Secretariat Report 2017

Welcome to the 2017 Secretariat Report.

MEMBERSHIP

Our membership has remained stable throughout 2017 at 3300-3400. Whilst membership has traditionally dipped in late February early March due to changeover, current systems to maintain contact during the most significant change time amongst RMOs has lessened this impact.

We do nonetheless still have a cohort who cease paying fees and don't tell us they are resigning or moving on at December changeover. Given our rules allow for three months to "catch up" in unpaid fees (allowing us time to alert members to non-payment) we inevitably have the greatest gap between genuine loss of members and our database recording them at this time.

Membership increases again after our annual delegates training session in late March as delegates return to the workplace and follow up those that have simply forgotten to renew. Our website allows for ease of application; automatic payment of subscriptions or by bank card for those who prefer, and seems to suit most people. However, we still have people who find it a surprise they are not a member. In this regard it helps immensely to have members openly discussing things that are happening, emails received etc. that alerts those not getting any of our communications to a potential problem. Thanks to everyone throughout the year who has assisted a colleague in this manner: coverage under MECA, back pay and assistance when caught in a tricky situation have been some of the examples where this has been of particular assistance to some.

ORIENTATION AND TI TO HO TRANSITION

In 2017, NZRDA become increasingly concerned at the impact of transition from TI to House Officer on some members. At one end of the spectrum, individuals were finding the transition so difficult they had to be withdrawn from work and reintroduced in a more supportive and planned manner. Members also expressed concern that they "hung on in there" but that the experience was incredibly stressful and detrimental to both their own wellbeing and potentially that of their patients.

Already aware of an increasing number of instances where intervention and support was being required, in 2017, we found ourselves representing new colleagues where their employer failed to provide sufficient support or respond appropriately to members in difficulty. This in one case required the threat of a personal grievance to get matters back on track.

The lack of support or proper process from some, and we make the point by far the minority of, CMO and GMHRs was nonetheless deeply concerning. The attitude that everyone has to be functioning to the anticipated level and no one person should need additional support is ludicrous: we all function at different levels and respond to the circumstances we are put in differently. This has always been the case and is more likely to be an issue if orientation is inadequate and transition unsupported. We cannot ignore the impact increasing service demand also continues to have on new graduates.

General concerns about the TI transition include:

1. Preparation as a TI to become a House Officer. Where high numbers of 4th, 5th and 6th year students are present in the same clinical environment, access to procedural skills and the ability to increasingly take responsibility under the supervision of the house officer or registrar is limited. This is exacerbated by the view that a 6th year "should" already have had such experiences, especially in the skills acquisition area, and so should "step back" and let 4th or 5th years have a go can result in TIs becoming deskilled.
2. A definitive lack of procedures being undertaken. House officers have reported graduating without performing IV line insertion or catheterisation (let alone a lumbar puncture) yet are expected to be proficient at such from day one.

3. A lack of practical knowledge of “how to” work as a house officer. Hospital systems, prioritisation and the need to achieve throughput (and not necessarily excellence all the time) challenge many.
4. A number of other comments lead us to look more closely at the balance between academic demand and practical experience in the TI year. Many commented that whilst their teams were more than happy and supportive of TI participation, the quantity of academic work including assessments, assignments and presentations was prohibitive. Some also commented that 4 week attachments were too short and that academic pressure was detriment to hands on clinical experience that should be available to trainee interns. A number commented that after 5 years of academic focus, the TI year should allow a greater proportion of time to fulfil its name: specifically practical training to be an intern.

A survey of first year house officers early in 2017 made the same points:

- Too few first year house officers felt well prepared in terms of work readiness; and
- Insufficient house officers found their orientation valuable; and
- More inclusion in the team as a TI was the overwhelming plea; and
- Having a buddy the single most helpful thing at the point of transition.

NZRDA raised these issues with the CMOs in 2017 and gained their support to take the matter to the Medical Advisory Group of HWNZ where all interested parties are represented. This group has the ability to form sub groups to undertake specific tasks, such as transition and we hope to see more progress made in this forum in 2018. There are a number of areas we believe should be explored:

1. Orientation must be improved and focus on practical knowledge doctors need. NZRDA believes that:
    a. A core nationally consistent clinical orientation is required to cover the essentials a new doctor needs to know, (acknowledging the local information and HR requirements of orientation also).
    b. All DHBs should include the provision of a HOTTI (House Officer Teaching Trainee Intern) peer to peer course run by house officers for all TIs. NZRDA has already prepared a course outline focusing on what a new House Officer needs to know including handover, prescribing, communication, simulation (e.g. the drowsy patient, SOB, chest pain etc.) and prioritisation.

2. The buddying system should be provided universally to all new House Officers.
3. That the TI year be acknowledged as a "training to be an intern" year as the priority.
    a. That we work with the universities to reduce the academic component of the TI year (push back into the first 5 years) to ensure TIs are free to attend with their teams especially when on medical or surgical runs.
    b. Where 4th and 5th year students are also present on wards, the distinctly different role of the TI should be made clear and actively delivered upon. This includes alignment of TIs within the House Officer/Registrar team.
    c. That limited registration is considered to enable TIs to undertake a higher degree of (appropriate) responsibilities.
4. That House Officers and Registrars have available to them "teach the TI" courses. Not only would this help with TI learning but all levels of ongoing learning throughout the doctors working (and teaching) lives.
5. That specific "new doctor mentoring/supervision" be provided including psychological support during the first month as a minimum to ensure the wellbeing of our newest and therefore vulnerable colleagues.

Whilst this work was underway, we were hit by the suicide of one of our newest colleagues, weeks before graduation. This sent shock waves through the graduating classes, Auckland in particular, and additional urgent support was sought from the DHBs. It would be unconscionable for us to go through another transition without having seriously progressed the above work with respect to operational delivery come November 2018.

We are also mindful of the need to look at House Officer to Registrar, and Registrar to SMO transition. Both these periods are stressful times in our lives which should be better managed.

MCNZ

2017 saw a continuation of productive work alongside MCNZ. Whilst we don't always agree, we have a productive working relationship that has facilitated at least some improvements for RMOs.

CBA: In 2015, the Medical Council New Zealand announced the introduction of a requirement for all resident doctors to complete a CBA in their first two years of practice (by the year 2020).

NZRDA ensured MECA was updated to allow those on a CBA rotation to remain employed under the MECA as well as the requirement for all CBAs to first be agreed. This latter provision allowed the run to become part of the normal rotation cycle for house officers having given us a chance to check for not just clinical and workplace appropriateness, but such things as accommodation and travel requirements for those CBAs away from the RMOs home base.

The staged program was introduced in 2016 and NZRDA has actively sought feedback from CBA RMOs since that time. This information has been collated and provided to DHBs, CBA providers, RNZCGPs and MCNZ. Overall, the feedback was positive with the majority of RMOs reporting excellent clinical experiences and that they were more likely to consider a career in community based medicine as a result of their CBA experience.

General practice was the most common CBA run followed by Hospice, then Accident and Medical (A&M) clinic placements. DHBs are clearly managing overall compliment in that there is a decrease in the number of CBAs available during the winter quarters, as DHBs require more staff to be based in the hospital in order to cover the inevitable increase in patient's numbers and staff sickness.

And the majority of RMOs also reported that any decreased run category associated with a CBA run was balanced against the lower hours and the enjoyment they gained from the run. The attempt to maintain salary category by some out of hours salary component from pm or weekend hospital based work has not been successful. The lack of relevance, failure by the DHBs to consider CBA house officers orientation requirements, plus the isolation of individuals given their lack of day to day connection to inpatient colleagues has made the role unsustainable.

Unfortunately the Auckland DHBs have not increased the number of CBAs for the past 2 years and will now struggle to meet the 2020 target. They have failed to formally identify what their objection is however we believe it is related to an attempt to secure more funding to pay for the CBA placements. In 2017 the opportunity previously offered by ADHB to spend time in general practice was also withdrawn and replaced by two runs within community mental health.

Whilst Auckland and particularly ADHB's hospital focus is concerning, Northland DHB by contrast has increased the number of CBAs this year capitalising on the future potential these runs enable.

In 2017, NZRDA made the following recommendations to MCNZ:

1. After hours non CBA work should become on a voluntary only basis (through the additional duties mechanism).

2. That definitive action to be taken to require the Auckland regional DHBs to establish sufficient CBAs to enable all House Officers to undertake one CBA by 2020.

Curriculum framework and Report: Whilst MCNZ continues to resist the provision for a RMO representative position of the medical education committee in favour of individual RMOs; we have continued to work on improving the "tick box" problems with report and have also been invited as the RMOs representative body to work on the curriculum framework review. The latter is in its early stages and we should have more to report next year.

Multisource feedback tool: We have also worked to support a meaningful multisource feedback tool that is fit for purpose here in NZ for house officers and will assist identify potential areas where an individual may improve as a result of appropriate feedback not just from doctors but other members of the team and patients.

The 10 week rule: Under the registration regime that predated the curriculum framework, specific runs and types of runs were required to be completed on the assumption that the experience itself (so specified) would be enough. Under that system, a 10 week minimum per run exposure rule existed. NZRDA did at that time ponder the value and enforceability of the 10 week provision given the lack of consistent application it could have due to the considerable variability between experiences (hours worked, types of clinical exposure, quantity, level and quality of supervision etc.). However, we never needed to press the matter further as no specific case came to our attention warranting such and with the change in system to the more robust and credible competency framework, understood that guideline was a thing of the past.

In 2017, we became aware however, that the 10 weeks provision was still in existence and that it had more recently also been applied to second years. MCNZ's verbal reassurance that it was only a guideline and that they would consider any specific circumstances as they applied to an individual did not satisfy us.

First, the provision under a competency rather than time served system should be redundant and furthermore it had come to our attention that it was used to significantly disadvantage one of our members. We wrote the MCNZ expressing concern and requesting the provision be abolished, following which a significant number of our hospital reps (having seen our letter to MCNZ on the issue) contacted us with concerning stories about a number of colleagues who had also been negatively affected, without good cause and notably regardless of the doctors' competence.

At time of writing we had not had a formal response.

MCNZ elections: The right to elect doctors to the medical council has not always been assured. For RMOs, the issue started a long time ago, before any of our current membership were even in medical school. At that time, the members of MCNZ were all appointed, and none were RMOs.

NZRDA started the campaign for elections in a bid to get some direct RMO input into MCNZ decision-making, on the basis that the council members at the time were so divorced from the reality of life for us. The introduction of the new Medical Practitioners Act (MPA) saw a new composition of council members incorporating more lay representation, keeping some appointed doctors but also enabling doctors to be elected by the profession. Hot on the heels of our successful lobbying, NZRDA worked hard to ensure at least one elected doctor was an RMO. The first was Dr Marc Adams, followed by Dr Kate O'Connor (who rose to the position of Deputy Chair), and most recently Dr Curtis Walker.

Our relationship with Council improved markedly during this time, with an increased awareness at the table of matters as they affect us in real life. Nonetheless, we did again have to defend the right to elect members when the HPCAA came into being.

The responsibility of "self-government" should be appreciated. Taxation without representation is wrong, but to earn the right is another thing. MCNZ's role is to protect the public, not be a voice for doctors, but they cannot do their role without us.
Likewise, the role is one we as a profession cannot do without. In this day and age not all our members are angels, and the activities of a few can impact on the credibility of us all.

As we present this report, MCNZ elections are nearing closure. NZRDA has endorsed Sam Holford and continues to support Curtis Walker in their bids for election. The benefit for us all in having an RMO – and not just any RMO but one who has some experience of the political environment within which medical politics plays out – should never be underestimated.

WAIKATO

Through 2017, Waikato DHB members continued to suffer under a management that seemed to not care from CE to RMO Unit. This amidst a wealth of other issues now well known to all of New Zealand and resulting in the resignation of the CE, Dr Nigel Murry. It is unfortunate our system allowed this regime to operate for so long; made it even more egregious to us as a group that warned the DHB prior to appointment of the risks associated with this style of leadership.

Serious concerns raised at delegate training in March of 2017 were followed up by a survey of our Waikato members that reaffirmed the issues. By mid-year we had recorded the issues with the DHB as:

- Insufficient cover for absent colleagues.
- Concern about the level of supervision provided to RMOs.
- Excessive workload (exacerbated by lack of leave cover) negatively impacting on:
    - physical and psychological wellbeing; and
    - training; and
    - quality of care received by patients.

A third of members had experienced or witnessed sexual harassment, bullying or inappropriate behaviour at Waikato DHB in the 3 months prior to the survey and described a culture of fear around reporting such events. The low morale at Waikato DHB was appalling with most RMOs not feeling unsupported or valued by their employer.

We proposed that the DHB needed to address the excessive workload on RMOs and inadequate resources available to cover absent RMOs and leave. The relief review (a result of the MECA settlement earlier in the year) indicated that the DHB was at least 18 relievers short. There also needed to be a significant shift in culture at Waikato DHB including the attitude of the RMO Unit to one of being helpful, friendly and dedicated to working with RMOs (not against them).

We also suggest that a clinical council comprising RMO representation from across our spectrum and lead by SMOs of RMOs choosing be established, which would be the forum for dealing with various issues, including supervision and training that existed at the time but also to get ahead of those yet to present.

Whilst the management of the day was slow to respond, pressure was mounting not only on the CE for his travel expenses, but also clinically. NZRDA made MCNZ aware of its concerns and in September of 2017, following an accreditation visit, Waikato DHB failed MCNZ accreditation for first-years. This came on top of the previous loss of O & G accreditation, and Orthopaedic, Radiology and Paediatric accreditation issues.

There were 12 actions MCNZ required Waikato DHB to perform to regain accreditation, a remarkably consistent list to that we had recorded only months before.

- Provide evidence that prevocational training is a key strategic priority.
- Ensure a governance group is established with the authority to affect change and facilitate support in response to identified issues.
- Ensure appropriate resources to deliver a House Officer training programme, including SMO staffing to provide supervision and support to House Officers.
- Ensure concerns about any House Officer be escalated appropriately.
- Provide appropriate SMO engagement at handover.
- Install mechanisms to facilitate efficient prioritisation of clinical tasks following handover.
- Ensure a ratio of 1:10 intern supervisors to House Officers.

- Address serious concerns about cover on medical night shifts addressed.
- Ensure workload is consistent, with good patient care and a safe working environment.
- Provide a safe workplace, free from bullying and harassment.
- Establish access to confidential counselling.
- Provide effective mechanisms to manage leave applications.

As a result of the pressure NZRDA was exerting, media coverage, the exit of the CE and the MCNZ review we started to gain momentum. Additional RMOs started to be appointed. The RMO Unit underwent review and the incumbent manager disestablished. Work on a clinical council got underway although it was a little side tracked when the role of and means by which RMO representatives were identified was "captured" by ER.

Waikato DHB has a notoriously anti-union culture, appearing to take every opportunity to undermine the representative authority and activity of unions – not just ours. Undermining the benefit to employee's collective activity and effective representation appears to be the goal. Having individuals as enthusiastic as they may be, "representing" without the back up and support of training, communications systems and professional advice is not just tokenism, it undermines employees' ability to effectively progress issues.

The proposal was also somewhat derailed by committee – the number of people who had a say without an apparent clear vision of what we were trying to achieve. The desire to keep the old council alive and kicking despite it having demonstrably failed given the accreditation losses was a case in point. This proposal remains a work in progress however lessons can be learnt by us all on the value of good process, and the lost opportunity presented by non-truly representative structures. Our issue with the nomination of individual RMOs to the MCNZ education committee also falls under this heading.

HEALTH SAFETY AND WELLBEING

Headspace

Headspace was launched to members (including TI members) on 15 June 2017. All members received an email and we posted the launch on Facebook. By November, 343 (by March 2018, 403) members had asked for the code to access the year's free subscription to Headspace as follows:

- 34 TIs
- 113 House Officers
- 192 Registrars
- 1 Fellow
- 2 Locums

Of those using Headspace:

- 6388 sessions have been accessed amounting to just over 1011 hours in total.
- The average number of sessions per week for users is 1.7.
- In November, we added 30 new members; in October, we had added 26 new members.

And the most frequently used packs were:

- The foundation packs (unsurprisingly)
- Goodnight-sleeping
- Health-anxiety
- Health-sleep
- Health-stress

A report on the first year of this initiative will be available mid-2018, after which we will need to make an assessment as to the value of continuing to pay for this app for members. A survey of those who have used the opportunity is planned to further inform that decision.

EAP

Employee Assistance Programmes are provided by DHBs for staff as a "confidential" service. They provide access amongst other things to councillors and psychologists for stress related workplace issues. In 2017 as part of our investigation into what was available to support resident doctor's health and wellbeing, we undertook a survey which identified that around 75% of RMOs do not know what EAP is. The 25% that did know and have used it however, found it helpful.

Concerns about confidentiality and the skill level of those available to assist were raised. Given the level of psychological stress Resident Doctors can experience, further interrogation of these barriers was undertaken from HR across the DHBs.

The main service providers for the DHBs are EAP Works and EAP Services Ltd. The majority of DHBs reported that information about EAP could be found on the intranet and that access was directly triggered by calling a 0800 number or emailing to (self-) request an appointment. The one outlier was SCDHB where employees cannot independently access EAP rather, they must go via HR.

The issue of confidentiality was of concern to many and the clear belief amongst those that did know of EAP was that it was not confidential. We found that contrary to this belief, EAP services are for the most part confidential with no identifying information about the RMO being made available to the DHB. Data is collected in terms of the types of issues that RMOs attend EAP for, number of employees using the service etc. But some words of caution here, some DHBs include a break down by specialty / 'business group' i.e. more specific than 'workforce'. In addition, the exception to this rule appears to be where an employee requests more than 3 sessions – then the employee's identity may be disclosed to HR and if you request time off to see a counsellor, employees may need to inform a manager.

We intend to do some more work in this space in 2018, engaging with the DHBs around how to effectively maintain confidentiality with regard to stats collection, and the level of experience of practitioners at the end of the phone. Once we have more confidence in each DHB's system, we can promulgate more information to RMOs about the service, assuming it passes the "personal safety" test.

Inappropriate Behaviour

Since we started this work in 2016, changing attitudes in the workplace have been evidenced. There is a wider understanding that the behaviours we may have accepted in the past are not acceptable any longer:

- belittling of individuals;
    - on ward rounds, or
    - at the bedside, or
    - in front of colleagues and team members;
- nit picking and excessive criticism;
- favouritism; and/or
- Socially isolating individuals etc.

Should all be (examples of) behaviours of a past era.

The difficulties RMOs have in “standing up” either personally or as bystanders however, continue to plague us and are a key impediment to getting concrete change.

NZRDA has been lobbying for the abolition of all confidential references for RMOs given they are key component to the “fear of career retribution”, which in turn inhibits RMOs ability to “stand up”. DHBs have now accepted that the requirement for confidential references should cease, starting with ACE in 2018. The colleges are a little slower in their processes none the less progress is being made.

A few of the DHBs are setting up “cultural change” programmes, including the Cognitive Institute programme. Timaru and Mid Central DHBs are the latest to announce their intentions to use this process to achieve organisational culture change to address these negative behaviours. Auckland DHB has embarked on their own programme: we wait with some expectation to see how the different approaches stack up in terms of real success at RMO level, as opposed to window dressing!

The Professional Behaviours Taskforce continues to meet and has achieved the following:

- Collected all the paperwork – policies etc. from DHBs, colleges, Medical Schools around bullying. They are now refining all this to identify what has had an effect and why.
- Collated what the various colleges’ approach to encouraging professional behaviours has been. This is a work in progress.
- Pondered how to evaluate success (or not) in the endeavours underway.

This group now sits under the overall medical workforce governance group (of which NZRDA is a member) and will be seeking further guidance on what it should be doing going forward.

Sexual harassment is an issue we have yet to truly address. It is likely to be difficult given too many behaviours in medicine have been normalised and we anticipate opening the proverbial can of worms when we do start this work in earnest in 2018.

HWNZ

The Medical Governance or pipeline group continued to work during the year and changed its name to the medical workforce advisory group.

The ongoing work ensuring all first years are placed, supporting the CBA process, and monitoring shortage specialties was augmented by discussions about a third medical school: whether that should be a rural school of health (not just medicine) or the Waikato idea of a stand-alone third medical school. The group unanimously endorsed the former and saw no material added benefit to the Waikato proposition.

Most of the year however was marred by the HWNZ proposal to change the manner in which approximately $160million is spent supporting training in the health sector. The vast majority of this money continues to be spent on vocational medical training, and amongst other things the proposal suggested the money be more widely distributed to fund all health employees' educational aspirations. Whilst admirable from a fairness perspective a few things concerned us:

a. The HWNZ money originally came off RMOs. It was money previously spent on RMOs by DHBs that was top sliced and given to HWNZ's predecessor (CTA) to spend on doctors. The idea back then was to hold the DHBs more accountable for training by enticing or punishing them through the additional payment or withdrawal of funding.
b. Yes nurses, allied, scientific and technical, midwives and others need educational support, but surely this should be new money, not medical money spread more thinly across everyone?
c. And if the money was "diluted" as far as supporting medical training is concerned, how will that "disinvestment" impact on us?

The theory behind CTA funding was never sound – the use of money did not affect outcomes and was (still is) put into the DHBs bottom line. HWNZ by contrast want to be able to demonstrate outcomes from this spend. Having said that we train some of the best doctors in the world; surely that in itself is an outcome albeit hard to "count".

HWNZ also argue that the money gives them no levers to:

1. Increase the amount overall to help afford "other than doctor" educational support, and
2. Improve the supply of hard to staff (medical) shortages (e.g. palliative care, public health, neurology).

On the former, the proposal was a rather bureaucratic way of saying “there is lots of education worthy of support but we can only afford “X” so we obviously need more money“. On the latter, top slicing a little more to afford these small initiatives without upsetting the entire apple cart seemed to us to be a less disruptive way and one that wouldn’t invite unintended consequences.

The proposal also sought “bids” for money that would be “ranked” against a set of criteria. NZRDA was concerned that such a competitive and bureaucratic process would exclude many from even attempting to gain funding. Up against our busy clinical lives, taking time out to bid would be a challenge. More so if unsuccessful as a result of being ranked below the cutoff for available funding: the enthusiasm to spend time would we postulated, wane rather quickly.

We were not alone in our thoughts; the medical profession excluding the RNZCGPs came together to oppose the proposition. At time of writing HWNZ had progressed the idea promising more detail on the criteria by which bids would be assessed and assistance for those unable to resource the process. However, a change in government seems to have slowed the process. At this stage, we can but await the next exciting installment.

EDUCATION TRUST

Two new trustees were welcomed this year adding to the valuable expertise and skill we need to ensure it continues to meet its objectives going forward. It also produced brochures to increase awareness of the Trust and its objectives and has also developed its presence on the NZRDA website to make the process of applying to the Trust for financial support more straight forward and to encourage more grant applicants to approach the Trust for financial assistance. As a result of the purchase of some commercial real estate to diversify their investment portfolio, the Trust has enjoyed some rental income which is now augmenting their support of further education and training of RMOs in NZ.

The Trust continued to provide financial support to NZRDA for delegate training including a day in September as well as the annual 3 day session in March. They sponsored a clinical leadership workshop in July organised by NZRDA, and supported the attendance of RMOs presenting at a CBA Symposium in April. The Trust also paid for 4 NZRDA members to attend the 2017 International Medical Symposium in Melbourne in March.

The Trust supported individual RMOs in the production a booklet for new registrars in NZ and a podcast to help PGY1 and PGY2 House Officers to improve the speed and quality of their clinical practice and potentially fill gaps in their knowledge.

Looking ahead, the Trust wishes to support a health and wellbeing conference for RMOs to be held in late 2018, as well as committing to a clinical leadership programme for RMOs which is currently being developed to build on the feedback from conferences and workshops held around this area of knowledge over the last 1-2 years.

Clinical Leadership

The clinical leadership project is progressing according to the project plan. The field work exploring factors that affect engagement of resident doctors in leadership has been completed.

A workshop was held in Northland and Hawkes Bay DHB, and one is planned for CCDHB in April 2018. 6 resident doctors across three DHBs are currently looking to start their individual projects who will also attend an advanced 1-day workshop in Auckland in early April 2018.

There has been very good engagement from all 3 trial DHBs, with the DHBs providing quality improvement advisors to support the participants. In addition to the 3 pilot DHBs, there has been interest expressed from ADHB and Southern DHB to participate in the program later in 2018. DHBs are talking about next steps and keen that the momentum and interest built in this pilot has continued. Given this, it is worth having a conversation about the support that is needed for the delivery of this program into the future.

GENERAL PRACTICE

Towards the end of 2017, we sought feedback from our members working in primary care around NZRDA communication. We want to increase engagement with those working in GP land – arguably harder to do as those members are spread out working in individual practices across the country. Feedback showed that more than two-thirds said a GP-specific monthly or bi-monthly newsletter would be useful and that connectedness amongst GP colleagues was raised as an issue and something that the members wanted to have improved. As a result, we are introducing the following initiatives:

- a bi-monthly newsletter to be sent to all members working in primary care, and a more dynamic and useful Primary Care section of the website, and
- a forum for interaction with colleagues (structure/platform to be confirmed), and
- a FAQs section on the website which includes questions both about the GPEP 1 agreement and about Individual Employment Agreements.

Following a rather short one year term for the 2016-2017 GPEP collective agreement, we re-entered into bargaining with the College late last year. The primary claim to increase salaries and seeking slightly longer 18 month term to enable GPEP 1 members to be more engaged with bargaining. The College has verbally agreed to change:

- College Discretionary Leave to Study Leave to provide more surety around obtaining leave, and
- make several amendments to the Parental Leave provision to make it more equitable.

Discussions around National Executive Leave and Programme and Travel Reimbursement continue.

The College continues to try and maintain the position that first and foremost, they are a training provider which we would argue (especially) in the context of bargaining is a restrictive one to take as the College is also an employer and thus we continue to remind the College of the importance to wear their 'employer hat' more readily. Negotiations will continue into 2018.

We continue to receive enquiries from members around the benefits of remaining with the NZRDA when no longer College employed. Whilst NZRDA does not engage in negotiations with GPEP2 and GPEP 3 individual employers we do review and advise on members Individual Employment Agreements. In addition, we provide advice and assistance with regards to all employment related issues which can and do arise. We have drafted a template Individual Employment Agreement to use as a baseline document and are currently putting together a resource which outlines the benefits of remaining an NZRDA member whilst employed in primary care which will be circulated to GPEP 1s towards the end of the training year and will also be made available on the Primary Care section of the NZRDA website.

We have followed up with the College regarding what they provide in terms of support processes for their employees. The College is actively working on improving this. We have also had discussions around the Employee Assistance Programme to confirm that this is a fully confidential process. The College has recently and helpfully changed wording in communication to members to make this clear.

TRAINING

Accreditation

The quality of our doctors, and of our training programmes, is integral to the productivity and excellence of service we provide for NZ. But that can only continue if all the participants respect and comply with what is required from each of us in this space.

We have seen 9 (training) accreditation's challenged in the last 2 years, more than we have ever seen in our history. NZRDA respects the colleges' role in setting standards; we also respect the role of DHBs in meeting those standards however in 2017, we noted that the expectations of the colleges and the behaviour of the DHBs were becoming more at odds.

NZRDA is possibly in a unique position in that we hear the DHBs and (some might be surprised to know) understand what they say in regard to issues delivering on requirements. We also hear the colleges and understand their position just as well. What we don't always see is an understanding between these parties, which leaves our members caught in the middle.

In 2017, NZRDA invited the colleges, MCNZ and DHBs to a meeting intending to have an open discussion and be honest about the barriers we are experiencing with the goal of collectively address whatever was needed.

The meeting was well attended and everyone happily expressed a commitment to maintaining the security and quality of our training programmes. There was a healthy exchange of the different points of view and largely, everyone came away better informed and on the same page. A number of things we discussed included:

- How to stay accredited – early warning systems and protocols on warning timelines for "de accreditation".

- Recognising and addressing the impact on the trainees when training is under threat.
- Clarity around standards (how far any individual party can go legally or with authority) and why.
- Involvement of all key stakeholders; and
- Role of MCNZ as the accreditation body.

We believe the day was beneficial from the perspective of getting the parties to talk directly to each other, in the same room, on the same topic. A remarkable amount of agreement resulted, in contrast to the comments we so often hear made by different parties in isolation. These parties do not often if ever, get together for conversations such as that we had was a surprise and perhaps something we need to be mindful of in the future. It was clear that everyone wanted the same thing – just exactly how, why and who can sometimes became clouded.

Regular Survey Tracking

We repeated our training survey in 2017. First undertaken in 2015, this high level survey is intended to track changes to overall training opportunities by looking at supervision, environment, communication, access and costs associated with training. In 2017, the number of responses increased by 350 and overall indicated no significant deterioration in training. If anything, the survey suggested an improvement, albeit small. Those areas that demonstrably improved included:

- Appropriate feedback in guiding performance.
- Clarity around who is responsible for supervision.
- Provision of the necessary clinical experience to meet training requirements.
- Attendance at college recognised activities and college promotion of health and wellbeing.

Areas of potential weakness included:

- Conflict between service and training.
- Access to protected teaching time.
- A worrying trend that appeared isolated to a few DHBs where RMOs increasingly reported feeling forced to cope with clinical problems outside their level of competence.

Rural Hospital Medicine (RHM) Training Programme

NZRDA has been participating in a Rural Hospital Medicine (RHM) Training Programme "group" for a little over 18 months now. First established to try and assist the RHM programme, it includes DHB representatives at both CMO and RMO Unit level, the Rural Health Medicine chapter of the RNZCGPs, the college itself, and the director of the South Island Workforce Development Hub.

Things have moved at glacial pace, however it is now getting to the pointy end of the discussion, with key issues including funding and placements given the programme requires both rural GP and rural hospital placements but also DHB based rotations such as in paediatrics, ED, medicine, ICU/Anaesthetics and possibly O & G. Rural hospital and GP placements appear slightly easier to arrange than DHB ones, although funding is a potential barrier. When it comes to hospital based placements both benefits and problems arise. In no particular order:

1. Given the inconsistent need for runs both in terms of what type and also when, it is hard for DHBs to plan and therefore accommodate.
2. There is the risk RHM trainees could displace hospital based specialist trainees or vice versa. Priority at law goes to current employees which the RHM trainees are least likely to be however, they would also be competing with other trainees coming from other DHBs. In specialties where there is competition for runs, this issue will be acutely felt.
3. The RHM Programme is not an employer so it has no authority in the employment relationship and cannot require runs, although it can say, as the training provider, what runs must be done to qualify. This is cold comfort to the programme however, what they are seeking to achieve is a viable programme producing fellows at the end of it.
4. When a RHM trainee is DHB employed, they receive the benefits of MECA, including costs of training, which they do not get in other placements in GP or non DHB run rural hospitals (e.g. those run by trusts). Nor do registrars routinely get transfer expenses, again because their employers in rural hospital trusts etc. are not party to the MECA, so again they are disadvantaged over colleagues in hospital based training programmes.

This brings us to funding. This is currently somewhat ad hoc, with HWNZ providing some funding but on an individual basis and to non DHB employers through a number of avenues. The lack of funding, lack of coordination and transfer of costs to the DHBs produces inequities across a myriad of players.

Next steps are to form a sub-group to look at the employment and run access issues for RHM Trainees in the DHBs. The matter of funding will be raised at HWNZ's Medical Advisory Group for discussion and hopefully we will be able to secure sufficient through a secure route to assist trainee progress through the required elements of the programme. We are also looking at mechanisms to entitle RHM Trainees to access the MECA even if their employers are not specific parties.

MECA

Schedule 10

You might have thought that given what we went through to get the safer rostering requirements agreed and included in the MECA, that the hard part was over; unfortunately, this may not have been the case. Once the agreement was settled, we began the arduous task of getting the rosters written and implemented.

What very quickly became apparent was both how poor DHB management are at drafting rosters but even more concerning how poor they are at engaging with RMOs. Some DHBs did not do enough consultation or left it to the last step in the process whilst others made it overly complicated and involved groups that were completely unnecessary and irrelevant.

To be fair, there were some gold star DHBs but the majority were the opposite. Some of the better DHBs included Lakes DHB and CDHB who, whilst perhaps not being 100% complete, realised that this was not going to go away and that there were some advantages in getting onto the work sooner rather than later.

At the opposite end of the spectrum were the three Auckland DHBs and Southern DHB.

The Auckland area DHBs claimed that their ongoing delay was due to their complex rosters and size, however when looking at their proposed timeframes (which initially included completion dates of 2020) it became clear that they were stretching out increases to required RMO numbers to fit in with budget rounds. We are continuing to apply pressure and have already attended one session of mediation to try and get these rosters addressed.

Southern DHB was different again, the delay here not entirely unexpected given the difficulties recruiting staff to this DHB and lack of resource over all. Again we are continuing to apply pressure.

The other learnings from this work include how important it is for members themselves to get involved and to demand compliance from their employers. Given the obvious lack of roster writing skill on the part of the DHBs, if the members took on this work themselves not only were they more likely to get a roster they were happy with, but get that roster sooner. It is also worth noting how close the additional staffing numbers estimated during MECA bargaining were, in order to fulfil the safer rosters.

It looks as though it may be a little while longer before all the rosters are compliant and we are now fine tuning some of those that have already been implemented. The feedback however from those members on the new rosters, is overwhelmingly positive.

Fears expressed by some surgical registrars in particular, about a negative impact on training have not been realised. In a few extreme cases, insistence that we continue to work unsafe rosters so as to protect current training opportunities had to be rejected. Most of the concern came around access issues however, where access was already an issue (Orthopaedics at Waikato) such continued, where it was not, no dilution has occurred albeit a little jiggling of clinic and theatre time has been required.

We need to acknowledge that the perception of threat did cause some members anxiety, including in O & G. Whilst this is understandable, it was not matched by those members with a critical look at reality, or the use of schedule 8 which ensures that any lost opportunity for training as a result of reduced ordinary hours participation, be matched elsewhere for registrars in training programmes. Change is inevitable and in this instance, supported not only by the Health and Safety framework enshrined in NZ law, but patient rights also. Whilst anxiety is to an extent understandable, we counsel members to also look to the protections NZRDA continues to put in place to ensure that whatever the change, our training is protected.

As a result of the O & G concerns around accessing major cases, we met with the college in August 2017. This college is moving to a competence based assessment system, not a "done the numbers" one, so whilst there was still a need to record cases, the emphasis is increasingly on competence. A number of constructive conclusions came out of this meeting:

- Regular contact with training supervisors and therefore regular updates and feedback on progress are important. If an RMO is concerned they are not progressing as well as expected discussing this and getting help earlier rather than later is advised.
- Participation in a training programme is a condition of employment for registrars on vocational training programmes, so we do have some levers with which to "encourage" DHBs to provide the clinical material needed to participate.
- Clarity around what should be recorded in log books helped immensely.

An invitation to meet with RACS to have a similar discussion has yet to be acknowledged.

Relief Review

One of the most frequent issues brought to the attention of NZRDA, are those relating to difficulties around getting leave. Through the 2016/2017 bargaining, it was revealed that far too many departments and DHBs were relying on cross cover rather than relievers to cover leave. Therefore, it was agreed that a nationwide review of reliever numbers would be carried out and identified shortfall in these numbers would be addressed.

In March, we got the ball rolling by emailing each DHB, asking them to identify how many RMOs they had on each run and how many relievers. These figures were to include leave relievers, night and rostered day off relievers. The DHBs also provided information around whether the relievers were in a pool, were attached to a particular run or department or whether the leave cover was being provided by internal leave cover relief. There was also the "leave cover" utilised by Waikato DHB known as embedded relievers – not a system we would recommend anyone else try; or at least not if you want to get fair access to leave cover!

We reviewed those figures in light of the ratios in the MECA and engaged with the RMOs as to whether they felt that the numbers were accurate and sufficient in order for leave to be taken.

Once we had this information, we then responded to individual DHBs advising them of where the numbers of relievers had to increase. A few DHBs questioned our figures and stated that they did not have high leave balances, so clearly did not need to increase relief capacity to which we replied that leave balances is not the only factor in determining whether the numbers are correct, it also depends on how the leave is being covered such as excessive use of cross cover.

Most DHBs stated that they were combining the recruitment for additional reliever numbers along with the recruitment of more RMOs to fulfil Schedule 10 requirements. We did stress in response to these replies that the two projects were separate and both required urgent attention.

Towards the end of 2017, we have resent the original request for RMO and reliever figures and are in the process of assessing whether the shortfall has been adequately addressed.

Remuneration Review

As part of the 2017 MECA settlement, the DHBs sought to undertake a review of the remuneration system by which the salaries of RMOs throughout the country are determined. NZRDA agreed.

The DHBs wished to address a number of perceived issues on their part with the current system, including:

- Complexity of the calculation process.
- Lack of transparency.
- Averaging resulting in a distortion between hours worked and payment received both for different individuals as well as for different periods of time (e.g. week to week).
- The impact of safer rostering and the second paragraph of clause 8.1.2. Suggesting that the concern over 8.1.2 has resulted in DHBs being reluctant to introduce safer hours. The DHBs did acknowledge that other staff do get “paid when not working” but in their view, only for days related to addressing fatigue issues.

NZRDA noted:

- The DHBs concern over second para 8.1.2 is misplaced: it is simply a means to determine a salary. In viewing the clause, as they do, the DHBs have caused the unravelling of the salary components which in turn has resulted in the RMOs low hourly rate (notional or otherwise) being clearly identified.
- NZRDA expressed frustration at the DHBs wanting a salary system but also signalling a preference (unintended or otherwise) for an hourly based system i.e. payment for hours worked not for those not worked, aversion to averaging and desire for improved transparency (by individual and period of time that has been worked).
- The averaging is a function of a collectively determined salary system, which is not an issue RMOs have identified as a concern.
- A concern to ensure we maintain a reasonable income for RMOs and that payment for unsocial hours (OT and PT) will be fairly reflected.

There are commonalities between the NZRDA and the DHBs around a desire to do without the deduction system associated with Schedule 10 rosters, to avoid unintended consequences of any change and for no pay drop for RMOs / no budget blow-out for the DHBs. The deduction model is also administratively cumbersome and imposes risk for the DHBs.

A number of alternative remuneration systems were explored and most rejected due to inequity that they would impose between different groups of RMOs on different types of rosters and seniority.

A fundamental barrier that appears irreconcilable was identified in that we have a system that averages both for individuals, over periods of time and into 5 hourly blocks; but the employers desire a system that seeks within that structure to pay only for some hours and not for other hours.

There can be two outcomes of this situation either of which is unacceptable to at least one party:

1. The difference in pay in a category drop is significant (~$10,000) and not directly related to the number of hours not worked. This can see a significant drop in pay for a minor reduction in hours worked, or
2. Conversely no drop in salary (loss of pay) as the difference in the number of hours is small +/- the category is close to the top of the 5 hourly block.

As an example, if on average the number of hours not worked is 3 per week and the number of hours making up the category is 59, there is no drop in pay. If the hours making up the category are 56 it will see a $10,000 pay cut.

NZRDA developed an alternative loading system which largely removed 8.1.2 second para and shifts this component to unsocial hours. The salary paid remains based on category determined by review of hours rostered and unrostered however, second para 8.1.2 is not applied except to the day night shifts start and the day night shifts end. (This latter provision could however be represented in alternative mechanism). Instead, overtime and hours outside of the ordinary are included in the review calculations using penal loadings e.g. hours rostered or worked between 22.00 and 08.00 are added as T2 for the purposes of determining category.

In developing this model, we were mindful of:

1. What value we apply to different times of the day and how safer roster patterns operate. As a result, the model comes as a package that is intolerant to shifts in loadings to different values and different times of the day.
2. The DHBs' concerns that:
    - The current system acts as a barrier to safer hours rostering. We have sought to encourage safer rostering.
    - Second para 8.1.2., in that it does not include payment when not working (except where fatigue related).
    - Improved transparency.

In summary this system was as follows:

1. Second para 8.1.2 does not apply (except to the day night shifts start and the day night shifts end).
2. Hours receive an additional loading when calculating run category as follows:

a. During the week
    i. Hours between 0800 and 1600 loaded at 1.
    ii. Hours between 1600 and 2200 loaded at 1.25.
    iii. Hours between 2200 – 0800 loaded at 1.5.
b. Weekends (0800 Saturday and 0800 Monday)
    i. Hours between 0800 – 1600 loaded at 1.5
    ii. Hours between 1600 – 0800 loaded at T2.

Tested on safer hour's rosters, the above has resulted in the same salary category.

Having presented the proposal to the DHBs, they adjourned to consider, returning a few months later to confirm in writing what we had already discussed above, and then silence. Given the issues with the salary structure are largely the employers, and yet we have been the only party to provide a workable alternative. At this juncture, we have to wonder at the employers' genuine desire to change models in a manner that does not disadvantage RMOs in their quest to resolve a philosophical position they have adopted. Unless the DHBs are prepared to accept our concerns as equal value to theirs when it comes to the security of our salary, we doubt this impasse will be resolved amicably.

Compliance

Cross cover outside ordinary hours has been a focus in 2017 with the Auckland DHBs in particular, continuing to fail in their obligations in this regard. Despite threats of legal action, these DHBs still have no contingency plan in the event a XCOOH situation arises, and even with notice, appear incapable of securing cover. Some of the problem is the NRA, sitting separate from the DHBs and the departments within which the XCOOH occurs, they absolve themselves from responsibility very quickly leaving those on the ground to cope.

However, we do not help ourselves when we accept these scenarios as acceptable, agree to "pitch in and cover" or don't raise the issue to NZRDA to deal with. XCOOH is a safety issue, just as much as safer rostering: if we do not stand up for minimum safe staffing levels we put ourselves and our patients at risk.

Cover for leave continued to be an issue however the safer hours process accompanied by the relief review, which we are now keeping updated, does appear to be assisting with improved reliever availability.

Issues around cost of training reimbursements have diminished this year.

PROFESSIONAL MEDICAL INDEMNITY INSURANCE

NZMPI is the only 100% NZ owned insurance company insuring RMOs, SMOs and GPs, including cover for those undertaking temporary work overseas and charity work in the Pacific. NZRDA owns 15% of NZMPI, having supported its establishment some 20 years ago. At that time, NZRDA was concerned that the only available option was through overseas based friendly societies with discretionary cover and wished to ensure there was a contractually binding insurance option also available for doctors; one that was NZ focused and operated.

Times have changed since then however. Internationally, the insurance industry was rocked by 9/11 as well as a number of other well-known disasters, including NZ's own. The Insurance (Prudential Supervision) Act introduced in 2010 was a move by the legislators to ensure minimum standards, including sufficient assets are available in all insurance companies to protect those they insure. NZMPI was able to comply with this legislation without issue.

In 2017, NZMPI was re-categorised as a "large insurer" albeit not a very large one. This change is determined by the Act which defines as "large" all insurance companies with a net premium over $1.5 million. The change will bring additional compliance requirements (and costs) all of which NZMPI is preparing to meet if it does not do so already.

One of these compliance issues is the requirement to have a rating. Given NZMPI are not one of the traditional insurance companies with billions in turnover, they will never qualify for an A rating and were pleased to secure a B+.

A significant surge in claims in 2017 has raised the possibility that a premium increase will be required. The last increase was over 10 years ago.

SOME HIGHLIGHTS OF 2017

- ✓ Settlement of MECA and good progress in agreeing safer hours rosters.
- ✓ Ongoing progress to abolish inappropriate behaviours in the workplace, including DHBs accepting confidential references are to cease for ACE in 2018 and thereafter, all appointments. Colleges also working to achieving this goal.
- ✓ Light at the end of the tunnel for Waikato members as the RMO unit is restructured; clinical council starts to get traction, improvement in reliever numbers and change of CE and management culture.
- ✓ Accreditation losses highlighted as an issue for all players in our universe: NZRDA sponsored a constructive forum for all the parties to seek better mechanisms to maintain accreditation.
- ✓ Introducing the Wellbeing app, Headspace.
- ✓ Clinical Governance and Leadership opportunities for RMOs being supported through to a trial to embed opportunities into our working lives.
- ✓ Completing a second 2-yearly survey tracking overall access to training and the training environment as an early warning system.
- ✓ Improved communication and responsiveness with our GP colleagues.
- ✓ A definitive plan in place to address TI to HO transition: work to be progressed in 2018.
- ✓ Relief Review resulted in improved relief capacity in some DHBS and provided a baseline for annual monitoring of adequacy of cover.

SUMMARY

NZRDA is financially sound, its democratic structures vibrant and strong, and its membership committed and responsive. For a relatively young union, NZRDA has come of age, confident and competent in the role it plays and the responsibilities inherent in the representation of its membership.

Protecting, enhancing and enforcing terms and conditions of employment remains "core business". In 2018, we will have the safer hours rosters to monitor and inevitably more to implement, adequacy of relief and remuneration to review, on call rosters to challenge on top of ensuring members rights to leave, costs of training and to be trained as examples, continue to be honoured.

NZRDAs work programme in 2017 was also focused on wellbeing; from TI to House Officer transition – ongoing work to improve behaviours, introducing a wellbeing app and reviewing other supports available to RMOs. This work will continue in 2018 culminating in a national conference on the issue in November. This in itself will undoubtedly generate more work to ensure our members wellbeing is enhanced and supported. Ensuring we have better supports in place for our graduating classes of 2018 must also be a priority for this year.

And we made strides in the area of clinical governance and leadership with our conference in 2016 having provided the platform for two training days and now a programme to involve RMOs in their everyday working lives, driving quality improvement programmes. Using the safer hours process to provide some valuable time to make this a reality, one of the benefits of an organisation that is well connected, does good planning and has a vision. The same can be said of our approach to CBAs, and we hope to the rural medicine training programme going forward.

It is vital that we adapt to the changing environment that is around us; it is also important we lead change in the right direction. It is after all more our environment, our futures and that of our patients, than that of the managers and in some instances our more senior colleagues. GP is a case in point here with a college firmly clinging to the old model, but new GPEP Registrars seeing the need and benefit of a different future to better serve their professional aspirations and also that of their patients.

Huge thanks to the executive and delegates alike for their work in 2017. From a second strike to the work needed to implement safer rosters and back into a new MECA bargaining round all in the one year, and on top of the other work of the Association, the commitment to colleagues every one of our 70+ delegates demonstrate makes all the difference to both the confidence of the executive in their decision-making and our effectiveness as an organisation.

Dr Deborah Powell

National Secretary