Minutes of NZAGS Executive Meeting held 15 April 2020, Zoom 7.30pm

Rowan French (President), Julian Speight (Past-President), Aleksandra Popadich (Treasurer), Bronwen Evans (executive Director/Secretary), Vanessa Blair (Vice-President), Simon Bann, Mark Stewart, Peter Shapkov, Bevan Jenkins, Sue Ong, Falah El-Haddawi, Marianne Lill, Gary Stone

1. Apologies: Sarah Abbott, Jasen Ly, Claire Nicoll, Gowan Creamer

2. Minutes of the previous meeting:

Peter Shapkov moved that the minutes of the previous meeting held 27th March 2021 were a true and accurate record. Seconded Aleksandra Popadich.

3 Matters Arising:-

3.1 Charities Hospital / Post Code Lottery Update– Funding model revamp could shake this up. Is it appropriate to continue work on this? NZAGS is in a wait and see what the new structure announced by the Government shortly after the March meeting evolves. Need to work with DHB for information but this needs to be led by NZAGS not an individual surgeon. Encourage heads of departments to get DHB's around the country to meet.

NZAGS should have a stronger political voice. How do we use NZAGS to be the voice for surgeons. To be discussed at the F2F meeting in November.

3.2 Practice Visits Update – Bronwen corresponded and spoke to the MCNZ about the 1-year allocation. There reply was that they saw no problem with multiple years allocated to the programme if the College agreed it warranted that length. Bronwen has drafted a letter to send to the College to see how to appeal the 1-year CPD points allocated.

3.3 Face to Face Meeting in November 2021 – it was agreed there would be a F2F in November in Wellington. To revisit the NZAGS strategy and develop a more political programme. Bronwen to send around a Doddle calendar to see best dates.

4 Reports

4. 1 President

Not much to report except what's coming up on the agenda below. Salutation letter has received no response. Did make an appearance on the WIS FB group. Suggested to NZNB that salutation letter was dropped topic as it needs more discussion.

4.2 Executive Director – Bronwen Evans

Working on items that are below. Investment policy, conference, and practice visits.

4.3 Treasurer's report – Alex Popadich

Income conf based with trainee fees. $10k balance increase from conference. All good.

4.4 Training Report –Simon Bann

Selection is June 30th. Interviewing 39 – 10-12 may be more depending on deferrals. At the airport.

The Tuesday prior meeting to look at the assessments for the new competency programme. Approval for more money for the software but may be back again as found some other forms need to be addressed. All needs to be done by February 2022 when new training programme rolled out.

Meeting AMC and MCNZ to meet with them regarding the programme. Some may run foul.

5. Business items

5.1 Management Report 31 May 2021 was sighted and read and approved.

5.2 Conference for 2022 – Gary Stone

Te Papa – 2 and 3 April. Ask Govt general to open but new one in September so have to re-ask.

When I first looked at building this programme it was 2019 before COVID. I therefore thought that we could provide a different sort of programme as members could travel to other major conferences for surgical craft. Two pronged – synergies that surgeons have with other specialties that they work with radiology, oncology, gastroenterology etc. aspects of their fields that surgeons should know and what overseas trends are heading this way. The second prong is Artificial Intelligence in surgery- training to endoscopy. This branch was with overseas speakers back in 2019. All agreed to participate via video conferencing – at least one, hoping two by hologram. NZ speakers – vast majority of them are female speakers. Dinner speaker is a female.

I'd like an update on training program – what is the new competency programme change?

Funding the conference. Attendees equals the income for speakers. Can we afford 2 holograms?

Te Papa is expensive puts budget up. Hologram cost is the same as bringing a speaker over from the UK. It's about $14k . We have only spent 1 International speaker so 2 holograms is a bigger investment. Still do video conferencing. Sponsorship of $5000 towards the cost of 2 hologram.

Bron: Budget – Donna's done the numbers on 120, 150 and 200 attendees with only 1 hologram. With 150 attendees which I hope we can get, we make a $5k loss (before the dinner speaker cost of $5000k) but with 200 attendees we make a profit. It's frustrating not knowing how many attendees we will get.

Rowan: Which speakers are hologram? – First is the man who Simon Bann knows is from Toronto who is doing AI in training. Get fatigue with a straight video presentations.

Bron: It's awful to say no and then we get 200 attendees and could have done 2 holograms. Want some direction from the board as to the risk they are prepared to take.

When do we need to let them know about a hologram? Don't know talk to Donna.

Falah – looked at average attendance over the past 5 years when doing Taranaki conference. Usually around 110. NP conference larger due to travel excluded in 2020. Slightly exceptional. Networking and CPD as can't travel overseas. 150 a good target but 200 a stretch. – Te Papa had a lot of technical issues so will affect this presentation. Hologram technology – what happens if it doesn't work.

Bron: I asked loads of people at the 2020 conference why they came. Christchurch was 150 but it hadn't been in Christchurch for over 10 years due to earthquake and surgeons supported the city. Main centers get more people due to flight availability. The NP conference we got a huge number of registrars and house surgeons. They were there for the programme. Everyone else networking and programme. Next year still not a lot of travel so 150 should be able to get.

If the hologram didn't work switch to video conferencing only. Talk to Donna – what's the cost if the hologram doesn't work? Do we still pay for it.

Te Papa venue only venue in Wellington now because of earthquake damage to old Duxton. To fit exhibition and conference numbers Te Papa is the only venue.

Julian: Not a disaster if we made a small lose. There can afford to make lose due to profits from Christchurch and Auckland.

Gary – increase the registration fee?

Bron – hasn't been raised in years so a CPI over last 3 years.

Rowan – surgeons have accumulated a lot of CPD funds due to travel restrictions so a small increase. Reasonable to do the 2 holograms as it's a AI. Is it a broad programme.

Simon – as to the new training programme it will be 2 months in by conference. Should be good to go through why it's gone this way. Presentations are being done to departments by Simon Harper. We can do an update – what's live and questions and answers. Give Claire the chance to do the talk at conference and showcase her work.

Bron to send Claire's email to Gary.

5.3 NZSG Discussion

Arose out of discussions Rowan has had with co-joint committee member Marianne Lill. NZSG is being kicked out of the GP accommodation at the end of 2022. They are looking at office space within our building. RACS hasn't any room in their allocation, but NZAGS could share office space. Does this provide NZAGS with the opportunity to engage with NZSG (a smaller society than NZAGS struggle to resource themselves) that benefits both organizations and helps develop endoscopy.

Bron – spoke with Anne the staff member if moving away from GP what does the organization look at doing moving forward. Anne couldn't articulate how they want to work together.

Rowan – starting point was the basic endoscopy course. At the moment they run it but they have limited resource. Maybe we could run it jointly.

Marianne – Rowan, Jeremy, Marianne met with NZSG board including Zoe the current president. How can we work more closely together on endoscopy training? Move away from thinking of GS trainees and SG trainees there are simply endoscopy trainees. How do we improve access to endoscopy for our trainees in the bigger centers. Tradeoff for NZSG is shared training days, resourcing of course etc. Therefore need more formal meetings with them. Only 2 courses a year so can't do enough training but if we could work with them then our trainees could get access to these training courses. The GP divorce gives us the opportunity to move towards this by offering to help with office space etc. Need a formal letter to meet with their executive and have a meeting.

Simon – believe in taking down walls. Strick understanding NZAGS and NZSG is separate. Working separately but together is good but running their payroll and software etc. is a bit of a muddle.

Falah – thanks Marianne for all her work. Hard to train a GS to their level in a small hospital.

Marianne – What I'm seeing although no data on this is that a lot of our trainees get nearly over the bar in a smaller hospital. Then they go to the bigger centers and get no access for two years and then we never get them back. If we could get them nearly there in smaller centers then back to larger hospitals where they get access to at least a run per week then we'll get more of them over the bar. They just need to come out as good solid endoscopists so they can work in this field in any hospital that employs them. Employment is the second issue to discuss but probably separately is that junior consultants get access to endoscopy to continue their skill but that's an employment issue so needs to talk to different area. The problem that I'm seeing is the training is closely controlled by the NZSG and GS trainees are being excluded. Dunedin for example. 18 lists only 1 was allocated to GS the rest went to NZSG trainees. Can we break this down. Don't need equivalent but just need more access. Is this something we want to talk about with NZSG more formally.

Bevan – highly supportive but endoscopy is a huge problem with the BSP and yet we have no access to be fully trained to help with this situation. Burden of undiagnosed bowel cancer and we could be scoping but no access.

Marianne – agree. NZSG has talked about the shortage. Their solution is to train more SG but we have our trainees that could fill the gap but we are not getting access. NZSG view is, why give a post to someone who will probably be a breast surgeon? Need to start making steps and help those that are keen to advance in endoscopy and this will help the workforce shortage

ACTION: Marianne to provide Bronwen with an Agenda so she can draft up a meeting letter and talk with NZSG.

Simon – next year we will have new hospital inspection standards. It will depend on what the TC wants in those documents section 7 what are the NZAGS expectations of what access to certain lists we require. Keep supervisors in the loop so we can have them included in the documents.

5.4 EGGNZ Discussion – Andrew Moot

How are they going to fund the organization. Funding model is about to fall over MOH take in house but last EGGNZ alternative is to have it under NZSG to keep independent from MoH.

Did it get pulled into bowel cancer screen programme. As there is no funding model. There wasn't any resolution. Could be an item to discuss with NZSG. Russell keen to get funding out of training funds but NZSG probably not keen.

No outcome let's just keep listening.

5.5 Letter from Phycologists Trainee Survey Cancellation

Just tabled so everyone can see their response. We will not be replying. As far as NZAGS is concerned they cancelled the contract in their response to our letter saying we would be relooking at the issue.

We paid the deposit of $9k but as they cancelled the contract we don't owe them the rest of the contract.

5.6 Investment Policy Ratification

Look at this at the face 2 face. Agreed. Please read and send back comments.

Falah – do we have an accountant? Have they looked at it?

Yes – an accountant and an auditor. No but we took advise from a financial advisor put together this information via the Investment sub-committee.

5.7 Ratify new RACS General Surgery Curriculum

Long document curriculum has now become a syllabus. Based around the ten core competencies. It's ongoing work still to do. Each level is defined. Curriculum is around the nine core competencies. The syllabus is the milestones you have to have for the examination.

What's the deadline – they want feedback. Gone out to all societies for feedback.

Have a look and feedback anything of concern. By the end of next week which is 25th June. Should be led by TC or NZBiGS – follow their lead.

5.8 BCCA Update – Jasen Ly

Jasen not at meeting. Hold to next meeting.

5.9 Ratify NZAGS member for Rural Health Advisory and Reference Group

Board ratify Gowen and Mark. Peter Stiven be asked to step up in 2022 or 2023. 1 year term for 2022.

5.10 Ratify Funding for SOLA already agreed via email

Approved the spending on SOLA as per the email trail.

6. General

6.1 Southern Cross

SX has sent us a letter to send to our members regarding wait times with ACC. Discussion at March meeting that SX might cover surgery while ACC makes a decision but this is not reflected in this letter.

Vanessa – the letter isn't telling us anything new. They want us to remind our members that this is how the system works and emphasis GS should cost shift to ACC. Overtly stated. Non-event. My ACC approval for hernias 11 days national average 25 days - high priority. Routine is 17 days national average so 54 days so I didn't understand the problem during the rest of the country. How can we help our membership with ACC claim times – what can we do?

Falah – SX won't agree to pay you if there is an ACC claim in the process. Will help patient fight ACC? How does that work? My experience with hernia's is not as good.

Simon – can NZAGS write to both ACC and SX asking to come to common ground so that the patient isn't stuck in the middle?

Rowan – some come to him with ACC approval via GP. Delay don't seem that great. It's the ones patient turns up with no GP work and could be ACC. That leads to a big delay as it's a treatment injury.

Julian – worked with ACC to sort out access criteria, problem is how they are applied. Word so the request ticks the boxes. GP can get permission to see a specialist, that's not approval for surgery and the patient is often confused and comes saying he has approval from ACC for surgery when it's only to see a specialist. ACC is more advantageous as they get extra costs covered.

ACTION: Vanessa – we need to go back and distinguish between groin hernias and incisional hernias. Remind our membership of the importance of persevering with ACC as it has significant advantages in terms of post-operative care and work etc. Vanessa asks them to broaden the letter before we send it out. Vanessa to draft a reply.

6.2 Breast PFET

We asked a lot of questions of Breast PFET – access and exclusivity. Looks reassuring. We have the document and we can keep this should things not follow this letter we can raise it.

What is GSA's response as they do have some issues. Bronwen to talk with Sarah Benson.

Agree to support the PFET.

ACTION: Bronwen to send them a letter to this effect.

Thank you everyone. Date of next meeting 14th September 2021. I hope it doesn't clash with any training meetings?

Meeting	***Proposed Dates***	**Proposed Time**	**Where**

Zoom	Tuesday, 14th September 2021	7.30pm	Zoom
Face to Face	?TBC November 2021	10.00am to 3.30pm	Face 2 Face – Wellington Airport TBC
Zoom	Tuesday, 22nd February 2022	7.30pm	Zoom
Face To Face	Friday, 1st April 2022	9.00am	Wellington RACS Boardroom

Meeting closed 9.15pm