NEW ZEALAND
Medical Laboratory Workers
YOUR UNION

2017 ANNUAL GENERAL MEETING

Secretariat Report

Welcome to the 2017 Annual General Meeting of NZMLWU.

MEMBERSHIP

The membership of NZMLWU remains stable at just over 1000 members. Our membership distribution continues to change with the majority of laboratory workers now private sector employees. In 2016, Taranaki DHB started a process to look at an alternative supplier and, whilst not over yet, this will result in these members leaving DHB employment also.

In 2016 we also engaged with APEX regarding possible amalgamation. We have always had a close association with APEX; however, the opportunity to improve efficiencies of scale and, probably more importantly, cement our position within the specialist allied scientific and technical union in NZ was attractive. Following amalgamation, service delivery to the new medical laboratory workers division of APEX members will remain seem less given both the unions use CNS as their service delivery agent.

NBAG

NBAG continued at a slower pace this year, with no significant issues being brought to the table and one face-to-face meeting having to be cancelled due to lack of (employer) interest. The expected “show down” with Waikato DHB over mask wearing during flu season for unvaccinated workers did not arise, as there was no flu season in 2016. Maybe within the month we will have this issue back on the agenda with 2017 tracking towards a flu season starting in June or early July.

The focus on bullying largely remained with the Medical Group as the DHBs collectively declined a national approach to culture change within their organisations. Some DHBs have started some work on this front; however, the initiative is generally poorly resourced and haphazard in its application. ADHB may be the exception to this rule with their "Speak Up" programme shortly to be launched. We will have to see how each DHB's effort to deliver progresses, and assess what to do next following that. The medical group continues its work, with the added resource of GMsHR on board. This may prove another avenue through which to generate change, although progress is slow. A recent clear case of group bullying in one DHB met resistance to even a preliminary investigation due to the seniority of the bully.

Protection for staff from violence at work progressed to the point of release of a guideline. We now wait to see how well applied it is across the DHBs.

HWNZ ALLIED SCIENTIFIC AND TECHNICAL GOVERNANCE GROUP

In holding any position of this nature we are always mindful of our primary commitment to representing our membership. Any conflict of interest would result in immediate resignation from whatever forum poses conflict. However, in the absence of such, benefit has been gained in our ability to influence on behalf of members, progress members' concerns that require a national platform, and at the very least see what is coming and therefore advance our planning processes.

HWNZ funding was opened to consultation this year with the NZMLWU and APEX joint submission concluding that although the current system isn't perfect, equally it isn't broken; for Allied, Scientific and Technical employees we could see no gain from a contestable sliding scale funding approach, and potential detriment if it risked the current funding streams.

Under current arrangements in the public health sector, post-entry training of Allied, Scientific and Technical Health employees is an accepted part of public health provision and is fundamental core business. On-the-job training is recognised as important and necessary, generally (albeit with some notable exceptions) occurring at sufficient levels to ensure workforces are maintained, and is funded out of existing DHB budgets. Whilst vigilance and lobbying on behalf of staff is sometimes required, we contend that these arrangements and the culture that supports it functions well and is appropriate. This describes the current reality.

We challenged the 'case for change' in the consultation document and in particular the assertion that 'the way in which training is funded is not responsive to future health needs'. We do not believe there is evidence to support that blanket contention. As the service responds to government priorities, changing community needs, and improvements in medical interventions, workforce development and training respond in a natural and timely way.

As an example, laboratory services in the future will require fewer cytologists as the move to HPV testing rolls out, and so there are fewer scientific staff with a cytology speciality being trained. Meanwhile, we are actively retraining cytologists in other areas of laboratory science. We have also recognised the need for more communicators in the laboratory sector as test results are provided directly to patients. Plans to increase workforce capacity in this area are already underway.

In view of that current environment it concerns us that a move to a contestable fund with a sliding scale runs the risk of:

- Adding bureaucracy to an otherwise efficient system.
- Creating a culture of 'robbing-Peter-to-pay-Paul' with the associated negative impact on service co-operation and team culture.
- Absolving DHBs from their duty to support post-entry training, as they do now, because they would be encouraged to see the responsibility for funding training moving from them directly to HWNZ.
- Employer-based funding being replaced with the insecurity of having to bid for alternative and limited funding, resulting from the above.
- Political interference in the size of the pool, creating a mismatch between training needs and available funding.

In our experience the service is already bedevilled by unnecessary layers of bureaucracy and form-filling for various (not necessarily training-related) funding requirements. This already unreasonably absorbs the time of clinicians who could better spend that time with patients deploying their clinical expertise. The proposed changes in the HWNZ-inspired investment approach would add another layer of form-filling and submission development to an already over-stretched service for no demonstrable gain.

The proposal would also risk an increasing division between those with and those without: well-staffed services with the resources to allow someone to create bids could do well out of the approach, but those less well-resourced would suffer, and continue to suffer.

To be clear, NZMLWU nor APEX was not saying Allied, Scientific and Technical Health Practitioners could not do more with more money, especially in the integration and innovation space. Nor that some obvious areas such as in the radiology field don't need more DHB resource and greater commitment to trainee positions. However, risking what we have in the context of bidding for resources in such a competitive environment, with the added concern that this could negatively impact on professionals within our teams, is not attractive.

Whilst on the subject of HWNZ, the AST Governance Group kept tabs on external activity and progressed a number of other internal initiatives:

- DHBSS Workforce Strategy Group (WSG) Radiology Work stream and physiotherapy workforce assessment
- Laboratory Roundtable's Workforce Group
- Psychologists Workforce Group (albeit this group appears to be a law unto itself and not well populated with stakeholder engagement)
- Workforce modelling on social workers, pharmacists, psychologists and physiotherapist workforces (with assistance from and to the regulatory authorities).
- Clinical Cardiac Physiologists survey work.

The group continues to work well but has been plagued by a lack of resource and support within HWNZ itself, and whilst we continue to celebrate and promote the role of AST in health, we struggle with the number of DHBs that continue to see AST as subordinate to something else, often the director of nursing.

HEALTH SECTOR DIRECTIONS FORUM

This group, largely driven by the CTU, set its sights on "High Performance, High Engagement" (HPHE), the latest managerial trend to strike the health sector in 2016. It is not new, and some say just common sense in that it promotes high engagement with staff and unions as a means to lift productivity.

HPHE requires both parties to engage on an equal footing with common identified goals benefitting both parties. Some would argue we already have this in some pockets of the

Health Sector where service managers and delegates work well together, supported by experienced leaders from both the DHB and relevant union. However, it would be fair to say that this is more a rarity than commonplace. Nonetheless the question arises: is HPHE just common sense but limited in application by other factors in our sector?

One factor that would influence the mutual potential of HPHE in Health is the degree of central control and political whim that impacts on us.

- Targets are set according to clinical priorities, and certainly not by us, but rather by politicians;
- Budgets are not set by a "mutual process", and all too often result in a cap or freeze on staff appointments;
- Wage movements are set by a central employer-controlled agency, restricting bargaining to an outcome that costs no more than….
- The list goes on.

It is hard to imagine a time when big financial decisions could be the subject of mutual agreement, which begs the question: "what happens to the relationship at grass roots, or at the board table, when a decision unfavourable to at least one unconsulted party is made and/or imposed?"

We doubt anyone would disagree that collaborative, on-the-ground decision making to improve productivity is great, but at what point do the staff see any tangible benefits from this work; is involvement itself to be enough? In bargaining, proving productivity gains due to staff effort in support of a better pay rise invariably gets the standard "all we have to spend is…" answer. Those that work hard to produce gains, or can produce gains (not all of us can) are treated the same as those that do (or can) not, so in our current system the sharing of the financial benefits of improved productivity is not part of the deal.

And what if the decision, made by consensus of all those at the table, has a negative impact on one union's members? Under HPHE the union affected is bound by that decision, severely curtailing their ability thereafter to act in the best interests of their members. Would that decision have been made anyway? No-one can know the answer to that; however, unions can and do get such decisions overturned or their impact minimized (number of redundancies reduced, for instance) by their ongoing lobbying on behalf of members—activities that could be prevented under HPHE.

And finally there is our culture of bullying; how can HPHE flourish in an environment plagued with bullying?

The main CTU proponent of HPHE is currently touring the country accompanied by a Ministry of Health assistant, talking to DHBs about the process. We are keeping our minds open. However, any decisions must be based on tangible benefits for members balanced against potential risks. We are not in the business of maintaining our existence purely for the sake of it; we are here to represent the interests of our members, to protect and advance conditions of employment, including job satisfaction.

LABORATORY ROUND TABLE

The roundtable continues to meet. The main areas of focus in 2016 were:

- issues of our cytology workforce
- workforce generally adding a medical workforce paper to the process
- ongoing frustration with the health-justice interface for coronial and post-mortem services
- seeking improving data usage including single references being applied

Under workforce, a potential review of the training and qualification framework has arisen as a new work stream. This largely arose from the threatened closure of the technician bridging course, but also from a perceived need to be more adaptive in our training for future needs, including technological change.

Four broad areas are under consideration. All have synergies and must be viewed in the context of cohesion amongst skill sets and workforce resource to deliver to the whole of service delivery.

1. **Technician Training**

   Do we need a nationally consistent minimum standard and skill sets?

   Do we need a more formalized (diploma?) level qualification framework?

   Will the technician training be technology driven (as opposed to scientific), and, if so, what impact on bridging will there be?

2. **Scientist basic training (MLS)**

How long does the MLS need to be and how could the internship be better managed?

What core competencies are required within scientific, technological and communication fields (and potentially others) and equally what should fit in the postgraduate space?

Should the internship follow the medical provisional registration model?

3. **Ongoing flexibility for deployment as needs change.**

   What impact will (1) and (2) above have on Technician Bridging to Scientist qualifications? Will there be a need in the future for bridging if one group is technology driven and the other scientific?

   How to maintain flexibility to redeploy with changing service needs and technological change?

   What of synergies and opportunities to cross-credit and retrain in both core (e.g. cytology to histology) and non-core medical laboratory fields (e.g. biomedical technicians).

   How can we deliver to small provincial laboratory capacity as well as large central laboratory capacity?

4. **Post-graduate scientist training.**

   What fits into this space, and for whom, when, and how would it be delivered?

   ? Navigator/communication:? Quality audit and safety : ? Subspecialisation : ?IT : ?Management

This work will be progressed further in 2017.

NLEG

The future role of NLEG will be solely to progress bargaining issues – although continued commitment from all participants will be required to progress the current work plan. Bigger-picture items in the future are best addressed and will gain more traction in other national forums such as the laboratory roundtable and the HWNZ Allied Scientific and Technical Governance Group.

Future Scope of NLEG: it is recognised that some issues that has been assigned to NLEG impact across the wider laboratory sector. Early conversations about the group's membership have occurred; however, they are yet to bear fruit.

Fatigue/Best Rostering Practices: it has been over a year since rostering guidelines were refreshed. At the time of writing, members and managers had been surveyed to see if any significant improvements had been seen by either party, and what suggestions for further improvements could be made. Results of the survey will inform the future work plan.

Incentive Rewards: employers have been surveyed and this information shared with LLEGs for their discussion and to give ideas of opportunities.

Career Progression: NLEG continues to monitor compliance with the current provision. A new project is being scoped to stocktake variations and to review suitability of the current provision, with a view to adapting a suitable process for scientists and creating a technician merit process.

Continuing Professional Development: the right training that is of value to both parties continues to be the focus of this work stream. Work is underway to formulate the application process for the new CPD fund, based on the principles of fairness, ease of application and transparency.

Systems Integration and Staffing Demand: this work stream is yet to gain traction and is dependent on the completion of other work.

Future-Focussed Training: it is recognised that technology and other changes in health and the way it is delivered will impact of scientific staff and their requirements in the future. It is intended that a stocktake of all education/training opportunities will be shared to inform an approach to training that ensures future readiness. This work is in its early stages with a scoping paper being prepared.

Horizon Scanning: this continues to be an important agenda item for discussion and informing NLEG participants, along with the sharing of upcoming changes and events with LLEGs.

LLEGs wobbled a bit off track during the end of 2016 and early 2017 with many not meeting, especially in groups needing support and using the meeting solely for NLEG agenda items but not seeking the opportunity to engage with their staff. However, 2017 has begun with a

renewed focus from NLEG on providing them with tasks to ensure continued engagement and that they continue to get value from meeting.

LAKES DHB CONTRACTING OUT

In late 2016 we were notified that the RFP for provision of laboratory services for the Lakes Region (Rotorua and Taupo) had been selected, and through the process of deduction it became evident that SCL was not the party. However, the final provider wasn't announced until March 2017. This did in fact turn out to be Pathlab, with change of business set for 1st July 2017.

Pathlab has decided to form a separate company called Pathlabs Lakes. This change will see our members in Lab services Rotorua (LSR) based in Rotorua and our members employed by SCL at Taupo being employed by Pathlab Lakes. Whilst this represents a change of name only for the staff at LSR, it represents a change of employer and processes for those employed at Taupo.
Preliminary work on a Pathlab Lakes collective for both groups is underway to ensure implementation near to commencement of the new business.

SCOPES OF PRACTICE

Changes to scopes of practice has seen the scope of MLPAT now encompass a wide spectrum of phlebotomy staff, specimen services technicians and donor technicians. Whilst this has resulted in an increase in membership across phlebotomists, with nurses previously employed in phlebotomy now being registered as MLPATs and coming under coverage of our collective agreements, we are yet to realise this for donor technicians.

Employers have also struggled with the implementation, and have been noted giving poor advice to members entitled to grand-parenting, not following up with registration resulting in members not being able to work until registration was confirmed, and uncertainty of how provisional registration is applied. After these initial hiccups it should be standard practice.

In recent bargaining of the MECAs, the changes to scopes of practice have been made to the collective agreements and will be tidied up in the others as they are renewed.

TECHNOLOGY

The move to the new Middlemore Hospital Laboratory has seen the implementation of front-end automation, with robotic specimen handling and storage system, along with a track

system. They have also taken the opportunity to introduce a WASP (walk-away specimen processing) solution for preanalytical microbiology including plating, Gram slide preparation and enrichment broth inoculation, to name a few. We will continue to see changes in Laboratories as they move to new builds or renovate implementing new technology.

Having said that, workload pressure continues with all labs looking for savings and efficiencies. We continue to have members report that they start early and finish late without claiming overtime or payment, don't take breaks and feel stressed at work. We advise members that if they continue to put through more work with the same number of staff, the situation will not improve, and they need to ensure safe practices.

TARANAKI MEDLAB

NZMLWU has been instrumental in tackling Taranaki DHBs ill-conceived process to outsource its hospital laboratory service and create a single hospital and community provider. With astonishing disregard for best practice and the Government's guidelines for procurement, Taranaki DHB, by decision of a largely retiring Board just prior to the 2016 local body elections, decided to seek a proposal from a single laboratory supplier for combined hospital and community laboratory services.

And when we say 'single', we mean unlike almost every other example of laboratory restructuring that has been proposed or pursued in the last twenty years, Taranaki chose to ask one supplier – Taranaki Medlab – to develop a proposal. At the time this was announced (November 2016) the impression of foregone conclusion was overpowering

NZMLWU sought from the DHB the information that the Board relied upon to make this decision and, more importantly, reject all other possible options. Such options include in-sourcing a combined lab run by the DHB, putting a combined operation proposal out to tender, and maintaining the current public/private split, not to mention various options for location and capital funding. The union has succeeded in getting the process to one that will allow full consideration of options over time, but the DHB has not been forthcoming with the information requested, and this matter has now been put into the hands of the Ombudsman.

MORTUARY

Late in 2016, endemic problems in the mortuary relating to staff behaviour and bullying came to a head. NZMLWU represents staff who have been caught up in the investigations and the yet-to-be-implemented proposed solutions.

Without breaching the privacy of any of the protagonists, there are some important observations to be made. Firstly we can confidently assert, contrary to recent suggestions in the media, that the standard of work and respect for the deceased has never been compromised at the ADHB mortuary.

The second observation is not unique to the mortuary. Whilst the New Zealand health system benefits from integrating clinicians from other countries – especially the United Kingdom – employees from overseas bring with them their own challenges and cultures. Much of what we do in New Zealand differs from approaches in other systems, even those thought to be largely similar, such as the UK. Whilst good ideas and different perspectives often inform and add value, sometimes we face work practices that are incompatible with the New Zealand context. Where good support and orientation exists, our new colleagues quickly learn the ropes of the new environment; if this does not happen, trouble inevitably follows.

We continue to work with our members and management to improve the culture and safety of the Auckland mortuary.

Not because of the issues discussed above, but coincidentally alongside them, concerns over health and safety in a mortuary were raised in 2016. The workforce group of the Laboratory Roundtable is currently revising a document which seeks to provide up-to-date guidance on matters that need consideration, including psychological wellbeing.

BARGAINING IN 2016 - 2017

Healthscope

Healthscope is the large Australian-based multi-national company that owns Southern Community Laboratories, Northland Pathology and LabTests, together with a number of other enterprises including Gribbles Veterinary. As such, mainly through its ownership of Southern Community Laboratories, Healthscope is the biggest private sector employer of NZMLWU members.

Because of our politically unaligned approach, NZMLWU has been able to take an agnostic approach to the growing incursion of Healthscope into the New Zealand Health scene. We have assessed Healthscope by what our members see and experience, without reverting to

pre-conceived ideas about the HR practices or service delivery capacity of private sector firms.

In light of that, it is fair to say that it is a mixed bag. There have been occasions when the 'Australian attitude' has flowed through negatively into the way SCL has managed its Labs. The somewhat uncompassionate response of local management in Wellington to the struggles its staff had during the Kaikoura earthquake and Wellington floods is one example. On the other hand, there have been occasions when issue resolution has proceeded without the dead weight of years of DHB intransigence sitting on the shoulders of the participants; this has been refreshing and constructive. Trying to design a modern fit-for-purpose shift leave clause at bargaining is one such example, although the development of a perfect clause remains a work in progress!

The parent company's unwillingness to fund HR to step up to the different needs of the New Zealand workplace is an ongoing source of frustration. And, as with so many New Zealand enterprises, the quality of the business' middle-management is patchy. However, the union is pleased that the business has been willing to enter into a formal consultative process designed to tackle those problems that 'just won't go away'.

DHB/NZBS Bargaining

This agreement was ratified in September 2016, and saw salary increases over a term of 3 years, similar to increases achieved across most other Allied Scientific and Technical groups. Bargaining took on the form of interest-based bargaining (IBB), with intensive bargaining occurring over 4 days of meetings.

Other improvements to the agreement included technical changes to pick up the recent scopes of practice changes, a dedicated CPD fund, and recognition of all instances when an employee works in a higher level role for a minimum period of 8 hours per shift.

Other issues that were assigned to the National Laboratory Engagement Group included agreeing the process for applying the new CPD fund, a review of the current career progression criteria, and fit-for-future training to ensure that employees are skilled to meet the future needs of the workforce, both scientists and technicians.

SUMMARY

It is with some sadness that I record this as my last report to the NZMLWU as a specific entity. I started working with the union in 1987, when Dennis Dixon-McIvor approached our firm seeking industrial assistance to form a union under the Labour Relations Act. Dennis and his colleagues were keen to ensure there was a strong representative organisation that would focus on laboratory workers, and not get side-tracked.

Under that Act, a Union had to have 1000 members, and this was the first hurdle we had to overcome. We did so without issue. It is perhaps noteworthy that many allied scientific and technical groups at that time had fewer than this 1000 membership minimum, but even those others that could reach this threshold failed to do so, eventually being amalgamated or absorbed into other unions, or not unionised at all. Unfortunately, some of these other unions had either an alternative primary focus, or too many foci to genuinely give allied scientific and technical practitioners the support each professional group needed.

That laboratory workers not only had the foresight but also the fortitude to set up an organisation to focus on their specific needs, and were prepared to take on the responsibility of doing so, set you apart from all else at a very early stage.

It hasn't always been easy. We have had some almighty struggles, especially during the antiunion era of the Employment Contracts Act (ECA), including large and very expensive legal battles that almost drove us under. But we survived. We continued to effectively represent medical laboratory workers and to a significant degree have protected all through our activities—whether members of our union or not.

The impact of herd immunity afforded to others by our work is often a source of frustration to members, but on reflection this is also something of which we should be proud — whether "they" recognise it or not. We will not leave our rich history to be forgotten. Over the next 12 months or so, a record of what we have done, what we have achieved, our triumphs and defeats, will be undertaken: both a record for prosperity but also a story worthy of being told.

Today we stand on the eve of amalgamation with APEX, which will henceforth genuinely be able to own the role of being the allied scientific and technical practitioners' union in NZ. APEX emerged during the ECA, looking after some smaller (<1000 member) groups of allied scientific and technical workers through an umbrella system that allowed each professional group autonomy as a division whilst being part of the same union. That way, control over

their own destiny, terms and conditions was preserved, but the 1000 membership minimum was also met through the one union model.

In a sense, the fortitude of these early APEX groups mirrored that of the NZMLWU (albeit a little later in the creation). Each wanted to take responsibility of their own affairs and not be subservient to the wishes of other unrelated drivers.

Whilst in existence in the 1990s, APEX has significantly grown over the last 5 years. At the time of amalgamation, the MLW division of APEX will still be the biggest single group of practitioners, and the largest division of APEX. We will, however, join nearly 3000 other practitioners with a similar philosophy and drive, in a union with some youthful enthusiasm.

The overwhelming vote by laboratory workers in favour of joining APEX was extremely encouraging. Since then, the enthusiasm being expressed amongst delegates about the amalgamation, and as a result the camaraderie being derived from a larger cohort of delegates, has been inspiring.

How APEX supports delegates is also slightly different, as a result of having so many new delegates and also turnover. In APEX, the view is that everyone should take a turn and that succession planning (an old hand teaching the newbie) operates. Within some areas, APEX delegates also cooperate to attend management meetings (usually in support of a colleague) from other departments. The “freedom” offered by an unrelated (external to the department), but still knowledgeable and skilled, delegate in small departments has its merits.

The role of the delegate is absolutely crucial to our functioning. The grass roots empowerment process we are built on requires communication and support. And our delegates do a fabulous job: the opportunity amalgamation offers to further support and grow this network is welcomed. With the biennial delegates training scheduled for August 2018, these opportunities will be further built upon.

To our national executive members: as always, our thanks. Your collective oversight has been hugely valuable, and whilst our structure will adapt a little as we move forward, all those involved and to be involved at national and local levels within the union will continue to actively contribute to the representation of members. We simply can’t do this without you, so taking a moment to refresh and rethink how best to help you give us so much in your already busy lives, whilst supporting you in these roles, is essential.

If I might, however: a special thanks to Stewart Smith, our National President. I don't know how many times this year I have called, often in the evening, just to say "what the….?" as something new in the laboratory sector has been sprung on us. Such calls have included reacting to the National Screening Unit "rejigging their forecasts" with a direct impact on the job security and the timing of such for a significant number of cytology staff in NZ, to discussing new technologies and what impact they will have, to simply having a good old grumble about the behaviour of Taranaki DHB. Who would have thought after all these years of contracting out that NZ had got it all wrong, and Taranaki was the only DHB who knew the correct (and to date entirely untested) way forward? Stewart's humour, knowledge, common sense and constant availability has been invaluable for many years now. We look forward to his ongoing contribution under APEX.

Also to Bryan Raill, who likewise provides considerable insight, advice and guidance on matters laboratory. I have mentioned before his attention to the financial details, and his ability to find things out, and these skills have not abated. We look forward to this continuing under the new structure.

2017 heralds a new era for the union in the midst of ongoing change for those working in this industry. As we see technology further influence the delivery of laboratory services, we must adapt at an organisational as well as an individual member level to stay ahead of the game. We cannot hope to do the best we can for our members if we are not adaptive and forward thinking, let alone provide the leadership needed to traverse this ever-changing landscape within which we work and deliver services.

Whilst a little sad, I am also very excited at what the future holds for us all, and look forward to continuing this journey with you.

Dr Deborah Powell
National Secretary