Council of Medical Colleges in New Zealand

Te Kaunihera o Ngā Kāreti Rata o Aotearoa

Unconfirmed Minutes | 2 June 2022

Held at 9:30am (NZST) via Zoom Videoconferencing and in person at Te Papa Tongarewa, Wellington

Business Session

1. Procedural business

1.1 Welcome, attendance and apologies

The meeting commenced at 9:30am (NZST) Dr John Bonning welcomed everyone in Te Reo:

	Figurative translation
Kia ora tātou	*Greetings everyone*
E ngā maungā kōrero	*To the speaking mountains*
E ngā wai tapu o te motu	*To those assembled from various parts of the country*
E ngā hau e whā	*To the waterways and four winds of this land*
Tēnā koutou, Tēnā koutou, Tēnā koutou katoa	*Greetings, salutation, acknowledgements to you all.*

The Chair thanked members for attending this meeting which is being hosted both face to face and on Zoom videoconferencing.

Dr Bonning acknowledged and thanked both Dr Sally Ure (ANZCA) and Dr Philippa Mercer (RACS) for their time on the board as this is their last meeting. It was also Dr Bonning's last meeting as Chair of the Board. Dr Bonning welcomed Dr Stephen Inns (RACP) to the Board.

The following attended the CMC Board meeting:

Board Trustee	Member college	College staff
Dr John Bonning CMC Chair	Council of Medical Colleges in New Zealand (CMC)	Virginia Mills (Executive Director) Rameela Patel (Secretariat)
Dr Kate Allan	Australasian College of Emergency Medicine (ACEM)	
Dr Nat Anglem Member CMC Executive	Australasian College for Sport and Exercise Physicians (ASCEP)	Diana Quinn
Dr Sally Ure	Australian and New Zealand College of Anaesthetists (ANZCA)	Nigel Fidgeon Stephanie Clare Adele Broadbent
Dr Andrew Stapleton	College of Intensive Care Medicine of Australia and New Zealand (CICM)	
Dr Jenny Keightley	The New Zealand Association of Musculoskeletal Medicine (NZAMM)	Ms Brenda Evitt
	New Zealand College of Public Health Medicine (NZCPHM)	Pam Watson
Dr Iwona Stolarek Member CMC Executive	Royal Australasian College of Medical Administrators (RACMA)	Cris Massis (online)

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Dr Stephen Inns	Royal Australasian College of Physicians (RACP)	Paula Birnie
Miss Philippa Mercer	Royal Australasian College of Surgeons (RACS)	Justine Peterson
Dr Peter Hadden	Royal Australian and New Zealand College of Ophthalmologists (RANZCO)	Mark Carmichael (online) Gerhard Schlenther (online)
Dr Susan Fleming	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)	Catherine Cooper
Dr Susanna Every-Palmer	Royal Australian and New Zealand College of Psychiatrists (RANZCP)	Jane Renwick
Dr Gabriel Lau	Royal Australian and New Zealand College of Radiologists	Megan Purves (online)
Assoc Prof Chris Hemmings	Royal College of Pathologists of Australasia (RCPA)	Debra Graves (online)
Dr Sam Murton CMC Deputy Chair	Royal New Zealand College of General Practitioners (RNZCGP)	Lynne Hayman
Dr Helena Haggie Co-opted Member of CMC Executive	Royal New Zealand College of General Practitioners (RNZCGP)	
Dr Kelvin Ward	Royal New Zealand College of Urgent Care (RNZCUC)	Adrian Metcalfe (online)
Guests		
Dr Sally Langley	Royal Australasian College of Surgeons	
Dr Andrew Connolly	Planned Care Taskforce, Health New Zealand	
Simon Everitt	Establishment Director, Public Health Agency	
Ailsa Claire	Workforce Taskforce, Health New Zealand	
Dr Dilky Rasiah and Sarah Marshall	Accident Compensation Corporation	

Apologies

Apologies were received from the following Guests.

Rosemary Clements	CEO of Health New Zealand
Fepulea'i Margie Apa	Workforce Taskforce, Health New Zealand
Dr Janine Ryland	Accident Compensation Corporation

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Apologies were received from the following college fellows and staff:

Kate Simkovic	CEO, ACSEP
Vase Jovanoska	CEO, RANZCOG
Dr Jim Miller	New Zealand College of PublicHealth Medicine (NZCPHM)

Trustee Terms of Service

The terms of service of Trustee members on the Council were received and noted by the Board.

Interest Register

The updated interest register was received and accepted by the Board. The Chair asked Trustees to forward any new interests or updates to the register to enquiries@cmc.org.nz

1.2 Minutes of the last Board meeting – 24 March 2022

Motion: That the CMC Board confirm the minutes from the CMC board meeting on 24 March 2022.

Board decision: Approved. There was no dissent.

1.3 Matters arising – review of actions

Matters arising from the board meeting on 24 March 2022 were noted. All have been either actioned or are in progress.

- Working groups to look at the Communications plan will be setup later today.
- There has been feedback from four colleges on the Allen and Clarke literature review and environmental scan of cultural safety training in vocational medicine.

2. Management reporting

2.1 Chair's and Executive Committee Report

The Board noted and accepted the Chair's report, for April to June 2022. The Chair spoke briefly to his report.

2.2 CMC financial reports for April 2021 to March 2022

Dr Bonning spoke to the financial reports and variances to budget.

Motion:

That the CMC Board notes and approves:

- the CMC financial reports for April 2021 to March 31 2022.
- for Dr Samantha Murton (Deputy Chair) to be added as an owner of the CMC bank account.

Board decision: Approved. There was no dissent.

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2.3 CMC Risk register

The draft CMC risk register was noted, and the Chair invited colleges to provide feedback. Dr Bonning noted the following significant risks -

- Reliance on busy volunteers.
- The issue of succession planning for key office holder roles.
- Potential of underperformance of contractors.
- Reliance on a sole charge Executive Director was a key risk, this would impact on business continuity in the event of staff turnover.
- Not meeting expectations of members.
- IT systems security.
- Compliance issues. Need a modernised governance structure for the Board to be able to look at compliance, health and safety, finances, and strategic direction of CMC as an organization.

3. Te Tiriti o Waitangi and Health equity

3.1 Cultural safety framework Update

It was noted by Dr Nat Anglem (a member of the CMC and Te ORA Interdisciplinary Māori Advisory Group) that there was a lot of enthusiasm about the work that has already been done. There is a positive feeling that the work will be beneficial to everyone.
There are two pieces of work. A draft literature review and the environmental scan was provided to colleges in March and feedback sought. Feedback has now been incorporated into the draft. This has informed the next piece of work, a cultural safety framework for training in vocational medicine, The framework aims to support colleges to operationalize cultural safety training.

Every college has been invited to attend a workshop to look at the framework in detail and provide feedback. There is a requirement from The Medical Council of New Zealand to progress the work in this area in all colleges, and for both Fellows and trainees to participate.

Dr Sam Murton acknowledged Dr Helena Haggie, Virginia Mills, and Professor David Tipene-Leach for their hard work on this project, and for ensuring a rigorous process was followed in developing the framework.

4. Medical education, training, and workforce

4.1 HQSC Shared goals of care programme

Dr Bonning provided an update on a meeting he had with Tammy Peg and Lee Hansen from HQSC, aligning with objective 2 of the Business Plan; to promote a well-trained and safe medical workforce. HQSC has developed E- learning packages to support shared decision making in advanced care planning, and has requested support promoting this work in in college communications; including the principles and shared goals of care in vocational training and CPD; and endorsing the E learning package for CPD points. This will be a significant issue in both primary and acute care, in particular for those in nursing

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homes. Discussions need to be had and are being had around shared goals in a culturally safe fashion with both whānau and patients.

It was noted that currently many patients are reluctant to have conversations around advance care planning. It is helpful for patients to have these conversations with all health providers involved in their care. These are hard conversations that need to be approached by many practitioners to support patients to feel comfortable to have these conversations. It was also discussed that sometimes patients are referred to hospital from aged care facilities, when a more appropriate approach would be mobile units that could go in and support patients and whānau in aged care facilities, when palliative support is needed. This is starting to happen.

It is important that the information given is appropriate and the level of certainty that is given is appropriate. Conversations with patients must be supportive and careful.

5. Inter-college collaboration

5.1 NZCSRH application for CMC membership

Motion: That the New Zealand College of Sexual and Reproductive Health be accepted as a member of the Council of Medical Colleges.

Board decision: Approved. RACP abstained.

5.2 NZMA Code of Ethics

Due to a decline in membership and a 15yr lease undertaken, the NZMA has been forced into liquidation. The NZMA is looking for homes for the following 3 assets. Dr Alistair Humphrey (Chair) and Esther Munro had met with the CMC Executive Committee on June 1 to discuss these assets. The Board discussed all three.

- Code of Ethics.

It was noted that individual colleges already have their own Code of Ethics and the NZMA Code of Ethics would be better housed with the Medical Council of New Zealand. It was discussed that the CMC was not the place to hold it.

Action: The CMC Executive Director to contact the NZMA and notify them of CMCs position and suggest they approach the Medical Council.

- Journal

It was discussed that taking on the journal was not on CMCs priority list nor part of its objectives. It was suggested that the best place to house the journal was one of the universities. Members noted the journals value and expressed a desire for a home to be found for it. It was discussed that CMC could offer to support NZMA in advocating for another home to be found for the journal.

Action: The Executive Director of the CMC to go back to NZMA with an offer to support in advocating for the importance of the journal.

- Benevolent Fund

This fund is for doctors' families that have fallen on hard times. The donations for this fund came from NZMA members, and the parameters of the fund are restrictive. Currently the fund supports 3 families. It was concluded that holding this fund does not

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align with CMC's core business and strategic plan, and CMC does not have the capacity to take the fund on.

Action: The Executive Director to advise NZMA that CMC is not in a position to take on the benevolent fund.

6. CMC Projects

It was discussed that a collaborative approach is needed for several pieces of CMC work, and suggested that working groups are formed to look at the following projects –

- CMC Communications and Media plan
- Review of the governance structure
- Review of the Deed of Trust

Actions: Volunteers from colleges to give their names to the CMC Executive Director.

7. Stakeholder Engagement

7.1 Mr Andrew Connolly, Planned Care Taskforce, Heath New Zealand

Mr Connolly gave an overview of the taskforce. Its purpose is to act as a final staging post for ideas, innovations and advice to Health New Zealand and the Māori Health Authority through to Ministers and Cabinet. The taskforce is not operational and does not hold a budget. The taskforce's role is to broadly assess opportunities, taking advice from sector experts and then endorsing them, to present to Health New Zealand for decision about what actions to take.
Treatment waiting lists for surgery, dentistry and interventional cardiology are a priority to assess, and accurate data is being collected on the waiting lists. This data is by specialty, by DHB(and therefore, by region), by waiting time and by ethnicity. The DHBs have been asked if they have the ability to do non-urgent work, to focus on patients who have been waiting over 12-months. Inequity issues are evident in waiting lists, with Māori and Pasifika patients disproportionately represented among those who have been waiting over 12-months for surgery in most DHBs.

Access to CTs and MRIs and ultrasound is also challenging, leading to clinical risk. Colleges could potentially support with solutions. There needs to be an investment in Radiology training. Collaboration between clinicians across scopes of practice regarding surveillance protocols after various cancers would also be useful.

In terms of first specialist assessments, limited data is available nationally, but there are many delays to accessing FSAs leading to clinical risk. The taskforce will attempt to quantify the resource required to complete all overdue surgical work. The challenge is with staffing and facilities. Productive discussions have been held with the private sector, though it is acknowledged the private sector will not be the solution to public sector pressures. Multi-year contracts to increase certainty for private providers and increase training opportunities are being discussed. The reforms will bring about improvements especially with no boundaries and may allow trainees to move across regions easier to receive training in areas their hospital does not have. The reforms will create more inter-hospital

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co-operation, use of resources, specialists, and training.

Board members raised issues for the Taskforce to consider several issues, including:

- The need for a national patient record to support provision of care across the country
- The need for acute surgeries to be factored into planning.
- Access treatment that can be provided in primary care.

7.2 Simon Everitt (Establishment Director of the Public Health Agency), Dr Jim Miller (Acting Director of Public Health) and Graham Cameron (Public Health Agency)

Development of the new Public Health Agency was discussed. Strategic intent of the unit, and alignment with He Korowai Oranga (the Māori Health Strategy) and the new Pae Ora legislation has guided development of the agency.

- Key threads – Equity, Sustainability, People/Whānau centred care, Partnership and Excellence.
- Identified purpose of the Unit includes–
    - Embedding Te Tiriti o Waitangi andprioritising equity, enabling cross-sectorial collaboration, public health leadership.
    - To lead public health strategy, policy regulatory, intelligence and surveillance and monitoring functions.
    - To establish a policy framework and strategy.
    - To collaborate and share leadership with Health NZ and Māori Health Authority.
    - Better connect Science & Health.
- The PHA will also support a new Public Health Expert advisory committee, to provide independent advice directly to the Minister of Health and Associate Minister of Health.
- The role of the Director of Public Health was explained. –
    - It is a statutory role inside the Ministry of Health. The Director of Public Health will have a key leadership role in both the Public Health Authority (PHA) within the Ministry, and the National Public Health Service (NPHS) within Health New Zealand. It will be a critical role for connecting both the PHA and the NPHS.
    -
    - Provide professional support and oversight for Medical Officers of Health, including improving alignment among Medical Officers of Health, with support from Māori public health leadership.

7.3 Dr Dilky Rasaih and Sarah Marshall, ACC

ACC talked about treatment injuries, defined as –

- A personal injury caused to a patient by treatment by a registered health professional. Treatment includes:
    - consent, diagnosis, advice and interventions

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    - failure to provide treatment or failure to provide treatment in a timely manner.
- Core requirements to accept a claim include that the injury is not:
    - a necessary part of the treatment
    - an ordinary consequence of the treatment
    - wholly or substantially due to an underlying condition (s32).

ACC talked about how Covid 19 had affected claim numbers. Graphs showed the drop in claims during lockdown, which is to be expected.
Members engaged with ACC on a number of issues, including:

- The importance of analysing claims data by ethnicity and identifying the cause of inequities in the number of claims lodged for different population groups, and the number of claims accepted. This is particularly relevant for Māori and Pasifika patients.
- The importance of analysing inequity in claims made and accepted geographically, to identify if inequities are driven by claims not being lodged or not being accepted.
- The need for ACC treatment injury forms to become electronic, which would support better data collection.

ACC is aiming to publish more data on treatment injury towards the end of the year and is interested in feedback from colleges about what data would be useful and how it can best be used.

8. Annual General Meeting

See separate minutes

9. Stakeholder Engagement Continued

9.1 Ailsa Claire, Workforce Taskforce

Ms Claire highlighted the nursing and midwifery workforces are critical and will be a top priority for the taskforce**.** With nursing and maternity there are two elements – workforce and recruitment.

1. **Workforce:** There are high attrition rates in nursing training (42%). Work is needed to increase movement of people through the pipeline to graduation, and also to progress through to becoming nurse practitioners. Currently there are a number of nursing projects both big and small underway, but these have not been coordinated and are unrelated. A small working group will make recommendations around the key issues and on the current project underway.

   The taskforce needs to establish Māori partnerships with all. All programs are going to be led by Māori or in a Māori partnership.

   There has also been a loss of home care workers due to pay parity, so home care patients end up in hospital, taking up hospital resources.

   There is a midwife shortage – the taskforce will look at a skill mix that could support them, as well as alternative ways to increase midwife staffing. CMC members indicated interest in being part of these discussions.

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2. **Recruitment:** A recruitment programme is being developed to create an effective international and local campaign, using media. Although the pressures nurses are under needs to be acknowledged, the campaign will focus on the benefits and value of becoming a nurse to encourage people to still apply. The taskforce will also look to establish a system for getting people through the immigration process.

In terms of funding for doctors it was suggested that funding should be attached to the registrar/trainee not the position, to facilitate movement around different locations and between hospital and community. The taskforce will consider this, this could also be useful for nurses as well.

Training of nurses in aged care facilities would be another option, this would also provide support in the community.

A number of issues about workforce were discussed, including whether New Zealand is training enough doctors; whether another medical school is needed; and processes for bringing IMGs into the country. Work is underway to look at all these issues. The taskforce is also looking at vulnerable services and resourcing and will connect and consult with each relevant specialty group. It was noted that many specialties would like to train more people but there is not enough funding to do so. As a result, some vulnerable services are stopping as there is no one to fill vacant positions.

Meeting Close

Dr Bonning confirmed the next Board meeting is on 18th August.

There being no further items listed for discussion, Dr Nat Anglem performed a closing karakia and Dr Bonning concluded the meeting at 3:30pm (NZST).

Approval of Minutes

Signed: .....

Dr Samantha Murton, Chair

18/08/22

Date

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