2016 ANNUAL GENERAL MEETING

SECRETARIAT REPORT

GLOSSARY

MRT – Medical Radiation Technologist

STAMs – Supervisors, Technicians, Administrators and Managers

ACC – Accident Compensation Corporation

MECA – Multi Employer Collective Agreement

2IC – Second in Command

NBAG – National Bipartite Action Group

CA – Collective Agreement

HWNZ – Health Workforce New Zealand

AST – Allied Scientific & Technical

CTU – Council of Trade Unions

HSRA – Health Sector Relationship Agreement

AOCS – Annualised Ongoing Cost of Settlement

CPD – Continual Professional Development

RT – Radiation Therapist

PG – Personal Grievance

MRTAC – MRT Action Committee

MRTB – Medical Radiation Technologist Board

MRI – MRT – Magnetic Resonance Imaging - MRT

CE – Chief Executive

DHBSS – DHB Shared Services

SECA – Single Employer Collective Agreement

PGG – Physiology Governance Group

RONZ – Rest of New Zealand

AT – Anaesthetic Technician

CASP –Career and Salary Progression

OT – Occupational Therapist

TOIL – Time off in lieu

CME – Continuing Medical Education

IEA – Individual Employment Agreement

2016 ANNUAL GENERAL MEETING

SECRETARIAT REPORT

Welcome to the 2016 Annual General Meeting of APEX.

MEMBERSHIP

APEX membership has continued to grow in spite of our policy of not actively seeking membership, rather responding to word of mouth referrals. This largely comes through two networks:

1. Amongst professional groups themselves talking to colleagues in other workplaces; and
2. Between closely aligned groups who pass on information in the single worksite.

This networking is increasingly resulting in interest from outside of our traditional "core" health areas with contact from ACC employed physiotherapists and more recently educational psychologists.

The trend for growth to come from public sector sources over private continues. Despite seeking more private sector members over the last year, this section of our membership remains relatively static. They do not seek membership where there is no issue affecting them, which is largely the case. No doubt a shake-up in funding could impact directly on this group of employees, as witnessed by the transfer of Fulford Radiology back to 100% Taranaki DHB ownership this year. In this instance however the clerical staff, MRTs and sonographers were already APEX members due to their originally having been contracted out from the same DHB.

APEX is currently embarking on a more proactive membership campaign driven largely by the following factors:

1. We have reached a size where substantially more members significantly improves the cost effectiveness of both the union's financial position and the members' industrial influence. Building on our current baseline will see increased membership providing income above current service level funding allowing more to be done.

2. Taking a passive growth approach at this stage will see additional costs not matched by the advantages of increased membership, unless that membership growth is substantial. Examples include the growth of the Anaesthetic Technician division, where MECA bargaining is now becoming a viable option for members' consideration. Also in groups such as psychologists where involvement in the wider labour market might be useful to apply further bargaining potential.

3. In some areas, dealing with the residual employers' tactic to play one union off against another is diminished the larger we become. Recognition as being "the" allied scientific and technical union also has advantages as we take the lead, and suffer less from the energy required in fighting off the decisions of others being applied to us.

RELATIONSHIPS

CNS

CNS is the company APEX contracts to provide the secretariat and industrial services offered to members. This high trust relationship is structured to ensure the union will remain financially sustainable whilst providing continuous quality services to its members.

The CNS vision is:

> *"To reflect the worth and value of health professionals and their work, while advocating for, advancing and protecting their interests; and*
>
> *To maintain a high trust relationship with the health professionals we represent collectively, independent of political affiliation, and built on integrity, knowledge, expertise and diligence."*

In keeping with this vision, CNS completed restructuring this year and turned the focus to responding to a member's service delivery survey undertaken late 2015. Improved turnaround times on communication and face to face meetings with members were two areas that survey asked us to focus on.

1. **Turnaround time:** We have restructured our email addresses to funnel inquires more directly to the best person to handle them. When someone is away we have also established a 2IC for each group who should be able to deal with most things, but in the rare event they can't and an urgent matter arises, can certainly find out how to or hold the fort until the specialist advocate returns. Just some words of caution:
   a. Many of the issues we deal with demand a little thought. Speed of reply in such instances (outside of acknowledgement) is not necessarily the best thing.
   b. Our advocates are not tied to their computers: they are often in hearings, bargaining, meeting with members, employers etc. When bargaining is on for a particular group for instance, energy is quite focused and the day to day issues often have to take a bit of a back seat.
   c. Whilst we do appreciate that to members the issue at the time is "THE" issue for them personally, it is often not that urgent in the bigger scheme of things. Being handed a suspension letter – yes that will get immediate attention, but legal action that does inherently drag on for ages (and is unfortunately largely outside our control) whilst frustrating, is not something we can speed up.
   d. Advocates will respond to delegates' inquiries and requests for support first. Our system is designed to empower members as much as possible, so working with delegates who know the people and workplace as well as they do to coordinate action, increases their knowledge and, inevitably ability to handle things closer to the source of the issue. This in turn speeds up responsiveness overall to members and hopefully helps members to increasingly know their own rights and, albeit with support from delegates, take steps to enforce them.

2. **Face to Face meetings:** Our focus is to empower the membership and promote resolution of issues as close to home as possible, and we work to try and anticipate problems before they happen so as to advise members of steps that can be taken before problems materialise. The risk in membership meetings without a specific purpose is that focus drifts to the advocate and away from the delegate and local mandate. It is easier to have "someone else" deal with things, but it is also an effective way to disempower individuals as responsibility is shifted.

   A second related issue is that our advocacy support structure is through divisional (professional) lines, so if an advocate is visiting a site with multiple

divisions present, they will only know well, those they work with. Given the distribution of divisional members throughout the country, specifically getting to all members in a single division can be time consuming and expensive.

Having said that, advocates learn a lot each time they do meet members in the workplace. Whilst the travel takes us away from the most efficient workplace (the office) we always come away from meetings feeling invigorated and more knowledgeable.

Balancing all these issues, going forward advocates will take opportunities to meet with members from the divisions they work with when in any specific site for a specific reason. However after discussion with the delegate(s) if a group has "no need to meet", we won't. If a delegate believes a meeting is needed, they are encouraged to let us know and we will arrange one and likewise in my role as National Secretary, meeting groups to get a bigger picture view of issues and concerns will continue as and when time and travel allows.

3. Increasingly advocates are taking up areas of special interest such as the Holidays Act, Health and Safety and parental leave. This will give everyone in the office a reference point where more in depth information is held, but also allows us to work on sustainable solutions where issues affect a wide range of our membership.

4. We have also moved to employ a social media coordinator to ensure most effective use of these media in our communication with members going forward.

As membership has continued to grow we have had new staff join us which likewise has injected new thoughts on how things might be done better as well as giving us the benefit of wider experiences into our decision making processes.

Both adding and losing advocates has meant a redistribution of divisional responsibilities this year. We try and keep the same advocates consistently with the same divisions to strengthen both working relationships but also knowledge of the group's issues and needs. Continuity with some of the issues we have is important as pursuing outcomes that can take a few years to achieve and not uncommonly a couple of negotiations. Our 2IC structure should also go some way to ensure continuity when advocates do change, as inevitably they will.

We have to acknowledge the work of our delegates when a handover to a new advocate occurs. They have taken the opportunity to not only "refresh" the issues but also assist advocates new to health to understand better the work health practitioners do. A number of you have hosted the advocates in your departments, showing them around and getting them better acquainted with the day to day realities of your lives as well as a better understanding of the "what's, why's and how's" of what you do. We greatly appreciate the time taken and hospitality shown on these occasions.

NBAG

We completed our term as Chair on NBAG this year. Whilst this has freed up some time to focus on other initiatives, the pursuit of some issues through NBAG has stalled. This includes protection of health workers from violence at work, and bullying, albeit that NBAG has been watching the work being undertaken by the medical taskforce on bullying, which slowed due to restructuring in the Ministry of Health.

On a positive note, we were finally successful at getting agreement with the sector on the issue of "passing on" which was acknowledged to be causing some confusion within DHBs not being sure what they are supposed to do. The agreed guidelines now give both the unions and DHBs a set of principles to follow when implementing "Passing On". They acknowledge:

1. That DHBs have an interest in ensuring all staff working in the same roles are on the same terms and conditions. Because:
    - **a.** Consistent interpretation and application of employment agreements across an employee group is made more efficient through the application of the same terms and conditions.
    - **b.** It is operationally inefficient and a potential barrier to effective functioning of teams for employees employed in similar roles and in the same workplace, to have different terms and conditions of employment e.g. hours of work.
    - **c.** The advantage offered by collective agreements in providing the same terms and conditions of employment is an example of the benefit collectively organized labour provides to the employer. Whilst recognizing the rights of employees on IEAs to negotiate in good faith with their employer, the ability to base an offer on one already settled with similar workers, is likewise an advantage to the employer.

2. It is however equally legitimate for Unions to want to ensure terms and conditions are not automatically passed on to non-Union members. Union members' resource the negotiation of terms and conditions of employment through their membership fees and by collective activity in support of the negotiation. The passing on of those terms and conditions is perceived to be unfair in that those employees, to whom the negotiated terms and conditions are passed on, contribute no resource to that process (free loading) but still gain the benefits. This in turn tacitly encourages non union membership and inevitably undermines union activity.

It was therefore agreed that 'Passing On' of all/some of a Union negotiated CA settlement to non-Union members is a legitimate concern for Unions, and for DHBs as employers, and that the parties in bargaining should seek a resolution that confers no advantage to those who have not participated in the collective bargaining, whilst responding to the employer's desire for consistency.

It is recommended that 'Passing On' concerns be discussed in bargaining and form a mutually agreed resolution in that process, including the detail of "what" will be passed on, and "when". This may include:

a. The application of a bargaining fee;
b. Time delays in the passing on of monetary improvements;
c. One off terms or conditions that apply solely to those participating in CA bargaining;
d. Recognition of the benefit gained through collective settlements, and the role of unions in this process.

We will keep watch through 2016-2017 as agreements are renegotiated under this policy.

APEX has always had strong union membership. Whilst extremely irritating that non-members get terms and conditions passed on for free, it must be equally recognised that employers pass on in order to undermine the activity of unions. Less members' means less union strength, which the employer often views as an advantage. Members need to be mindful of why employers pass on and actively discuss the negative impact non-members have on the maintenance and improvement of terms and conditions of employment. The idea held by some non-members that they are neutral is absolutely wrong.

As an aside, research shows for the last twenty years in New Zealand the average pay rise each year for workers on collective agreements was 20% higher than the average for all workers. We believe that for some of our groups, recent experience has shown that is a little on the low side, especially where we have had close to 100% membership.

Passing on is not relevant to the situation where there are two union negotiated collective agreements in place for the same group of workers. This scenario is becoming less frequent as APEX increasingly covers all unionised workers in each professional group on each site. However in BOP DHB this year we experienced difficulties for our physiotherapists when that DHB felt it unfair that our (physio) collective agreement conferred better terms and conditions than that of another profession negotiated by another union. More on that situation below.

A second work stream that arose at NBAG was that of staff influenza vaccinations. Initially prompted by Hawke's Bay DHB producing a draconian effectively compulsory vaccination policy or negatively effecting individual's employment through to potential redeployment, the focus on punitive behaviours has more recently shifted to Waikato DHB who have used mask wearing (and disciplinary action in the event of refusal) for non vaccinated workers as a means to improve vaccination rates.

We are bound to defend our members' right not to be vaccinated but also wish to avoid the punitive behaviours demonstrated by Waikato DHB. We were also mindful of the public health benefit vaccinations provide and the possibility more DHBs might take the punitive approach if rates amongst staff do not rise. This was reinforced this year when despite the NBAG guidelines, the Ministry of Health endorsed the tactic of mask wearing.

The educative, supportive and encouraging method has again this year been evidenced to be successful in achieving targeted vaccination rates. The trail completed in 2015 at Northland DHB involving APEX, NZMLWU and NZRDA proved the point. Overall vaccination NDHB rates improved from 54% to 68% in 2015. But those of our 3 targeted groups (MRTs, Laboratory workers and RMOs) were on average 80%. In 2016 progressing the trial saw all three unions achieving the target of 85% vaccination rates across all groups, again higher than NDHBs overall vaccination rate albeit that again NDHB has achieved an improvement overall in rates up to 77% at time of writing.

The flu season is yet to hit us in 2016, we will no doubt report back on "Waikato versus the rest" in next year's report.

In 2016/2017 we will be focusing NBAG efforts to ensuring the issues of bullying and protection for staff from violence at work are progressed.

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 advantage our planning processes.

Progress from the centre is slow, however a number of advances at HWNZ include:

1. The recognition of the role of AST as communicators within health, a key role as it is perceived to be going forward with increasing technological influence and patient controlled care.
2. Workforce modelling being applied to Laboratory Scientists, Psychologists, Pharmacists and Physicists in the first round, with Anaesthetic Technicians and Physiotherapists to follow.
3. Support for Anaesthetic Technicians expansion to scopes of practise.

A review of HWNZ funding is currently underway that may give some focus to what should be funded as priorities and could give us some further levers to improve support for training for at least some of our divisional members. We will report back on this work in next year's report.

HEALTH SECTOR DIRECTIONS FORUM

This group arose from the Health Sector Relationship Agreement signed by CTU unions, the previous Labour government and Ministry of Health. As previously reported we would not have signed this agreement (had we been invited, which we were not) due to it cementing prior agreement by the Unions to support efficient, effective healthcare delivery even where such would be detrimental to the Union's members.

Whilst APEX has no issue with efficient or effective health care delivery, our purpose is to represent and protect our members' interests. It is important we do this well as we are one of the balancing elements in health that ensure all (and not just the financial) consequences of decisions in health are given due weight. To undermine our primary role to represent

members' interests is not an option, however if we were to do so we would also be doing the health service a disservice.

None the less, as APEX (NZMLWU and NZRDA) have grown, we became too large to ignore, hence the establishment of a related group with all the same HSRA participants plus us, even though we are not signatories to the agreement.

The forum meets twice a year and hears from Treasury, as well as the CTU's alternative economic view, which relies on the same data but reaches a different conclusion. The Ministry, HWNZ, funding-distribution issues and government priorities and plans including the Vulnerable Children's Act in 2015-2016, are the kind of topics for discussion in this forum.

Most of what is discussed is already known to us, however it sometimes provides a little more insight into what lies behind the decision-making and in 2015-2016 gave us the chance to push for more money to be made available to employees through increasing the DHBs Annualised Ongoing Cost of Settlement (AOCS) figure from 0.7% to the current (but soon to be reviewed) 1.7%. This has resulted in slightly higher wage settlements in bargaining throughout Health in 2015-2016.

INDIVIDUAL GRIEVANCES

We continue to represent members involved in individual grievances or who are the subject of allegations from their employers. The number of bullying complaints has not abated, nor the tendency of inexperienced HR staff to turn the simplest of a performance issue into an investigation / hearing type situation.

Workplace stress is increasingly demonstrated in sick leave usage concerns, relationship "breakdowns" in the workplace and disempowerment of members generally. When an individual becomes the identified victim arising from systemic problems, it can become difficult to unravel. We continue to urge members not to take on the problems of the sector as if they are your own. Waiting lists in particular have become the focus of some members, feeling the need to somehow "keep up" with a ballooning list. The unmanageable stress this can engender can be enormous; yet a waiting list is not of any practitioners making, nor to be honest likely to be in any one person's ability to resolve.

Increasingly the DHBs focus on patient-centred care is forgetting about the staff who deliver that care. We need to take every opportunity to remind the DHBs that their role is to care for

staff, who in turn will care for patients. There is an uneasy sense of the DHBs trying to claim the patient as "theirs'" and as a consequence, any employee who refuses to fall into line is unprofessional, uncaring or worse. The employee's rights are being sacrificed to those of the patients in this messaging and something we need to be aware of.

We have always had waiting lists: they are one of the (many) mechanisms by which healthcare is rationed. DHBs make conscious decisions not to apply additional resource and leave a wait list as it is: for staff members to take that on in the absence of the necessary resource inevitably ends in tears.

Our advice is to be realistic as to what you can and cannot control. The employers will always accept more work from you, even if at personal cost. However, rewarding you for that work will not in our experience be so forthcoming, nor will general resource to support your work. If you think about it, why would a DHB put more resources into an area that doesn't have a waiting list or even one where the list is being controlled?

Another area of ongoing concern is members' who forget that "private information" means exactly that. It is irrelevant if the person is a mother, child or neighbour; personal health information should remain exactly that. The defence that members were asked by, or had the permission of the individual to look something up is no excuse. Apart from the employment relationship issue that breaches of patient privacy result in, we suggest the professional relationship between practitioner and patient should be more respected: no one is immune from bias or potential miscommunication when advising a family member or friend. Our advice; leave the communication of health information to the person's practitioner. Decline any inquiries for assistance.

BARGAINING IN 2015 - 2016

The collective agreements negotiated by APEX (as at July 2016) is summarised below.

	START END DATES	Status
Dental Therapists	1 May 2014 - 30 April 2015	Under negotiation
Waitaki MRT's	1 October 2013 - 7 October 2015	Under negotiation
Canterbury Pharmacists	1 May 2014 - 30 April 2016	Under negotiation
Fulford (TDHB) admin staff	1 July 2015 - 30 June 2016	Under negotiation
Fulford (TDHB) MRT's	1 July 2015 - 30 June 2016	Under negotiation
Auckland Region Sonographers	1 August 2014 - 31 July 2016	Under negotiation
Sonographers South of Auckland	1 October 2014 - 31 July 2016	Under negotiation
West Coast IT	1 October 2013 - 30 September 2016	IEAs
Southern Pharmacy	1 October 2014 - 14 October 2016	Under negotiation
STAMS Southland	1 October 2014 - 14 October 2016	In term
Waikato Anaesthetic Technicians	1 July 2014 - 31 October 2016	In term
Auckland Audiologists	Out of PSA	Under negotiation
BoP Pharmacy	12 July 2014 -5 December 2016	In term
Clinical Physiology	1 May 2014 to 7 December 2016	In term
Waikato Pharmacy	1 November 2014 - 31 December 2016	In term
Scientific Officers	1 December 2014 - 3 April 2017	In term
Northland Sonographers	1 May 2015 - 30 April 2017	In term
Northland Physiotherapy	8 January 2015 - 31 May 2017	In term
BOP Anaesthetic Technicians	15 February 2015 - 31 July 2017	In term
Canterbury Anaesthetic Technicians	1 May 2015- 30 Sept 2017	In term
Nelson Marllborough Pharmacy	31 October 2017	IEA
Southern Anaesthetic Technicians	31 October 2017	IEA
Southern Audiologists	31 October 2017	IEA
Northland Social Workers	1 August 2015 - 30 November 2017	In term
Northland Anaesthetic Technicians	1 August 2015 - 30 November 2017	In term
Northland Dietitians	21 September 2015 - 14 January 2018	In term
ADHB Perfusionists	1 July 2015 - 16 February 2018	In term
Northland Pharmacy	21 December 2015 - 22 April 2018	In term
Waikato Physiotherapy	28 December 2015 - 28 April 2018	In term
BOP Physiotherapy	29 Feb 2016 -26 July 2018	In term
Hawkes Bay Anaesthetic Technicians	1 August 2015 - 31 July 2018	In term
Medical Physicists	26 November 2015 - 31 August 2018	In term
MRT National Collective	8 February 2016 - 3 February 2019	ratification
Radiation Therapists	7 April 2016 - 7 April 2019	ratification
Waikato Perfusionists	1 April 2015 - 30 September 2017	In term
Psychologists	1 June 2016 - 28 February 2019	ratification
Northland Audiologists	Out of PSA - following ADHB negotiations	Under negotiation
Waikato Audiologists	Out of PSA - following ADHB negotiations	Under negotiation
Waitemata Audiologists	Out of PSA - following ADHB negotiations	Under negotiation
Mercy Hospital Anaesthetic Technicians	1 October 2013 - 30 September 2015	lapsed

As mentioned above the AOCS was improved in 2015-2016 to 1.7% resulting in largely two types of salary increase offers from the DHBs:

1. A 4 month delay in any increase following expiry of a CA then 2% and a further 2% a year later for a 29 month term; or

2. 1%, 2% and a further 2% (with backdating) for terms around 3 years.

Different groups within APEX have taken different views on these options either seeing the longer term under ongoing tight governmental financial oversight as “money in the bank”. Others have chosen the shorter term for a variety of reasons usually related to wanting the opportunity to renegotiate sooner should issues during term not get resolved.

Possibly more noteworthy has been the change to terms and conditions over and above the straight salary increase many of our groups have achieved. In the area of CPD, psychologists have achieved their own allocation similar to that enjoyed by sonographers and physicists. MRTs have also progressed the CPD agenda by securing a dedicated and contractually cemented pool of money to be managed through a Union-management committee similar to that originally devised by the RTs. In other areas we have progressed health and safety provisions including the Monday off as paid time when working greater than 14 hours on call back over the weekend and payment for telephone calls that do not result in a call back. The MRTs pursuit of free eye examinations resulted in the DHBs doing a deal with Specsavers that will be made available to all DHB staff.

The PSA Auckland regional MECA faced penal rate clawbacks in 2015-2016 and limited strike action by their members. Whilst the DHBs eventually withdrew the clawbacks, not before these members lost a year’s worth of salary increase and overall only a 3% salary increase, falling behind the minimum 4% movements generally being applied for similar terms elsewhere. Whilst successful at retaining a T2 penal rate, these employees paid for it. APEX negotiations in 2015 - 2016 have not faced clawbacks, however members would be wise to note the possibility and if this were to occur the importance of not letting the dispute drag on too long.

HEALTH AND SAFETY

The 2014 delegates conference was focused on Health and Safety in anticipation of the new Act. That Act took nearly another two years to be passed, so a refresher for delegates is now in order. None the less it was good to get ahead of this issue and raise awareness.

More work implementing the new legislation through work groups and health and safety delegate election will now occur as well as a refreshing of all members understanding of the importance of this issue in all workplaces.

The "safety against violence towards staff" and bullying work being undertaken at a national level will come down to each workplace taking some action in the due course of time however we need all members to become more aware of potential issues and commit to raising and seeing resolution occur. It can take some persistence as our MRTs in Northland DHB found this year when their solo practice in the department overnight came to light.

Leaving a single worker, alone and isolated with patients, family, their friends and whomever, especially at night and especially when drugs and alcohol might be a factor (many of the MRTs workload comes through ED) is not safe practice. Persistence finally saw a radiology assistant rostered to nights so two workers are now in the department at all times. Not only has this diminished the risk of injury to staff and potentially to patients (one person assisting a patient on and off equipment raises the potential for patient injury as it does staff injury) but also fatigue.

We had to suffer a trial and the DHB are still working on a business case to justify the successful trial….. so as I say, persistence is required.

DELEGATES TRAINING

We have run all-inclusive delegates training sessions every two years, which have grown into quite an undertaking, now running over three days.

The first day previously reserved for new delegates training, has been popular with all delegates keen to have an update as well as network with those new to the role but diluting some of our original intent. In addition, with new delegates coming on board over the 2 year period, we have found waiting until this event to give them training was too long. As a result we have now introduced a specific one-day, new delegates training three times a year at our offices and included day one of conference within the entire three day programme.

Feedback on the conference reinforced delegates desire for more occupational or divisional group time. We are not convinced this is constructive time in the sense of improved union performance however, as no one was particularly clear on what they wished to discuss. None the less a clear desire to have such time was articulated and has been incorporated into the 2016 timetable.

The conference is resource intensive in planning and running; it is also financially draining. We simply could not afford to hold such a conference every year, however given its popularity, quality and benefit to delegates, a decision to continue holding it has been made. We will however have to remain mindful to ensure it is providing value for money.

ENGAGEMENT FORUMS

The prevalence of engagement forums has continued this year, again with some constructive outcomes, and some not so much. Where issues have languished however, returning them to the bargaining table has seen more success as the various excuses the employers give can be rebutted. Both MRTs and psychologists progressed issues this year after the employers failed to engage in a constructive manner away from the table. Individual reports on progress or the lack of it will be made under the divisional reports.

DIVISIONAL REPORTS (in no particular order)

The following reports largely provide a snapshot from the year. It is not the intention of this report to provide details of every event, PG or issue that has arisen, unless it is of relevance to the greater membership. This year we are focusing on bargaining outcomes as they have increasingly tended to diverge at least on some issues.

Medical Radiation Technologists

APEX initiated for renewal of our National DHB MRT MECA on 10 August 2015 and started bargaining on 26 August. Bargaining was finally completed in March 2016. The term of the MECA runs until 3 February 2019 and includes pay increases totally 5%.

Perhaps of more significance (and as referred to elsewhere in this report) some of the better gains lay outside of straight salary increase:

The move to 40 ordinary hours per week (8 hour day)

MRTs were the only professional group that had members still working a 35 or 37.5 hour weeks. During the term of the previous MECA, the DHB MRT engagement Committee

(MRTAC) began work on bringing all MRTs onto a 40 hour ordinary week but unfortunately made insufficient progress resulting in the matter being a key claim in bargaining.

The DHBs initially claimed poverty and that they couldn't afford to increase so many MRTs pay (as they worked to the 40 hour week rather than a lesser number of hours) due to budget constraints. In reply, APEX presented the following:

1. The number of examinations per FTE had increased by 112 per annum, from 2189 per FTE in 2013 to 2301 in 2015: this represented an increase in productivity of 6%. We put it to the DHBs that the MRTs had earned the right to increase their hours to 40.

2. The budgeted FTE had increased, while the actual FTE hadn't correspondingly increased to the budgeted level. This meant that the DHBs were pocketing money that should have been spent on increased staffing levels. We argued that they could use this unused budgeted FTE to pay for the move to 40 hours.

Despite two DHBs holding out, agreement was finally reached, spurred by the decision of the MRT membership as a whole to strike if necessary in support of this important claim. The collective support and therefore strength of this group continues to be a lesson for us all, which was applied here even though the issue affected a minority within the collective.

Including the right to work a 40 hour week means an increase in guaranteed pay of ~14% for those previously on 35 hours and ~7% for those on 37.5, in addition to receiving the 5% pay increase over the term (40 months) of the MECA.

Continuing Professional Development

Another substantial advance for the MRTs was the move towards greater MRT control over the amount, approval and allocation of CPD funds. Again, a poor response from DHBs on this issue during the term of the MECA resulted in limited room for them to manoeuvre when it came to bargaining.

Over the years we had tried with limited success to work with the DHBs to improve access and responsiveness to general MRTs CPD issues. Unfortunately this critical issue for professionals is not held as importantly by our employers. As many APEX members will have experienced, when budgets get tight, CPD money is one of the first to be cut. Management often made arbitrary decisions based on financial constraints, rather than on

the educational merit of the CPD requested and MRTs faced unacceptable delays as management literally sat on their application.

We are pleased to say we believe these deficiencies will now be rectified. The MRTs now have a minimum pool of money per DHB for CPD. A joint APEX MRT and management committee will receive and decide on CPD applications in a timely manner. The chairing of the CPD committee will be rotated between an MRT and management person and the CPD pool managed in a fair, transparent and consistent manner. Full financial records will be maintained and reasons will be given for any declined applications.

Each employee shall also be entitled to a minimum of 2 days per annum on pay (accumulative for two years) to attend relevant continuing education including courses, conferences and/or study. These paid days can be used on a day off.

MRT thanks go to the RT division of APEX who forged this system for CPD: whilst adapted for MRT specific needs, the RT provision was used as a basis for development of the structure and functioning of the CPD committee.

Health and Safety

MRTs often work excessive weekend call that can amount to working more than two full shifts in the weekend. The net effect sees MRTs not having any days off in 12 consecutive days and suffering from fatigue as a result. In order to rectify this, full time MRTs on call who work more than 14 hours over the weekend, will get the Monday (or Tuesday with agreement) off as a paid day to recover and rest.

The issue of part timers was contentious: the employers argued part timers do not suffer the impact of work induced fatigue to the same degree so should not be entitled to the time off. They argued an employee must present to work fit to work: a full timer may be prevented from doing so due to the hours of work, but not part timers. The flip side is that part timers don't spend their non-working days resting in preparation to go to work. Where the balance in this debate lies is still to be determined, but for now at least some of our staff will get the benefits of recovery time off.

We have also included best practice rostering guidelines in the MECA. During term MRTAC will sponsor a project to assist DHBs apply the guidelines to all rosters. The intention is to support the health and safety of employees including adequate time off and recuperative

time, employee's work life balance, efficient rostering in line with evidence based parameters concerning fatigue, productivity and optimum performance.

The best practice guidelines are:

- No more than 4 consecutive night shifts.
- 3 sleeps after nights (if less than 3 night shifts, 2 sleeps off).
- Overnight on call should not be followed by a pm (late or afternoon) shift.
- No more than 7 days rostered in a row (ideally 5)
- Call rosters should be considered as if duty rosters to ensure the impact on the MRT is appropriately considered.
- Two consecutive days off a week.
- No more than 1 weekend rostered on call in every 4 consecutive weekends.
- Forward rotating shift patterns.
- Fewer shift changes as possible.
- One work period per 24 hours – no split shifts.

The MECA has a very long term to it, but we have many things to do during this time to ensure its smooth implementation. Within the next six months we need to ensure the move to a 40 hour week is implemented and the CPD committees are set up and running as they should be. Monitoring the best practice guidelines in MRTAC and taking steps to assist DHBs to comply will be a focus throughout the whole term.

Maintaining MRI as a Separate Scope of Practice:

Last year the MRT Board (MRTB) announced that it would be investigating workforce issues and regulation. An impending shortage of MRI MRTs saw the Board being pressured by employers/radiologists to reduce the standards for MRI registration, with it being suggested that having MRI as a separate scope of practice and requiring a post-graduate qualification was impacting negatively on workforce issues.

APEX was alarmed; the role of the Board should be to maintain standards, not lessen them. Nor should the MRTB be deciding on standards that focus on workforce issues as the driver. All registration Boards are tasked with setting standards to protect the public: nowhere in the Act does it refer to making it easier on employers to employ people of lesser skill or qualification or working in the interest of employers who want to make foreign recruitment and registration easier rather than, in this case, investing in the MRI training of our NZ MRT workforce. Our MRT MRIs and their standards of work are known to be some of the best in

the world: this reaps huge rewards for our sector and its patients and something to be proud of and maintained.

In response MRI members flooded the Board with submissions. The Board subsequently announce a series of consultations which resulted in the decision to retain the MRI separate scope of practice and post-graduate qualification. Well done to all who got involved in this process.

Fulford Radiology (FRSL).

Last year, APEX members at Fulford in the Taranaki went on strike after they were offered a 0% pay offer in bargaining. In the midst of the bargaining Fulford was bought back under 100% ownership of Taranaki DHB having previously been owned 50% by TDHB and 50% by effectively the local radiologists.

The previous "public-private partnership" arrangement had seen Fulford with monopoly control over an essential service required by the DHB to function. Years of cost plus behaviour were finally clamped down on by the DHB but unfortunately the staff (who were entirely innocent of doing anything but working hard) got caught in the cross fire. Fulford claimed the DHB wouldn't pay more, so no pay rise: TDHB said Fulford was the employer so we had to bargain with them.

When all was said and done, privatisation under the guise of 'public-private partnership" had been demonstrated to be an utter failure. We were finally able to settle their CA at the beginning of the year and will be bargaining the CA again in 2016, this time with TDHB as the 100% owner.

Sonographers

Unfortunately, despite our warnings, the workforce shortage has not improved since we last reported to the Union. We have the same number of vacancies and only a minority of DHBs have increased the number of trainee sonographers. The DHBs are still largely understaffed, have long wait lists, unable to meet future service growth projections and are failing to recruit and retain sonographers. A few DHBs are even at risk of losing their entire ultrasound service.

The gap between private and public sector pay rates continues to widen. The differential in wage rates between a senior sonographer in the private sector (Auckland) is approximately

30-35% higher on the hourly rate. When we last bargained in 2013 this pay differential was only 12%.

Sonographers continue to work in the DHBs because of their commitment to the public health system and because they prefer the more challenging work. However we are currently at a tipping point; there is only so much commitment to be had before the realities of being undervalued kick in and that walk down the road becomes a very attractive option. Bargaining for both Auckland and South of Auckland sonographers will occur in 2016.

Despite the shortage of sonographers, in 2016 Wanganui DHB bucked the national trend and decided to make sonographers redundant! We successfully opposed their plans which was noted by the delegate at this DHB as "proving the necessity of having a strong and active union representation".

While some DHBs recognise the coverage of cardiac sonographers under this MECA, others are resisting. The sonographers MECA has always covered cardiac sonographers, however the increase in pay this coverage attracts sees some DHBs resisting. Tairawhiti responded positively to the issue in 2016, however Southern DHB remains resistant and has resulted in a case being filed with the Employment Relations Authority. We hope to have this matter sorted out by the end of 2016.

Radiation Therapists

The past year has also been a big year for Radiation Therapists, with their MECA being bargained and efficiently settled in December 2015. This was largely due to the work done during term of the document where the DHBs and APEX worked together to enable all DHB RTs to transition to the (higher by 3.6%) Auckland rates of pay, importantly without disadvantaging Auckland colleagues in the process.

The hard work was successfully done prior to bargaining commencing, resulting in negotiations being (for once) relatively stress free and completed in a timely manner. What a breath of fresh air! We were able to progress the original Auckland scale by a total of 5% (1+2+2) over the term of the MECA, incorporating transition to those rates for those in the 5 more Southern DHBs.

The MECA expires in Feb 2019, so throughout the term we will focus on MECA compliance and in particular:

- Monitoring transition.
- Provide support for those members who reapply for merit.

Another substantial issue APEX was able to resolve this year was at ADHB who were forcing our members to work a late starting shift (9am). APEX viewed this as a deliberate breach of the MECA and after many months was able to reach an agreement with the DHB going forward that will see no members being forced to work in this manner.

Physicists

Last years' report highlighted the workforce crisis that had developed for medical physicists and been largely ignored by their DHB employers despite several high-level reports identifying the issues.

Strike action by physicists in mid-2015 finally galvanized some attention from their employers (Auckland, Waikato, Mid-Central, Capital Coast, Canterbury and Southern DHBs).

DHBSS first initiated yet another workforce investigation to inform the parties about possible solutions. The report had been intended to be conducted completely independently by an outside agent but was undertaken by a career public servant who it later transpired may simply have been (successfully) auditioning for a job with the newly created DHB workforce strategy group.

Added to the lack of genuine independence was the use of a workforce assessment tool – developed from an MA student thesis – that APEX opposed as completely unsuitable given amongst other things it asked about public profile (i.e. political / industrial risk): hardly a workforce parameter albeit an industrial one.

Use of the tool involved teleconference meetings with the six physics centers to achieve agreed 'scores' for workforce vulnerability measures. It was a disastrous waste of time and further provoked our members as agreement on some scores was not possible, the exercise simply set our members and their senior managers at loggerheads. This report did also not address the 'elephant in the room' which was the 30% to 50% gap between pay for medical physicists in New Zealand compared to Australia, and their relative internal disadvantage

within the radiation oncology workforce (i.e. everyone is paid less than in Aussie, but RTs and Oncologists are not as disadvantaged as physicists.)

APEX produced our own workforce report, and new strike notices were issued that would culminate in a full week stoppage. As this stoppage loomed closer the DHBs made overtures to APEX to convene an urgent meeting of key CEs to find a solution and avert the strike. Notwithstanding the usual brinksmanship and grandstanding that is inevitable with that sort of initiative, the 'urgent meeting' with the CEs was ultimately successful in achieving a breakthrough. The strike notices were withdrawn and a settlement achieved that delivered:

- 7.1% pay increases across a 36 month Agreement until 31 August 2018.
- Separate funding for 'paid professional development leave' (sabbaticals).
- Security of employment for registrars when they qualify.
- Establishment of a Chief Physicists Group.
- Endorsement of the other Key Workforce Recommendations including in respect of independently recommended minimum staffing levels.

The physicists original wage claim amounted to approximately 15% over a 36 month agreement; approximately half of the smallest gap to the Australian rates. Although 7.1% is only around half that again the overall cost of the settlement is considerably in excess of the AOCS (annualised ongoing cost of settlement) guidelines that DHBSS was working to at the time. There is a clear lesson from the physicists' campaign. It is that a well-researched workforce argument, combined with membership determination that includes the preparedness to follow through with strike action, works.

Perfusionists

This division has grown with colleagues in Waikato DHB joining APEX. The negotiation of the first Waikato SECA commenced September 2015 with the agreement being ratified recently. The biggest goal for this group (other than a salary increase) was a minimum recovery period between shifts which was successfully achieved as part of the settlement.

The Auckland Perfusionist SECA was also settled this year for a term through to February 2018. It included the following new or changed terms and conditions:-

- Changes to the salary scale
- Payment/toil for overtime
- On call leave

Retention and recruitment are areas of ongoing concern for this group and whilst trainees either have or will be appointed, problems are expected to continue: another small but essential workforce that demands better attention to planning by the DHBs.

Clinical Physiologists

The Physiology MECA settled in late 2014 for a 25 month term during which the parties agreed to take an Interest Based approach to examining significant workforce issues in a jointly convened Governance Group (PGG).

Four work streams were established;

- Advanced Practice,
- Merit Progression,
- Workforce, and
- Salaries / Relativities.

By late 2015 progress was such that the group was able to recommend a variation to the MECA in respect of salary steps and possibly also merit progression. Work on defining Advanced Practice had also progressed well and continues. The Workforce stream has been hampered by insufficient resource for a very complex area, and lack of buy-in from DHBs to participate in assessing their future workforce requirements.

The impact of the variation was to delete two steps of the qualified scale, and the entirety of the provisional scale.

Through a series of (DHB) mis-communications, the impact of the variation on new entrant physiologists flew below their radar until DHBs were asked to implement the changes. Somewhat astonishingly DHBSS attempted to assert that the deletion of the provisional scale was a mistake and then refused to issue implementation instructions for that part of the variation. Enforcement action was initiated by APEX and the matter went to mediation where the parties agreed to enter into a new variation that introduced a single step provisional scale with a salary that is $926.00 / annum shy of the first qualified rate in the document. When combined with the deletion of two salary steps in the fully qualified scale, the effect is to knock three years off the time it takes to reach the top of the automatic pay scale. This compromise was seen as satisfactory and was overwhelmingly endorsed by members.

Work on the other three PGG work streams continues, albeit in an atmosphere of severely diminished trust.

Anaesthetic Technicians

At time of writing we have the following sites with SECAs:

- Waikato DHB
- Hawkes Bay DHB
- Northland DHB
- BOPDHB
- Canterbury DHB
- Mercy Hospital Dunedin

Of particular note this year was Canterbury DHB which has one of the biggest Anaesthetic Technician Departments in the country, including 72 techs and 43 anaesthetising areas, at the time of bargaining (this has since increased). Despite the job of the Charge Techs and Team Leaders being much larger than other DHBs, they were paid the same under their previous 'one size fits all' MECA. In bargaining we sought to address this through creating three new steps on the pay scale and moving these members to them. The result: a pay increase (backdated for 9 months) of up to 12.2% with another increase of 2% in September this year. Well done to our senior ATs in Canterbury for the intelligence they brought to the table (as well as their work) that assisted in achieving this outcome.

More recently we have seen an increasing membership of AT groups joining APEX and we are pleased to say that we are now the majority union representing ATs. The new members are at the following DHBs:

- Nelson Marlborough DHB
- Lakes DHB
- Southern DHB
- Midcentral DHB

The trigger for them joining is often due to a former APEX member relocating to a non-APEX DHB site and realising that alternative representation might be in their best interests with respect to gaining improved terms and conditions but notably also dealing with day to day issues that are arising and for many not being managed well.

These new groups previous MECA expires in Oct 2017, at which point we have the option of bargaining for an Anaesthetic Technician national MECA. If the remaining DHB sites were

to decide to join us it will improve our chances of successfully concluding such a MECA. This will be discussed amongst the AT delegates shortly and will be a focus over the next year should it be a desired direction of travel.

APEX is also becoming more proactive in supporting representation of professional issues for ATs. We believe that the scope of practice should be widened for ATs who work in theatre, so that it mirrors that of Britain. We will be working together with Health Workforce NZ and the NZ Anaesthetic Technician's Society in trying to achieve this.

Scientific Officers

The SECA for Scientific Officers was ratified 20 November 2015 and will run through to April 2017. The agreement included the formation of a working party to review existing merit progression criteria and develop solutions for issues identified in bargaining including:

- Criteria used,
- Process,
- Documentation required,
- Lack of transparency.

This working party is about to get underway.

Social Workers

Access to leave, cover for leave and acknowledgement of the impact of providing cover for leave are major concerns for this group. Given the specialised nature of individual social work departments, cover for leave is not a straightforward issue. A topic of some discussion during the year and ultimately at bargaining in early 2016, a working party has been formed to address this area.

Backfilling when staff from small professional groups are away is an issue for many APEX members, with scant slack in the system to enable a single person to do the work of two, let alone when that work is of a different nature, as it is with social workers in maternity versus mental health as examples. We will watch the progress of this working party closely to ensure it delivers and is not simply a stalling mechanism by management.

NDHB also implemented consultation around compulsory registration for social workers this year (the last DHB in the country to do so) and as part of bargaining for renewal of the Social Workers SECA, it was agreed that anything required to obtain registration, be it time or costs associated with meeting criteria, would be met by the DHB.

The need for Social Workers to better value their role became apparent throughout the year. Whether it is insisting they be consulted with regarding new buildings or to have a voice on various groups looking at moving more care into the community, Social Workers have to speak out. With integrated care a key focus of the health reforms, we will need to ensure we support a more proactive level of engagement on this front.

Physiotherapists

We have three SECAs for Physiotherapists - Northland DHB, Waikato DHB and Bay of Plenty DHB; all of which have concluded bargaining in the last year. In Northland, settlement was achieved without difficulty as it was in Waikato where a 2% +2% over a 28 month term settlement was settled. The same could not be said for BOP.

Bargaining was difficult and protracted in this DHB as management wanted to change the merit salary step progression to bring it in line with CASP and reduce the number of automatic salary steps in our scale. The DHBs "problem" appeared to be that APEX physiotherapy members progressed more readily than those in other professional fields (e.g. OTs) who were covered by a different agreement and therefore different terms and conditions.

The changes proposed by the DHB would have seen our members no longer progressing within the Merit steps and would have resulted in substantial cost saving (at our members expense) of around $20,000. Our members rejected the DHBs position and prepared to initiate strike action in support of their SECA.

A one day strike was agreed by the members as a starting point but was not ultimately needed as settlement was achieved when the employers withdrew their clawbacks and offered a settlement in line with our Waikato colleagues.

Following on from this dispute, we have agreed with senior BOPDHB management to meet and discuss the approach APEX and this DHB may wish to take going forward.

Psychologists

Psychologists continue to be a growth group within APEX, with increasing membership and room to grow within allied fields. Recent inquiries from within the Ministry of Education and

ACC Psychologists may see additional growth and the potential to improve wider workforce opportunities for this professional group.

The psychologists' energy is boundless as is their willingness to actively participate in the improvement of their employment conditions. This commitment makes for some work at the APEX office managing a variety of views and input to the point of collective consensus, but none the less very worthwhile give the overall achievement able to be made by these members.

Following on from feedback from the CNS survey in December 2015 it was identified that psychologists would benefit from increased site visits in addition to those for pre-bargaining meetings. Better forms of communication with the group were needed, to improve what can be a difficult process to coordinate with psychologists so often being service based and spread across work sites.

The major issue for this group can be summed up by the following: psychologist's feel and are undervalued by their employers. This is perpetuated by the lack of compliance with the MECA by the majority of the employer parties on a number of fronts.

One area not often recognised by the psychologists themselves, is the additional hours they work above their FTE. The perceived requirement to do more but not be paid overtime for it, with a global acceptance that they will just continue to treat more patients, including travelling and completing administration tasks in their own time, adds to the perception of being undervalued.

There has been the offer of various time off in lieu (TOIL) scenarios by a majority of employers, however due to work load, limited or no TOIL is able to be taken. Payment for overtime is a key indicator for employers: it signals both workload and FTE drivers in need of review. Hiding this indicator by not claiming does no one, the practitioner nor the patient, any favours as it results in staff to workload ratios remaining inadequate.

There have also been multiple sustained breaches of the collective with regard to the merit progression process and the preference to still apply another union's process, as well as the delivery of fair and transparent CPD funding and CPD leave with psychologists at the point of self-funding CPD as the DHBs processes become too onerous. This has been frustrated further by CPD being continuously raised as an issue at the last few sets of negotiations, with the employers continued preference to maintain the status quo.

Psychologists always strive to work with DHB's in the most collaborative manner possible. They are acutely aware of maintaining on-going relationships based on good faith and trust with their employers. Going into bargaining was no exception. At the time of writing Psychologists have just completed interest based bargaining, which has proved to be useful for this group and enabled them to express their frustration over lack of compliance with their MECA directly to their employers. At the end of bargaining there was agreement that all work including that above FTE should be paid for, including calls taken while on-call that are patient related but can be dealt with without returning to work. It has also been agreed that the APEX merit progression process is the only process to be applied to psychologists covered by the APEX agreement, and that given the inability for the majority of employers to comply with the current CPD provision, allocated funding will be provided.

Once the MECA is ratified and implemented we look forward to seeing improvement in conditions for this group. Delegates and their advocates alike will need to work on ensuring compliance over the term and act upon breaches in a timely manner.

Dental Therapists

APEX Dental Therapists remain a proactive group when it comes to raising concerns with regard to their employment conditions, their entitlements and their rights as employees. They are acutely aware that the delivery of high quality services is dependent on well trained employees who are supported in their professional development, and are always seeking to further their skills and knowledge within their field.

The main concerns for dental therapists are around health and safety and, staffing numbers. New dental therapy facilities across Auckland are not designed in the same way and each pose different and difficult challenges; from lack of space due to the design of the surgeries to the type of equipment each surgery is fitted with. There has also been an increase in investigations following patient complaints made by parents.

Pharmacists

The pharmacists' focus this year has been employer compliance with their collective agreements, with the majority of CEA's in term till late 2016 to early 2017. There has also been work done to formulate and agree merit progression criteria: the test will be the next 12 months to ensure effectiveness of these new processes.

Employers continue to fail to address the widening gap in salaries between public and private, a factor that will continue to negatively impact on trainees and members' work-life balance.

Pharmacists and pharmacy technicians' scopes of practice continue to be extended, with pharmacy technicians' training in the Pharmacy Accuracy Checking Technicians qualification, as well as the new level 6 pharmacy technician certificate. Pharmacists are also taking up the opportunity to obtain their post-graduate qualification in prescribing. APEX continues to warn members to ensure that they receive improved remuneration prior to taking on these new responsibilities. Remuneration for the added value these roles bring will be an issue for all groups in their upcoming negotiations.

This division continues to grow with Nelson Marlborough DHB pharmacy joining APEX in early 2016. They are currently covered by the terms and conditions of their previous union on individual employment agreements and work will begin late 2016 to set up for bargaining their own site specific CEA.

We will continue to see this division grow with interest being shown by other groups including pharmacy staff from the private sector.

Dietitians

Our small division in Northland ratified their collective in late 2015 for a term of 28 months and 2+2% increase in salary. Over the term of the previous collective a dietitian-specific salary progression process was implemented, has been tweaked, and will now be further tested to ensure it works.

Being service based and therefore responsible to a number of different managers (as opposed to having their own department and manager), this group has continued to struggle to have their terms and conditions applied consistently across their profession. This includes access to leave, leave cover (as there are no locums or relievers), and the fair application and distribution of Continuing Professional Development / Continuing Medical Education Leave (CPD/CME). A Director of Allied Health was appointed in early 2016: we look forward to working with them in addressing some of these issues.

In a recent Health Workforce New Zealand position paper the contribution dietitians can make to fewer hospital admissions and better health outcomes was evidenced in the areas of Diabetes and Cardio Vascular Disease (two areas of concern for the Northland

Population), and that they are an integral part of the primary healthcare workforce as opposed to the current situation of predominantly hospital based care. In the Northland Health and Service Plan there were also recommendations to move to integrated care with a focus on patient/whanau centric community based care. We will no doubt see more groups in the future including Dietitians working in the community.

IT

Despite having significantly improved these West Coast professionals' rates of pay, their numbers have dwindled as the original protagonists have moved on and new employees have not joined. We are balancing the interests of the members through IEA negotiations at this time, maintaining the benefits we have achieved whilst progressing what we can.

Audiologists

In last year's report we stated:

> *"This (group) could prove an interesting test of the new 'MECA busting' amendments to the Employment Relations Act since APEX will be seeking a MECA across at least four DHBs …"*

And we were right. All 4 DHBs opted out of a MECA. We subsequently initiated bargaining for SECAs, leading out in Auckland first. The philosophical approach of the employers, versus our pragmatism was obvious. Complaining that they would have to expend resources on negotiating a MECA was not matched with the resources they are now having to spend negotiating SECAs. Both employer and union parties have to provide resources for bargaining. As a general rule, MECAs are less resource intensive as commonly one person per site attends whereas for SECAs three or more may be required.

ADHB resisted negotiating at all, but have now conceded that it will be required.

Managers

A quiet year for the managers whose SECA is in term, no specific issues have been raised.

SUMMARY

Members continue to grapple with increasing demand, workplace issues and pressures, balanced against professional and personal demands. It is imperative balance in our lives exists; if it doesn't we risk becoming physically and psychologically damaged as an imbalance takes hold. However, this does take work and determination. If we let it all get on top of us, or if we turn a blind eye, who are we really kidding? In 2015 we posed that *"possibly the greatest challenge facing us is workload, up against maintenance of*

professional standards, adequate resources, work life balance and quality of care." That continues to be the case.

And to add to that mix is the Health Sector Plan pushing further towards community based care, whilst care of the ongoing hospital patient load continues undiminished. No transitional resources appear to be available to maintain current demand whilst moving to the new models of care that will (apparently) improve our overall performance as a sector going forward. We remain concerned that additional resources should not come from staff themselves.

We are also concerned at the shift in language amongst the DHBs. Patient-centred care appears to be without regard for the needs of those providing that care. As the integration agenda is progressed we will need to be mindful of negative impacts and consequences on members.

APEX also continues to grow. We are now at a stage where active growth will best improve both our financial position but also our industrial opportunities to advance members interests. APEX is the allied scientific and technical union with the specialist knowledge that comes from having its only focus on these workforces. With recent interest from the OTs in joining, we will shortly represent all the main groups traditionally captured under this title.

To our national executive members; as always - our thanks. Their collective oversight is hugely valuable; activity members see little of, but nonetheless provides an ever present rudder that steers us. Our entire national executive contribute a wealth of talent, knowledge and commitment worthy of thanks from us all.

And again - a special thanks to Peter Gene who continues in term as National President. His humour, knowledge, common sense and constant availability has provided for stable and effective governance over the last 10+ years. Whilst usually quietly working away in the background, members should never underestimate the role he plays in keeping our ship on the right course. My admiration and thanks to Peter for his support, advice and wise counsel.

And to our delegates who never cease to amaze me with their common sense, energy and sometimes against the odds, perseverance. Whilst sometimes we get lost in the day to day grind, they none the less manage to lift themselves to keep on keeping on. With members' interests in their hearts, they are a force to be reckoned with. Of course they are

strengthened by the support their members give; we must never forget that each and every delegate deserves the support of each and every member. But on the evidence to date; no worries there! It is a daily joy to work with such a team.

I believe 2016 will see an increasing emphasis on the role of delegate. Health and safety, change management, integration with community provision, increased collaboration with other social agencies and work on different models of care will see your leadership skills being essential.

I look forward to working with and supporting you all and in anticipation wish to thank you. Not simply from my perspective but on behalf of all members who may not fully appreciate your commitment and motivation, and how that genuinely improves their everyday lives.

Dr Deborah Powell
National Secretary