other relevant issues.

Website

Maintaining an effective website remains a key focus with the homepage continually evolving to accommodate the latest relevant news and information. As well as providing the latest health sector news, the site continues to serve as a 'one stop shop' for SMOs seeking advice and current industry information. The site attracts 2,300-3,400 unique visitors each month.

In order to improve efficiencies and allow the ready introduction of additional features we are exploring options to upgrade the website software; but the overall look and layout of the website is not expected to change significantly.

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

The ASMS website is often the first point of contact for senior doctors and dentists seeking employment in New Zealand, accordingly the vacancies section, *jobs.asms.org.nz, a*ttracts around 1,400 visitors each month; around half of total site visits. Despite a few DHBs refraining from utilising the service, it remains one of the most comprehensive listings of specialist and medical/dental officer job vacancies in New Zealand. The number of job listings averages 60.

Because *jobs.asms.org.nz* is a service rather than a business, the rates are very affordable with proceeds put into growing the market and enhancing our services to both jobseekers and their prospective employers. The new, user friendly jobs portal commissioned in 2012 went live in March 2013. The vastly improved facility has attracted very positive comment from advertisers and allows job seekers to access full job descriptions, apply directly to employers and register for job alerts.

Other Matters

John Chambers

The Annual Report 2012 reported the unacceptable threatening of disciplinary action by Southern DHB against emergency medicine specialist and Otago Branch Vice President Dr John Chambers for exercising his right to participate in public debate and dialogue over lack of progress in working to achieve the six hour target in Dunedin Hospital. Prior to last year's Conference the Executive Director became directly involved and this continued until early this year when the threat was withdrawn.

Returning Officer

Earlier this year Ron Burgess advised of his decision to stand down from his position as Association Returning Officer. He is the Association's second Returning Officer and has performed this role very ably for nearly 20 years. The National Executive is appreciative of his willingness to undertake this role so competently for many years for a payment well below the minimum wage. The Executive is pleased, that former Executive member John MacDonald agreed to accept this position effective from 1 January 2014.

75th Anniversary of the New Zealand Public Health System

In September the Executive Director, Deputy Executive Director and Executive member Judy Bent attended an interesting seminar at Counties Manukau DHB organised by Ko Awatea in recognition of the 75th anniversary of New Zealand's public health system. It was well facilitated by former Government Statistician Len Cook.

New Zealand Integrated Acute Care Conference

On 18-19 April the Executive Director attended a very good conference in Christchurch on integrated acute care. It was organised by Pegasus Health with the support of Canterbury DHB and the Ministry of Health. Subjects included the challenge of population aging for acute care, progress on the King's Fund research into the Canterbury Initiative, development of 'hospital in the home' in Victoria, general practice team involvement in higher acuity acute clinical care, and chest pain assessment and management as well as a number of workshops.

Vulnerable Children Bill

The Association made a submission to the Parliamentary Social Services Select Committee on this Bill. Points addressed were the concentration of the Bill on a particular group of vulnerable children to the exclusion of the conditions that cause that group to exist; the confusing and unnecessary interference with the Employment Relations Act which may achieve no useful purpose, the extra burden proposed on the Medical Council (and other regulatory authorities) which will serve no useful purpose and is likely to increase costs.

Surveying DHB Senior Medical Staff Superannuation Entitlements

Superannuation entitlements have now been surveyed for 13 years. The pattern over the period has been a gradual decrease in members who are in the GSF and NPF schemes (which closed to new members in the early 1990s) and an increase in those who receive the 6% subsidy under the MECA clause. As at 1 July 2013, 334 were in GSF and NPF (compared with 419 in 2012 and 644 in 2005) with 3,487 senior medical and dental officers receiving the 6% contribution as at 1 July 2013 (up from 3,374 in 2012 and 1,477 in 2005).

North Shore Elective Surgical Centre

In the 2012 Annual Report the Association reported on its involvement in the controversy over the plan by Waitemata DHB to employ surgeons and anaesthetists as private contractors in its new dedicated elective surgical centre which commenced in July this year. Although confronted with some questionable tactics and a dubious process, the Association did succeed in negotiating an enhanced MECA arrangement for all anaesthetists as employees rather than contractors that enabled the new facility to become operational. There is division among surgeons and the numbers who have accepted contractor status is unclear. In recognition of its implications and the risk of other DHBs adopting this approach in the introduction of new models of care, the Association published a *Health Dialogue* on the subject which has also been discussed in the various Joint Consultation Committees.

Complaint from Chair of Waitemata DHB

On 30 April Waitemata Board Chair Lester Levy wrote to the National President complaining about comments made by the Executive Director in a paper given to the Australian Medical Association's Industrial Coordination Committee on early 3-4 April, including alleging that they were defamatory. Following the National President's reply Dr Levy again wrote on 5 June. Again Dr Stander replied. With the endorsement of the National Executive, the National President did not accept Dr Levy's complaints including the allegation of defamation. Legal advice was obtained before the National President's correspondence. No further communication has been received.

Associate Membership

Clause 7 of the Constitution provides for former members no longer eligible for membership to apply to the National Executive to become associate members ($100 per annum subscription). The main benefit is receipt of Association publications and the right to attend Annual Conference as an observer. At its May and July meetings respectively the Executive approved applications from former National Executive member and recently retired Dr John MacDonald

and Dr Jackie Broadbent (previously employed by Canterbury DHB but now working as a locum). The Association now has four associate members.

Telehealth and Recycling Mature Physicians

On 12 September the National Executive discussed an interesting email from a Northland member on the subject of telehealth and the recycling of mature doctors. It was agreed that this subject deserved further discussion with branch officers and at local levels noting that these involved local challenges requiring local solutions. His email was published in *Executive Direct* for discussion and debate.

NZMA Specialist Council

The Association has been invited to send a representative to the New Zealand Medical Association's Specialist Council (the NZMA also has two other councils for general practitioners and doctors-in-training). This request was considered by the National Executive at its September meeting but deferred until its next meeting on 27 November. The difficulties are two-fold – no Executive member is also an NZMA member and none are Wellington-based where the meetings are held.

Commercial Discounts

At its meeting on 12 September the question of whether the Association should negotiate commercial discounts for various products and services was discussed. The National Executive resolved by a straw poll (7-2) not to pursue this.

Medicus

On 9 April the Executive Director and Senior Industrial Officer met representatives of Medicus on their initiative. While cordial no practical outcomes arose out the meeting. It appears that the Medicus membership is very low.

Jeff Brown
ASSOCIATION NATIONAL SECRETARY 19 November 2013