APEX
New Zealand's Specialist Union
Allied Scientific & Technical

# TO THE POINT

June 2019

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## Divisional Newsletters

# From the President

Well, it's nearly halfway through the year already. It just seems to go faster every year. I hope everyone is coping. A shout out to those of you in the midst of bargaining. Keep going whatever you decide and remember we're all behind you - and more of us are joining the bargaining ranks as the weeks go by. I don't think it's possible to ever have multi division bargaining at the same time, but you never know the way it's going at the moment. I see health isn't alone in recalcitrant employer behaviour which drives such alliances, as NZEI and PPTA have just demonstrated.

### APEX, Our Union

APEX is an organisation that contracts for the provision of its core services. We have high expectations from the relationship; we make heavy use of our excellent, well-informed delegates and our structure has high needs in terms of responsiveness. Personally, I believe responsiveness should be a characteristic of any union. The role of the executive in terms of this is akin to the governance role of a company or a school for that matter. What we don't and can't do is get involved in the day to day management of things - that's not how we work. Recently, with the extra growth of APEX, it has been necessary to explore a different executive structure. This does not mean the executive will be more management orientated but is a consideration of whether functions can be split to focus experience where it's needed in an efficient and cost-effective way.

Since there is already a diverse range of professions to cover, each with similarities but also with their own unique set of quirks, a new structure should retain and build on the positives of the current arrangement while allowing APEX to accommodate growth. The discussions we are having will allow the executive to continue to service the best interests of the membership and ensure APEX continues to be a strong voice in the Allied Health, Scientific and Technical arena. It will retain the responsiveness that APEX is known for and valued by members, especially when you're in trouble. Knowing there is someone in your corner is comforting.

### The Proposed Therapeutic Products Bill

While APEX will continue with business as usual, which includes bargaining, member welfare, regular delegate training sessions and representation on various committees, APEX will continue to be involved in the sector in other ways. For instance, this year APEX became aware of this Bill which could be concerning for many of our divisions.

APEX was present at several meetings where Ministry of Health (MOH) representatives discussed different elements of the Proposed Therapeutic Products Bill. The bill sets out changes to the way activities are regulated in the health sector and could have quite far reaching effects. While some of the changes seem positive, APEX is concerned others may have unintended consequences. APEX submitted on behalf of members and many thanks to Deepana, APEX Associate Advocate, for her great work pulling this together. Visit the APEX website if you'd like more information.

### From the Members

In the news department, the Medical Laboratory Workers and Scientific Officers divisions are currently considering amalgamation. I don't believe there have been significant objections from either group - we will keep you posted on this.

And I've had complaints from members regarding work meetings. Upon attending, they find that what began as a friendly conversation didn't continue to be quite so friendly and they have even felt personally attacked. If you attend a meeting and someone behaves in this way, there is no requirement to stay. Just get up and leave. Of course, it might be appropriate to give us a ring and/or get hold of your delegate. Either way, make sure you record what happened and if necessary, pop it in an email.

Finally, can I encourage all of you to encourage all new employees in your workplace to join APEX. We will stand up for all our rights and we make no apology for that. If not us, then who?

Stewart Smith

APEX President

# APEX STRUCTURE DISCUSSION

The structure of unions is not often a topic that gets the blood surging through our veins. It is nonetheless an important issue to ensure we are governed correctly, that democracy is not just on the papers but effective and ultimately to ensure that we are fit for our purpose that being in the best space to ensure your interests are not just being served but that you are the drivers of how and what we are doing.

APEX is structured along divisional lines with each division holding a degree of autonomy over their activities. This is one of the fundamentals of how we operate, given each division is formed around a professional group of workers who have common interests, work practices, qualifications and training (both initial and ongoing competency related) and impacting authorities such as regulatory bodies. Each also has a distinct labour market.

Our divisions do morph to some extent as can be seen with the sonographers separating out of the MIT division and conversely the scientific officers potentially merging with medical laboratory workers division. Our industrial agreements, whilst largely along divisional/ professional lines, need not necessarily be so. Examples include potential PHO agreements covering a range of different professionals, the MIT MECA covering IT workers where they are functioning as part of the intraradiology PACS team, and Laboratory documents covering admin and courier staff.

Each division has a President and a Secretary (collectively known as the divisional executive) elected from amongst their members. The divisional executive becomes involved where there is a dispute within the division that may be escalated to the National Executive if necessary, and as the senior office holder of the division, sometimes at MECA bargaining.

A Divisional Executive may delegate its authority or any part of it to the National Executive or any other person or persons of its choosing and must also comply with any decisions of the National Executive and decisions made by Divisional Membership Meetings.

The day to day functioning of the division is largely left to delegates in conjunction with their advocates. Delegates are responsible to their Divisional Executive and in addition to their role in the workplace, serve as a liaison between the Divisional Executive and the Members. Are you still with me?

The Divisional President is a member of the APEX National Executive (with the Secretary attending if the President is unable to do so). There are also nationally elected positions for National President, Vice President, Executive Secretary/Treasurer and National Secretary.

As a result, the National Executive currently comprises 25 members, who are responsible for the day to day functioning of the Union between AGMs. The role of the national

executive is as follows:

**a)** to take such action as it deems fit to promote the objects of APEX.

**b)** to ensure appropriate implementation of any decisions made by Annual General and Interim National Membership Meetings;

**c)** to hold other structures, bodies and officers of APEX accountable for their functioning;

**d)** to resolve disputes or problems encountered between APEX members or bodies.

**e)** to ensure that there is sound financial policy and that the financial policy is consistently implemented across APEX;

**f)** to ensure compliance with the rules;

**g)** to perform the other functions conferred on it by the rules and by law.

## Emerging Issues

As APEX has grown, we have been

struggling with ensuring efficient decision making occurs in a timely fashion largely around the day to day functioning of what is now an organisation of significant size and complexity.

CNS is contracted to APEX to deliver its industrial services. CNS employs all the staff from membership and accounts people, media and communications staff through to advocates and their support staff. CNS reports to the National Executive at their meetings and via email as well as the AGM through an annual report. On a fortnightly basis (or more frequently if required) the National President and National Secretary hold a phone call to discuss emerging issues, update on what is happening and what needs to happen.

Ultimately, the staff responsible for the delivery of services to the members are responsible to the National Secretary for performance, and the National Secretary to the National President. The National President is responsible to the Executive and from there to the AGM.

## Efficient Decision Making

Due to the relative autonomy of each division, the call on the National Executive has been limited allowing for one Executive meeting a year to look at the big picture and trends. As we say, the National Executive is sizable with 25 current members. The cost of calling meetings is considerable, and the ability to be efficient restricted by size as well as meeting frequency.

However, we are increasingly utilising the resources of the Union to undertake wider "whole" of membership activities, a trend we expect to continue. What we want to do is importantly directed by the AGM and National Executive; decisions needed to actually get the work done in real time however needs efficient decision making around issues such spending money upgrading our website or the development of a student / new employee focused web-based resources. Our current structure is not supporting a nimble process, leaving too many of the decisions in the hands of very few people, largely the National President, Secretary and Treasurer.

Whilst there is no question these people are doing a fabulous job (or not any we are aware of) it is quite a responsibility for which more immediate support would be valuable and ultimately from a good decision making perspective, appropriate.

## Proposal for Change

There are two key elements we suggest we must retain:

1. The divisional structure where each division represents a professional grouping with the synergies and identity that inherently arises. This is a huge strength for us and one we must support.

## Current Structure

2. The ability to share knowledge, experiences and opportunities between divisions and work as a whole of allied scientific and technical team in progressing our members issues. Our recent success at lobbying to have a senior AST lead in the Ministry of Health alongside the chief medical and nursing officer is a case in point. But equally, all delegates from the one employer can provide support to each other as well as a strong voice when organisational change management proposals arise.

We also need a more responsive decision-making system, which fundamentally must be held accountable to the divisions and to the membership as a whole through the AGM.

We suggest the following for consideration:

The Annual General Meeting will remain the policy making body of the Union where annual reports are tabled etc. The role of the AGM as currently provided for under our rules is as follows:

**a)** to set APEX's vision, mission and core values;

**b)** to determine APEX's strategic plans including its financial strategy;

**c)** to establish systems and bodies of governance and delegation for APEX, to elect members to those bodies, and to hold those members and bodies accountable; and

**d)** to evaluate APEX's performance against its agreed strategies and plans.

We suggest we would be better served if the AGM received an annual financial report as well as from service provider(s) so suggest the role be amended to;

**a)** to set APEX's vision, mission and core values;

**b)** to establish systems and bodies of governance and delegation for APEX, to elect members to those bodies, and to hold those members and bodies accountable; and

**c)** to receive the annual financial report, a report from the National President on the activities of both the NDC and National Executive during the year and annual performance reports from service provider(s).

This brings us to the NDC - short for National Divisional Council.
We propose that we form this new structure which would comprise both divisional presidents and secretaries.
This would meet at the AGM and again roughly six months later to discuss in depth the broader trends and bigger picture issues affecting us or likely to affect us. It gives the opportunity for the different divisions to share knowledge and improve communication and our collective knowledge base.
This group would be central to forming and confirming APEX's strategic plans, evaluating performance against those strategies and plans and of course adapting as necessary. The NDC would be chaired by the National President and all nationally elected National Executive members would be members.

The national executive would as a result be pared back to ten members as follows:

- The current nationally elected positions (National President, Vice President, Executive Secretary/Treasurer and National Secretary) on the national executive would continue as currently structured. These positions are elected from the membership as a whole for a two-year term, with two of the four coming up for election in alternate years to provide continuity.
- Six members of the NDC would be elected to a national executive. These individuals would not operate on divisional representative lines for the purposes of their national executive role, rather provide a spread of views and skill sets that could manage those operational and decision-making issues that arise during the year. Support to the President and Treasurer in particular with respect to allocation of funding and investments, would be provided by this group but the NDC could also refer matters to the executive for consideration. We suggest a three-year term for these positions and that no division could hold more than two positions on the national

executive at any point in time to ensure breadth of participation.

### Summary

In summary, the role of setting APEX's strategic plans and evaluating performance against those strategies and plans, consistent with the core aims, values and mission of APEX as directed at the AGM, would fall to the NDC. The national executive would be responsible for implementation and day to day decision making.

### Going Forward

Our timeframe for thinking about this and making some decisions is as follows:

**May 2019** - Circulate proposal to the membership

**June 2019** - Collate feedback from membership, circulate outcomes.

**24 September 2019** - Delegates Day to further discuss the proposal face to face followed by the AGM where the proposal will be voted on.

**25 September 2019** - National Executive meeting to discuss and progress the decisions of the AGM.

We look forward to your feedback which you can provide by email to secretary@apex.org.nz or talk to your delegates or divisional executive members (see Structure of APEX diagram on page 5).

## Proposed Structure

**AGM**

**Key Points**

- To set APEX's vision, mission and core values;
- To establish systems and bodies of governance and delegation for APEX, to elect members to those bodies and to hold those members accountable; and
- To receive the annual financial report, a report from the National President on the activities of both the NDC and National Executive during the year and annual performance reports from service provider(s).

**National Divisional Council (NDC)**

**Key Points**

- Would comprise both divisional presidents and secretaries.
- Chaired by National President.
- Those nationally elected would be members.
- Central to forming and confirming APEX's strategic plans, evaluating performance against those strategies and plans.

**National Executive**

**Key Points**

- To consist of ten members; National President, National Vice President, National Secretary, National Treasurer and six members elected from the NDC.
- Day to day management and function of the Union.

**AGM 2019 - *Nomination deadline: 24 August 2019***

**Date:** 25 September 2019
**Time:** 3pm
**Place:** Ellerslie Event Centre, Ellerslie Racecourse, 100 Ascot Ave, Remuera, 1050

**NOMINATIONS**

Nominations for Executive Secretary/Treasurer and National Vice President are open.

Any nominations must be:
**a)** in writing.
**b)** signed by the proposer and seconder (both of whom must be Financial Members).
**c)** endorsed with or accompanied by the candidate's signed consent to nomination, and
**d)** received by the National Secretary at least 30 clear days prior to the Annual General Meeting.

Please find the Nomination of Officers form on www.apex.org.nz/about-us.

APEX Feature

# SOCIAL CHANGE AND HEALTH: FROM GOVERNMENT POLICY TO EMPLOYMENT IMPACTS

*This feature piece contains information found in Issue 27 of the Aotearoa New Zealand Social Work Journal 2015 which discussed the future of social work in Aotearoa New Zealand.*

Issues such as the changing nature of political thought concerning how services are structured and managed, the type of agency that is regarded as suitable for providing services, and changing expectations of those receiving governmental assistance, are ongoing preoccupations of government. Strangely maybe, they are also issues that concern us to at least the point of staying on top of what change is in the wind and what current or future strategies and philosophy will impact on those we represent.

Within Health, problems of health inequality, chronic illness and management of lifestyle risk threaten to overwhelm health resources, so new ways of providing the same level of service, but more economically, have been looked into for a few years now without let up in sight. The "connectedness" and impact of Education, Housing, Justice and Social Services with Health are increasingly being looked to for answers.

Over the years we have seen:

- the redistribution of material resources to the less advantaged so as to ensure a more equitable society,
- a steady overhaul of welfare benefits along with new legislation that results in welfare funding and resources being noticeably more or less difficult to obtain.
- a number of new, additional social problems including student loan debt, poverty wages and casual part time no fixed hours employment contracts, rocketing housing costs and banishment of lawbreakers back to their country of origin...

Neoliberal philosophy emphasised individual responsibility and saw individuals as rational, self-directed and self-interested beings "irrespective of context". This in turn saw past Governments "responsibilising" citizens and implimenting strategies such as persuasion, enticement or "nudging" to get people to behave in a more "responsible" manner. It is widely accepted that neoliberalism succeeded in widening inequality.

Nudge theory: is a flexible and modern concept for: understanding of how people think, make decisions, and behave, helping people improve their thinking and decisions, managing change of all sorts, and identifying and modifying existing unhelpful influences on people.

But the "transfer of risk from the state to the individual" might also see a focus on individual patient choice. For example, clients with long-term disabilities may be provided with individual budgets to meet their identified needs enabling clients to take back power and control over their lives. Surely everyone has strengths and preferences and everyone has the right to make their own choices about what types of services they need? The terminology is important here – are we talking about patients or clients? And those budgets – who is going to set them or put another way decide how much is enough? Will this enable true client choice or increase vulnerability?

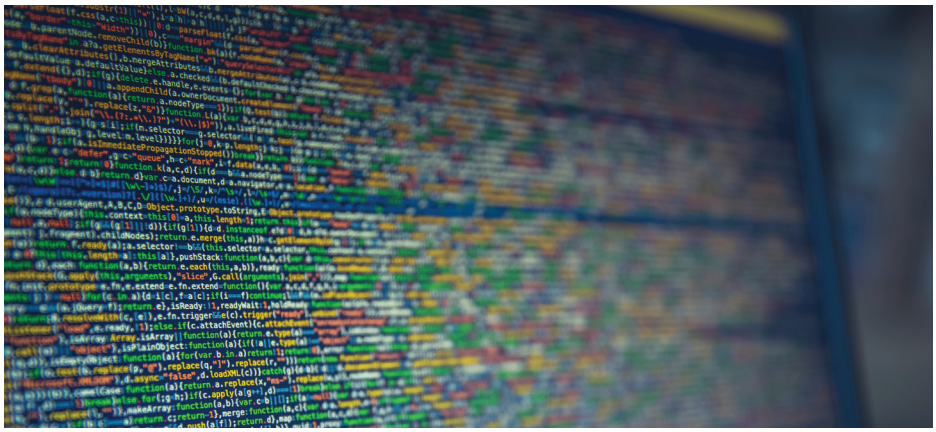
Not currently in vogue, but very much so in the past was privatisation. "Serco" running some prisons and private Laboratory Providers,

cases in point. Claims were made that this would result in the same service being delivered more cost-effectively and that it was appropriate for funders of social services to expect a "reasonable" return on their investment. Others including our current Minister, claim (amongst other things) that because the focus of private enterprise is solely about profit, it is an inappropriate model for the public sector.

Government has also invested in exploring how to harness statistical data about social service clients for planning social services now and in the future. Data is being pooled, and algorithms developed to identify behaviour patterns likely to impose future costs on health and welfare. Big Data, variously known as Predictive Analytics, Predictive Risk Modelling or Risk Stratification has already been applied in criminal justice, identification of at-risk children and health settings. However, use of big data is still controversial because of concerns about the accuracy of the data being generated and what could potentially happen to those affected by incorrect data. Our current debacle over the census should cause a moment of reflection about how reliant we are on such data and what happens if it is incomplete and/or we use algorithms to fill in "gaps".

Predictive analytics: the branch of the advanced analytics used to make predicitions about unknown future events. It uses many techniques from data mining, statistics, modelling, machine learning and artificial intelligence to analyse current data to make predicitions about future.

In 2011 the NZ State Services Advisory Group published a report called "Better Public Services". It suggested that Public Services needed to cease being a collection of siloed, individual services and instead become part of a "system" focused



on outcomes while at the same time achieving value for money. This would mean State Services creating cultures of continuous innovation and improvement where results mattered. Leadership "responsibility" to the entire system was as, or more desired than "accountability" within each department. Three years later it was noted "it (state sector improvement) is about retaining the strengths of individual agency accountability within a system which encompasses collective responsibility" The commitment to State Services reform was affirmed in March 2014 by the "Brackenridge Declaration" signed by Public Service Chief Executives as proof of this systems wide, collective commitment to change.

In August 2015 The NZ Productivity Commission released its final report on "More Effective Social Services". It appeared earlier concerns about bureaucratic, inflexibility, waste and inability to learn from experience still remained and that Govt was particularly displeased with the contracting interface between government agencies and non-government providers, a situation described as a "particular pain point". It diagnosed that systemic failure was worst around people with multiple, complex needs who had "little capacity to access services".

**The Brackenridge Declaration**

**WE are the leadership team for the State Services**

Our purpose is: Collective leadership for a better New Zealand

Towards this we will:

- Be collectively ambitious for New Zealand by focusing on the needs of our customers
- Mobilise our people and resources to ensure those leading complex system wide issues are successful
- See past any barriers and make what needs to happen, happen
- Champion state sector reform in our organisations
- Support each other as a team 'out together, back together', pick up the phone
- Collectively and individually support and implement the work of functional leaders
- Own and champion decisions of the State Sector Reform Leadership Group
- Prioritise our biannual State Services Leadership meetings

Within the report there were a number of references to "stewardship" whereby Government, as the major funder had the overall responsibility for the way in which the social services system performed. The Report identified a short, pithy statement as an example of what the Government was trying to achieve **"Prepare rather than repair"** - social services should target early interventions in the expectation these would offset problems developing at a later date, otherwise known as reduced "future welfare liability" (FWL). FWL could be used as a proxy measure for determining whether some strategy had been successful or in the words of the report, FWL was a measure of "net fiscal benefit to Government when taken on a long-term perspective".

The Health system was described as particularly suitable for integration, not only integration between the various health sectors but also integration with other social services. The Commission proposed to set up DHSBs (District Health and Social Sector Boards) which would buy services such as education and housing using navigators as brokers. Many users would get individual budgets to spend on their chosen provider, "including alcohol and drug services".

**Health and Health Inequalities** – today health systems all over the world continue to grapple with complex, "wicked problems" resulting from pervasive social disadvantage amongst some population groups. While there is acknowledgement of the role socio-economic disadvantage plays in health and wellbeing, the system still seems to prefer an individualistic focus on healthy/ unhealthy behaviours.

Over the past few decades, NZ society has also become markedly more, not less, unequal (UN Task Team 2010, the NZ Health Strategy 2002). The Primary Health Sector has responded with suggestions including muti-sectorial paradigms that address the social determinants of health and reinstatement of a health equity focus by MOH and health equity indicators via PHOs and DHBs. Some commentators have suggested a continuing, explicit focus on health inequities using programmes with a proven success record.

However it is also suggested that the biggest gains in reducing health inequities are likely to occur outside of the treatment arms of the health service, through such means as ensuring people become tobacco free, improving the safety and "walkability" of neighbourhoods to increase physical activity, and addressing poor quality rental housing. To date social housing provision has fallen far short of demand and the poor remain segregated into distinct geographical areas that lack the amenities and resources of their more affluent peers. Our crime statistics reflect these areas.

The use of Health Promotion strategies to address inequality are regarded as absolutely essential. Health education and health literacy strategies are seen as positively impacting upon health behaviour and peer exemplars are widely promoted through social media to this end. Another strategy currently favoured by Government in reducing inequalities is to ensure all health services are available, accessible, acceptable, affordable, appropriate and integrated. Primary Health is believed to be the best location where this can happen. Relocating health workforces into primary

health settings fits with the aim of social service delivery that is "better, sooner (and) more convenient". Key improvements anticipated include better integration of services to enhance service delivery and enhanced access to primary medical care to improve health inequalities.

The transfer of focus onto whole of system means to improve health outcomes, delivery at the primary care level is set to continue. The Simpson Report into health is due to be released this year and it is anticipated will focus on exactly that.

So what for workers in this field? The Primary Health arena at first glance appears to be a crowded, complex, competitive and chaotic place. In addition to the traditional participants, other players in the primary care/social support context include volunteers, Kaiawhina, navigators and NGOs/Iwi providers, community support workers and Whanau Ora personnel are all involved in direct service provision. Within the next few years the Kaiawhina workforce is expected to swell to 20,000 because it is seen as being more flexible and adaptable in terms of conditions of work.

Taking the social work role in a primary health setting as an example. Seen as operating at the top end of scope potential problems emerge concerning the nursing workforce and its developing specialisations across multiple fields of practice. Both social workers and nurses (but not only these two professions) may be case managers, navigators, discharge planners, counsellors and clinicians.

Rather than "professional boundaries", skills, knowledge and competence are likely to be the currency of successful job applicants going forward. Whatever comes next, no doubt adaptability amongst the workforce will be as essential as the instruments we use to protect and advance the rights, terms and conditions for those so employed. And on a final point: whilst good at coming up with "preventative" strategies, on the issue of Chronic Illness our system is still failing to adapt. Over the years medical treatment has dealt with the treatment and elimination of most infectious diseases that once killed thousands of people. The health system has also developed ways of coping with acute medical conditions requiring one-time interventions.

## Chronic illnesses

- Heart disease
- Type 2 diseases
- Lung cancer
- Arthritis
- Depression
- Asthma

However, Health has struggled to cope with chronic illnesses that are now more prevalent than any other type of medical condition and involve ongoing treatment and significant out-of-pocket expenses for those with chronic conditions. Too late for prevention, how will strengthening primary care options manage this wave of demand?

And ultimately, what will all of this mean for the makeup of the workforce over coming years?

## Kaiawhina

This refers in general to the non-regulated health workforce. For example, this includes:

- Dental assistants
- Lab assistants
- Mental health workers

## Simpson Report

Led by Heather Simpson, the date for the final report is now no later than 31 March 2020.

- Health Minister Dr David Clark has announced a wide-ranging review designed to future-proof our health and disability services.
- "New Zealanders are generally well served by our health services, particularly when they are seriously unwell or injured. Overall we are living longer and healthier lives - but we also face major challenges," says David Clark.
- "The Review of the New Zealand Health and Disability Sector will be wide-ranging and firmly focused on a fairer future. It will look at the way we structure, resource and deliver health services – not just for the next few years but for decades to come.
- "We need to face up to the fact that our health system does not deliver equally well for all. We know our Maori and Pacific peoples have worse health outcomes and shorter lives. That is something we simply cannot accept.
- "We also need to get real about the impact of a growing and aging population, and the increase in chronic diseases like cancer and diabetes. Those issues in turn create pressure on services and the health workforce that need to be addressed for the long term sustainability of our public health service.
- "The Review will include a strong focus on primary and community based care. We want to make sure people get the health care they need to stay well. Early intervention and prevention work can also help take pressure off our hospitals and specialist services.

# EMPLOYMENT COURT: "A SONOGRAPHER'S WORK IS AUTONOMOUS"

The Employment Court has ordered Southern DHB to pay Kerren Glasson, a cardiac sonographer at Invercargill Hospital over $120,000 in back pay in a judgment released on 30 April 2019.

## Six-Year Dispute

The judgment ends a six-year dispute between Southern DHB and APEX, who represented Ms Glasson, over whether Ms Glasson's work is covered by the clinical physiology or sonography MECA. The dispute had originally been decided in Ms Glasson's favour in the Employment Relations Authority in 2017, but Southern DHB appealed it to the Employment Court.

## Expert Evidence

The Employment Court relied on expert evidence from Dr James Pemberton, consultant cardiologist, and Professor Gillian Whalley, sonographer and academic, who both submitted that Ms Glasson was working as a sonographer.

Judge Smith, who heard the case in Invercargill decided, "I accept Dr Pemberton and Professor Whalley's assessments of Ms Glasson's work. That can be contrasted with the DHB's witnesses who did not have direct knowledge of her work."

Unfortunately, SDHB's managers lined up to oppose Ms Glasson's application, and employed scare tactics. Chief Allied Health Officer, Lynda McCutcheon even said "if each of the DHB's echocardiographers

was required to register with the Technologists' Board the department would have to shut."

But the Court was not impressed by the DHB's evidence, stating "The DHB was also caught in a contradiction over how it regarded Ms Glasson's work, considering her to be a sonographer when she sought registration but then deciding she was a clinical physiologist."

And the DHB did not call as a witness in Court the direct manager of the diagnostic testing department. So Judge Smith stated in his judgment that the DHB did not call the manager, because "what she might have said would not have helped the DHB's case."

## Sole Charge of Cardiac Ultrasound Service

In support of Ms Glasson's case that she fell under the sonographers' collective agreement were some simple facts.

The Court noted that Ms Glasson...

- Has spent 90% of her working time doing ultrasound.
- Has sole charge of cardiac ultrasound service at Southland Hospital for 20+ years.
- Registered as cardiac sonographer.
- Trained in cardiac ultrasound, with diploma.
- Position titled - "specialist technologist – echocardiography".
- Position description stated requirements to supervise

## Question of Coverage

The fundamental legal question the court had to decide was whether

Ms Glasson, who originally began work as a clinical physiologist, was now covered by the coverage clause of the sonographers' collective agreement.

In determining this question, Judge Smith held, "The vast majority of Ms Glasson's work is in performing cardiac ultrasound. Her work is consistent with her training as a sonographer and the requirements of the Technologists' Board. It is consistent with the scope of practice for a sonographer."

Judge Smith distinguished sonographers from clinical physiologists by careful attention to the regulatory boards scopes of practice, "If it had been necessary to do so, I would have held that the Physiologists' Board contemplates clinical physiologists undertaking cardiac ultrasound under supervision. That conclusion removes Ms Glasson's work from its ambit and from coverage under the clinical physiologists' collective agreement."

## Defining "Charge" and "Specialist"

After finding that Ms Glasson was covered by the sonographers' collective agreement, Judge Smith had to then determine where on the pay scale Ms Glasson should be placed. If Ms Glasson was a charge sonographer, she would be paid at step 8. If Ms Glasson was a specialist sonographer, she would be paid at least step 6.

The DHB stated Ms Glasson was not a "charge" because she reported to the manager of the diagnostic testing department. Judge Smith disagreed,

***Despite the fact that she is not the administrative head, or manager of the department, the evidence points towards Ms Glasson discharging functions falling within the definition of "charge". The job description makes Ms Glasson responsible for the echocardiography service at Southland Hospital and that much was evident as long ago as January 1996. She is clearly in charge of the echocardiography service because she is required to take responsibility for it. The definition also refers to being in charge of staff. Ms Glasson is in charge of a trainee.***

With that decided, the pay step Ms Glasson was entitled to was determined. However, to complete his judgment, Judge Smith played out the DHB's argument that Ms Glasson was not a specialist:

***Had Ms Glasson not fallen within Step 8, I would have held her work was within the first part of the definition of specialist. A plain reading of "specialist" in the context of the agreement refers to someone who performs a special role. That is evident from the words in brackets, referring to reporting on work that clinicians act on independently. Ms Glasson reports directly to clinicians. The DHB did not suggest that those small portions of Ms Glasson's work where she seeks further advice, such as from Dr Pemberton, mean that she would fall outside of this definition. Seeking a second opinion, or feedback, does not suggest a lack of specialty or a need for supervision.***

## A Sonographer's Work

Throughout Judge Smith's judgment is an awareness of the role of the sonographer and the value of their work for the DHB. At the beginning of the judgment the court Judge Smith states:

***A sonographer reports his or her findings and they are linked to the symptoms for which the ultrasound was performed. Even if a study is reviewed later, by a physician, all that can be seen and verified is what the sonographer has saved. In practical terms a significant portion of a sonographer's work is autonomous.***

And near the end of the judgment Judge Smith observes:

***The waiting list for cardiac sonography in Invercargill has been growing, recently extending from about six to eight weeks up to twelve weeks, caused partly by an increase in demand. Ms Glasson is as busy as she has ever been performing ultrasound work and the demand seems unlikely to abate.***

This is the conundrum Ms Glasson faced for many years, and which the Employment Court has resolved. Despite being recognised for her work by other specialists, despite increasing service demand, and despite working in a highly autonomous and specialist way, the DHB failed to recognise and remunerate the Ms Glasson for her skills, experience and qualifications and tried to undervalue Ms Glasson's work by over $120,000. Fortunately, justice has been done, and Ms Glasson will be paid what she is due.

# FLU SEASON IS HERE AGAIN

Influenza is a significant public health issue in New Zealand. Each year it has a huge impact on our community, with 10-20% of New Zealanders infected.

Influenza will typically put you out of action for a week, sometimes longer with symptoms including a sore throat, runny nose and eyes, headaches, aching muscles and joints, fever, cold, sweats, chesty cough and a lack of energy.

Some infected people become so ill that they need hospital care, and some people die. In 2019 we have already had two deaths as a result of this year's flu season, and it has only just started!

## The influenza virus

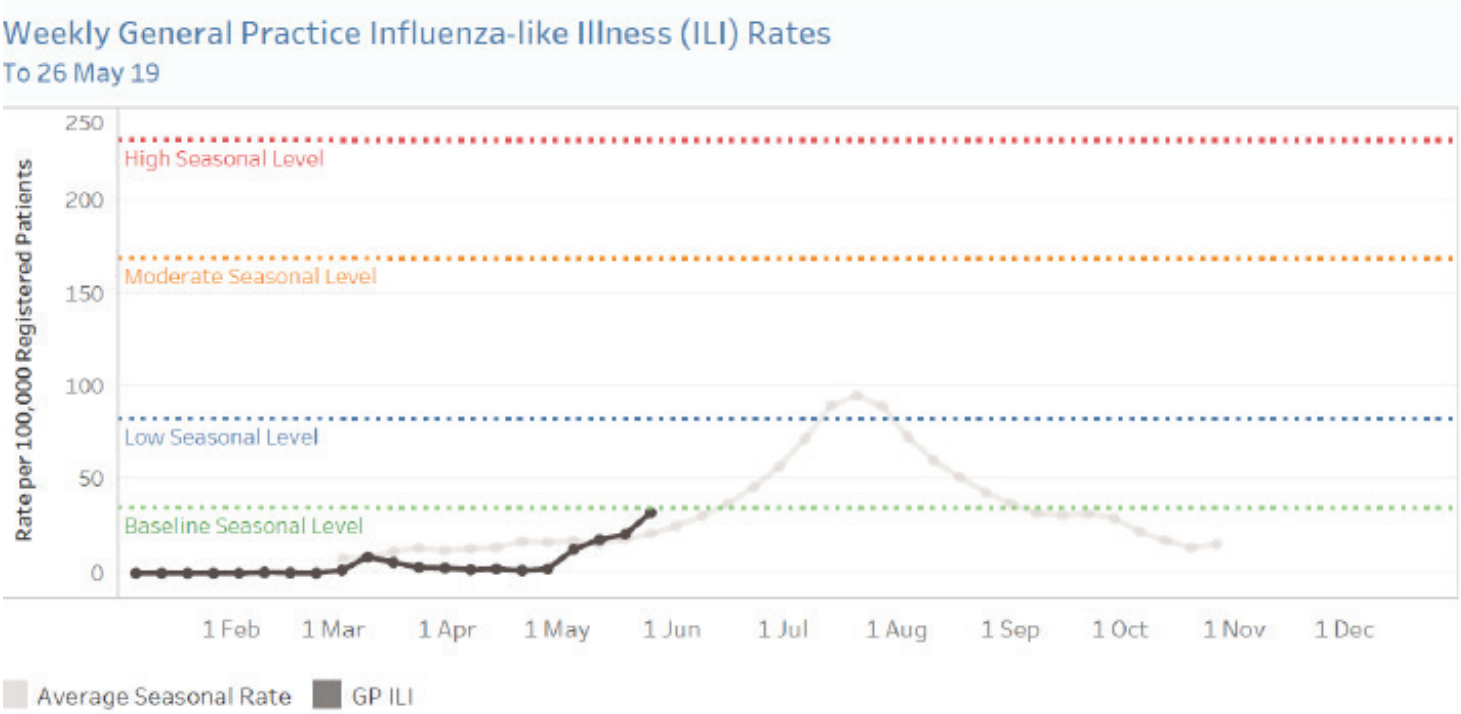
The Influenza virus spreads very quickly from person to person through touch as well as through the air; you can transmit the virus even before you know you are sick. Admittedly, immunisation (the flu jab) is not a perfect remedy but it is the best defence against Influenza that we have.

## Protecting your community

Influenza has a financial impact, particularly in workplaces, and can potentially overwhelm both primary care and hospital services during winter epidemics. Healthcare workers, by virtue of their occupation, are at an increased risk of contracting Influenza and may transmit the infection to susceptible contacts with the potential for serious outcomes. But that should not be our only consideration: we all have families and live in communities. It is been recommended that every fit and healthy person should get the flu jab in order to protect not just themselves but also to protect others in our community. Even if you become infected with the flu and 'get over it', you should get immunised because you could infect others and not everyone may be as healthy as you are!

## We're in for a flu season...

And we mustn't get complacent – we didn't have a flu season in the last two years technically speaking (i.e. rates did not go above "Baseline Seasonal Threshold") however monitoring suggests we are in for




one this year (see above graph from ESR who track ILIs- Influenza like illness).

The lack of a season in previous years might be explained by the higher rates of vaccination we are seeing in our country, but we still haven't got to 80% which is probably where we need to be. And as always we are up against a nasty bug that mutates every year – hence having to get vaccinated every year against the latest dastardly version!

### Vaccination support

So yes, we do support vaccination: speaking of which, you might also want to ensure you are covered for measles and whooping cough – check with your GP if you are uncertain!

We also have a role to protect the rights of those whose employment is being negatively affected due to a choice not to be vaccinated.

APEX was instrumental in getting guidelines on vaccination agreed through NBAG (National Bipartite Action Group). The main finding of the research done at that time was that trying to force vaccination, including through punitive actions, did not work and if anything only made people more 'bloody-minded'.

A recent draft policy out of Nelson Marlborough DHB referring to suspension and possible dismissal if staff did not respond positively to a "re-education programme" (my words not the DHBs) was not only against the NBAG guidelines, but simply unacceptable due to its punitive nature. We have responded accordingly.

### To sum up

Long story short, when it comes to being vaccinated:

- If you have been – thanks!
- If you haven't been – please do!
- If you can't be – thanks to those that can!

# THE IMPORTANCE OF EMPLOYMENT PROTECTION PROVISIONS, REDUNDANCY PROVISIONS AND HOW UNIONS CAN HELP

## Employment Protection Provisions

An employment protection provision ("EPP") outlines a process that the employer agrees to take when restructuring. It allows employees to refer to the EPP and see what to expect in terms of consultation, the opportunity to negotiate and whether there is a possibility of a transfer. Section 69OJ of the Employment Relations Act 2000 ("the Act") sets out that having an EPP is mandatory. In addition, the duty of good faith contained in section 4(1A)(c) is now extended to restructuring. The duty requires the employer to provide the affected employees access to information and an opportunity to comment before the decision is made.

Having a robust EPP clause in the contract ensures that employers must adhere to a fair process during restructuring and redundancy.

A fair and reasonable decision-making process must contain genuine consultation, your employer can't just consult with you as a formality after they've made the final decision. The duty of good faith contained in section 4(1A)(c) requires your employer to be responsive and communicative in these situations.

## Redundancy clauses

All of our agreements set out what will occur in a restructuring process. It allows the employee to consider the options available to them when a restructuring occurs. For example; being reconfirmed in their position, being redeployed, going on leave without pay or enhanced early retirement.

## Manaia PHOs and Te Tai Tokerau

Manaia PHO and Te Tai Tokerau PHO are located up north. Recently they have been restructured to become a new entity – Mahitahi Hauora – beginning on the 1st of July. This situation has demonstrated the need and vital importance of having EPP and redundancy provisions contained in your agreement. Not only did these employees have little to no redundancy provisions but most agreements did not actually contain an EPP – which is a legal requirement. Employees are unable to refer to an EPP in their agreement: not knowing how the process will unfold has become nerve-wracking and scary and every step of the process is clouded with uncertainty.

## How can unions help?

Before the process occurs:

- Advice on applying for positions in the new entity.
- How to best promote yourself to the new entity.

During the process:

- First negotiation of leave provisions to be transferred over to the new entity.
- Engaging with the current and new employer on your behalf.

After the process:

- Negotiation of a collective agreement with favourable terms and conditions including EPP and redundancy provision so that affected employees do not find themselves in this position again.

# REST AND MEAL BREAKS: NEW RIGHTS FROM 6TH MAY

The law changed on 6 May 2019 and this may affect your rights to meal and rest breaks.

**The new provisions specify when rest and meal breaks are to be taken. If you work an 8-hour shift, the law specifies that so far as is reasonable and practicable:**

"(a) a rest break halfway between the start of work and the meal break; and

(b) the meal break in the middle of the work period; and

(c) a rest break halfway between the meal break and the finish of the work period."

Because some of the work we do is essential where continuity of work is critical to public safety, and we may not be able to be relieved from work, sometimes it's impossible for us to get our rest and meal breaks as normal.

In those cases, the new law states that we should have agreed with our employer, "compensatory measures" such as financial compensation, time off work at an alternative time, or both time off at an alternative time and financial compensation.

If you're concerned about whether you're correctly getting your breaks, and at the right time, and whether compensatory measures have been agreed – get in touch with your delegate.

# A LETTER TO MY BOSS...

I have enjoyed working here these past several years.

You have paid me very well and given me benefits beyond belief.

I have 3-4 months off per year and a pension plan that will pay my salary till the day I die.

And then the plan will pay my estate a one year salary death bonus.

Further, it then continues to pay my spouse my salary, with increases until he or she dies, along with a health plan that most people can only dream of having.

Despite this, I intend taking the next 12-18 months to find a new position.

During this time I will show up for work when it is convenient for me.

In addition, I fully expect to draw my full salary and all the other perks associated with my current job.

Oh yes, if my search for this new job proves fruitless, I will be coming back with no loss in pay or status.

Before you say anything, remember that you have no choice in this matter.

I can, and I will do this.

***Sincerely,***

***Every member of Parliament running for re-election***

APEX
PSYCHOLOGISTS
Newsletter
April 2019

# NEW GRADUATES REPORT PIECEMEAL CLINICAL EDUCATION IN DHBs

**In response to the proposal at MECA bargaining by DHBs for a stepped CPD allowance from $1500 to $3500 depending on years post-graduation, many new graduate psychologists wrote to us – providing a stark picture of how little clinical education is being provided internally within DHBs.**

As one psychologist reported to us, "In-house DHB CPD has been pretty piecemeal and variable."

At MECA bargaining in March the DHBs' representatives had argued for early career psychologists to have more of their CPD needs met internally. One DHB representative said, "For the really early career psychologists in a general sense they require consolidation of skills they've learnt at university or internship. Often training requirements are either free or very local."

DHB representatives also stated at the negotiation table, "Because of the way the training programmes operate there is a gap in the base expectation of skills of new grads. Different type of training is required in first years of practice – which is more about consolidation of skills. Skills that should be available locally as they are basic sorts of skills."

But the information from psychologists in their first three years of post-graduate practice is that very little formal clinical education is being provided internally, including on core parts of a psychologists practice, such as advanced therapy and assessment skills. The in-house training that is provided is often at a basic level, that does not extend the knowledge and skills graduate psychologists enter employment with.

This feedback came from graduate psychologists across the country, from both North and South Islands and from metropolitan and rural DHBs.

As one new graduate psychologist noted to us of what sort of curriculum a post-graduate training programme would entail, "I needed more therapy training and also more differential diagnosis training specific to the target population at that point, not refreshers from an advanced course I had just finished. Advanced CBT, advanced ACT, family therapy training, countertransference, narrative therapy techniques, art therapy techniques, open dialogue, cognitive analytic therapy, a repertoire of ways to do things - this is what I needed and have sought overseas."

DHBs contain scores of senior and consultant psychologists with knowledge of the advanced therapy, assessment and other skills that a post-graduate training curriculum would include. Implementing the curriculum would require co-ordination between DHB psychology leadership to develop the teaching material and service managers to allow release of psychologists to attend training sessions.

# “LITTLE TO NO INHOUSE TRAINING”

## New graduates on DHB Clinical Education

“I am a psychologist and am just beginning my third year of practice. There are no in-house trainings that support the development of a psychologist’s therapy skills or more advanced skills in assessment and formulation.”

“There has been no formal inhouse CPD provided which is directly and specifically relevant to my role as a psychologist.”

“Whilst most Psychologists here readily provide trainings within the DHB, they are usually to non-psychology staff and at a basic level. I myself attend these trainings where possible as a ‘refresher course’ to compliment what I have recently learnt through my study. Topics typically cover basic behavioural strategies for managing anxiety or depression or risk management. However, these trainings would not suffice in order to maintain or improve my competence in providing therapy to people with moderate to severe complex presentations.”

“Regarding in house DHB CPD this has been pretty piecemeal and variable. I have attended several introductory workshops in house on Family therapy, which was more the theory and model with some role plays to get people interested in applying for further training. This was great and informative but did not lead the way to being able to provide this as a service.”

“The in-house training provided is very basic information about topics like self-harm, substance use, sensory modulation, certain psychometrics, developmental histories…all things a new grad clin psych has just spent many years studying at a far greater detail than these trainings provide. We need training that will extend from where we have left off.”

“Over the last two years I have been to some great inhouse trainings including supervision workshops, introduction to Te Reo, a workshop on the Treaty of Waitangi, and Trauma Informed Care. These were all very helpful and I got a lot out of them.”

“I am in a provincial DHB and there was little to no inhouse training. The psychologists as a group tried to organise education sessions but this was limited as often there was insufficient time to prepare presentations due to workload.”

“In my 14-months at DHB there has been two in-house training opportunities of CPD level for psychologists.”

“Interpersonal therapy could probably be taught in-house, but I’m not aware of anyone who could teach ACT or Schema therapy in-house - perhaps there are trainers in other DHBs and we could all attend such a workshop.”

“I would be very reluctant to rely on the DHB for inhouse professional development. This is because the learning modules that are compulsory within the DHB, which I have attended so far, have been at such a low level of quality that I didn’t learn anything from them. For example, on Tuesday I attended an all-day orientation which included a half an hour presentation on how to make a phone call.”

## WHAT’S COMING UP

**DHB MECA BARGAINING:** Next negotiation postponed to 3 May. DHBs requested bargaining be delayed. DHBs told us they needed time to get their funding arrangements in place before coming back to negotiations to offer us salary increases in line with other groups. Negotiations for APEX MECAs covering medical physicists, radiographers, radiation therapists have also been delayed for the same reason.

**MINISTRY OF EDUCATION:** Joint Working Group meeting dates agreed for 10 May, 7 June and 1 July. Terms of reference are signed, and Kirsty Ferguson has been appointed as the external facilitator of the working group for the parties that will look at:

- Identification of appropriate workloads
- Workforce capability and development.
- Improving retention of specialist staff
- Safety and quality of practice

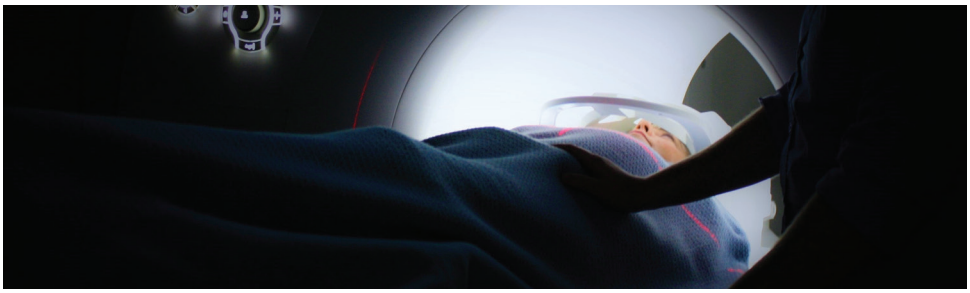
The terms of reference are available on the Psychologists’ Division page of the APEX website.

APEX

# MIT news

Medical Imaging Technologists' News APRIL 2019

# MORE PRIVATE MITs JOINING APEX



APEX has been the leading union for MITs for decades.

Fair pay, fair treatment, and health and safety at your workplaces is our core business.

We now represent thousands of Medical Imaging Technologists, from Kaitaia to Invercargill, with our strong membership base across all twenty DHBs now extending into:

- Auckland Radiology Group
- Bay Radiology (Bay of Plenty)
- Broadway Radiology (Palmerston North)
- Hamilton Radiology
- Marlborough Medical Imaging
- Medex Radiology (Tauranga)
- Mercy Radiology (Auckland)
- Pacific Radiology (Nation-wide)
- Timaru Radiology
- TRG Imaging (North Island)

With growing membership in private practice, we can initiate for collective bargaining to enhance our members' terms and conditions of employment.

Unfortunately, some MIT terms and conditions have slipped in private. This is a direct effect of having non-unionised workforces, with research confirming a minimum 10% pay advantage (let alone other terms and conditions) for unionised workers.

Private used to pay more on base salary and most private MITs worked 9-5, meaning regulating hours of work was not so much of an issue.

But times have changed. Not only are hours of operation expanding, pay rates are not keeping up with these changes, especially where no penal or overtime compensation exists.

Earlier "family type" radiology businesses have also made way for larger commercially driven operations where profit or shareholder returns come ahead of improving wages for staff.

Bay Radiology is a recent success story, where collective bargaining secured our members a 5.1% pay rise last year, a further increase of CPI plus 0.5% beginning from this month, a new theatre on call roster with a $10/hr on call allowance on top of T2 call backs, and 1.5 extra

# NEWS IN BRIEF

**Canterbury** DHB's CT night shift is increasingly under the pump, with CT MITs processing patients and perform as many as 17 scans a night on their own. This reflects the ongoing nation-wide growth in demand for CT. We are investigating this situation and looking at potential solutions, including on-call back up or adding another MIT to the night shift if necessary.

**MidCentral** DHB's CT team have been struggling, with very onerous on call. The DHB has been repeatedly calling the on-call MIT for non-urgent matters and disrupting their sleep while refusing to count these as call backs. We wrote to the Chief Executive about this and personal security for isolated night shift MITs. Night shift MITs have now received personal alarms and the DHB has promised to reduce unnecessary calls. We will continue to monitor the situation for improvement.

**Nelson-Marlborough** DHB's roster overhaul has started effective 1 April. After years of complicated and non-compliant rostering practices, the new roster represents a major victory for MIT health and safety with reduced on call and increased staffing for shifts, despite noteworthy teething issues.

**Flu vaccination** season has now begun across New Zealand. Many employers will provide free vaccinations, others subsidised, while others will leave it up to staff. Your employer cannot require you to have a flu vaccination. Nonetheless, we recommend that you get the flu vaccine if possible.

members! You can read more about how joining APEX improved working life for MITs at Bay Radiology in our featured interview later in this newsletter with APEX Delegate for Bay Radiology, David Kirk.

We are currently in bargaining for our first collective agreement with Pacific Radiology Group. Despite a slow start, at our bargaining session on April 4th and again on April 15th, we reached agreement in principle on several key claims and are in the process of finalising agreement on a new salary scale.

The impetus for a new collective agreement arose mainly out of PRG employees being frustrated with a lack of consistency in pay rates between employees, not receiving fair pay increases, and not being listened to by management. Key issues to resolve in the new collective agreement include security around days of work and place of work, a more transparent pay system, and penal rates.

## Nurses Taking X-rays?

The Nursing Council has authorised Nurses at Hibiscus Radiology (Warkworth) to take X-rays.

We are gravely concerned at the prospect of Nurses, without the years of Radiation Safety training which MITs receive, taking X-rays.

The MRTB advises that they have raised concerns with the Nursing Council but they have no jurisdiction over Nurses and cannot directly intervene to stop them.

Our next step will be engaging with the Nursing Council to ensure that only properly qualified MITs are taking X-rays.

## Greater Recognition for 'IT PACS'

There aren't very many people from an IT-only background capable of stepping up to the RIS/PACS role. But those who do deserve to be recognised by their employers as core members of the Radiology team.

Late last year, APEX was contacted by a newly-appointed PACS member at a regional DHB to go over the contract they had been offered. What started out as a double-checking exercise quickly turned into a drawn-out dispute over whether PACS from an IT background deserve to be hired on comparable pay and terms of employment to their MIT PACS colleagues; same job, same pay.

The issue was this: our member had taken sole control of PACS for the DHB, was working on call, and was collaborating with PACS teams including extensive experience in Radiology IT projects.

Despite this, the DHB offered them a contract with no overtime rates, no CPD, and a base salary around 15% less than if they were an MIT under the APEX MECA.

It took months of negotiation, culminating in mediated bargaining, for us to reach a settlement. But in the end, we managed to secure overtime and penal rates for them and roughly halved the salary gap.

If we succeed in our claim to cover these individuals under the DHBs MECA, we can guarantee them fair terms of employment without the uphill battle of an individual negotiation. This also minimises the financial incentive for DHBs to outsource specialist RIS/PACS work to other IT professionals who putting it simply are a lot cheaper!

# NEWS IN BRIEF CONTINUED...

### Easter Break

Happy Easter everyone! Remember that you are entitled to an alternative holiday if you were required to work on a public holiday, whether on duty or on call. Any hours worked must be paid at a higher rate of either T1.5 or T2 depending upon your employment agreement.

# BARGAINING UPDATE

### DHB MECA Bargaining

This formally began in December 2018 but quickly stalled with the DHBs cancelling our early February bargaining dates and taking months to settle on new dates. We have now agreed to resume bargaining on the 6th and 7th May and hope it will be productive. However, we are also preparing to ballot for strike notices to be issued if the employers frustrate bargaining once again.

### Pacific Radiology Group

Bargaining had been progressing at a snail's pace, but we have now reached agreement in principle on several key claims and hope to reach settlement in the coming weeks.

www.facebook.com/APEXUNION

# ANAESTHETIC TECHNICIANS

APEX

Newsletter | MAY 2019

# SUMMER STRIKE WAVE: WHAT NEXT?

After fourteen strikes, half a dozen mediations, two trips to facilitation at the Employment Relations Authority, and hundreds of cancelled operations, the wave of strike action which has rolled through DHB operating theatres this summer has highlighted both the resolve of APEX members and the bureaucratic barriers preventing resolution of workforce issues.

"A summer strike waved bloomed across the country as our frustration boiled over"

Most collective agreements for ATs are now settled, including agreements at Hawke's Bay, Northland, Midcentral, Southern, Nelson Marlborough and Canterbury DHBs.

Lakes DHB remains unsolved, where DHB senior management are trying to claw back 12-hour rest breaks members got between shifts.

From October to April, a summer strike wave bloomed across the country as frustration boiled over with DHBs who wouldn't commit to addressing critical workforce issues – retaining experienced technicians in the public sector, ensuring technicians are well-rested between shifts, and ensuring stable investment to grow the size and skills of the workforce.

It has been bitterly frustrating bargaining, where DHB leaders brought a myopic, one-size fits all approach to bargaining, which blocked the flow needed to get a common-sense approach to the issues we raised and desperately need addressing.

## So what next?

We now need focus on establishing working groups to review and determine criteria and process for merit step progression. We need to ensure our members are not made to jump through hoops and that merit steps are achievable. Merit criteria should be prescriptive, relevant to what you actually do, transparent and achievable.

"We are looking forward to the first ever APEX Multi-Employer Collective Agreement (MECA)"

With most APEX and DHB agreements set to expire at the end of October 2020, we are looking forward to bargaining the first APEX Multi-Employer Collective Agreement (MECA) for Anaesthetic Technicians.
An Anaesthetic Technician MECA is a needed step to get the focus and investment that other workforces with MECAs have. We need conditions of employment that are tech-centered in order to grow and retain the workforce.

During facilitation of the collective bargaining with Northland DHB, the Employment Relations Authority recognised the perilous state of the profession and recommended we agree (as well as changes to the merit process); "a recruitment/retention strategy including, but not limited to:

- Consideration of AT trainee roles for Maori trainees
- Bonding of trainees
- Role/Remuneration of trainer/ support
- Retention of AT staff."

These are not Northland only issues. These are national issues for the workforce to tackle and it makes sense for us to get organised on a national level with the backing of the majority of Technicians from around the country to advance our professional interests.

# TIMELINE OF STRIKES

- **3 & 11 October – Northland DHB, two 24-hour strikes -** "NDHB cannot fill its five full-time vacancies out of a total of 19 positions – the service is at best "stuttering along" with one- quarter of positions vacant. Around 50 surgeries in the past two months have been cancelled as a direct result of insufficient Anaesthetic Technicians."
- **5 October – Hawke's Bay DHB, 24-hour strike -** "Part of our problem is getting effective bargaining across the table with the DHB."
- **10 & 18 October - Lakes DHB, two 24-hour strikes -** "We rejected the take it or leave salary scale offer from the DHB. We wanted a 15% upfront increase to address recruitment and retention."
- **25 October – Southern DHB, 24-hour strike –** "Key among the claims is the requirement for Southern DHB to employ one new Anaesthetic Technician trainee each year at Southland Hospital, to ensure adequate staffing levels for the future."
- **7-9 November – Northland DHB, 48-hour strike -** "At the table the DHBs are turning up with the same pre-determined settlement offers that fail to address local issues or reflect previous discussions. Bargaining breaks down when the DHBs refuse to budge, citing the need for Ministry authorisation. If the DHBs maintain this approach, the strikes will continue."
- **17-19 November - Hawke's Bay DHB, 48-hour strike -** "NZ is in the midst of a growing workforce crisis for ATs. Instead of fighting to retain their competitive edge, HBDHB is throwing in the towel. Not only are they offering their ATs proportionally worse gains than any other comparable group in the health sector, but they're abandoning their position as the best DHB employer of ATs in NZ."
- **21 November – Nelson Marlborough DHB, 24-hour strike –** "Our AT members have only been receiving offers to consider once we've given notice of strike action. Sadly, Nelson-Marlborough DHB is no exception."
- **10 &11 January – Southern DHB, 33-hour strike -** "This strike is about protecting the future of this profession. Inadequate staffing levels, insufficient trainees, and poor provisions for recognition and development have resulted a perfect storm: the sustainability of this profession is now seriously at risk in NZ."
- **23 & 25 January – Lakes DHB, two 24-hour strikes -** "Lakes DHB knew how essential it was to our members that they get a decent chance to rest between their shifts. Our members were appalled that the DHB would turn around and throw this already-agreed health and safety provision by the wayside."
- **18-23 February – Lakes DHB, five-day strike -** "The difference between the DHBs pay offer for settlement and our offer is a total additional cost of $25,000. However, interference from Wellington seems to have prevented settlement."
- **26 February to 1 March – Northland DHB, 72-hour strike -** "We were hopeful that the Employment Relations Authority recommendation would bring an end to this protracted dispute. It's disappointing that NDHB has rejected the recommendation of the Authority, which has led to our members voting for a three-day strike."
- **14-16 March – Hawke's Bay DHB, 48-hour strike –** "There is something seriously wrong with the DHB's processes. After several strikes, we finally reach agreement around the table and it's approved by Kevin Snee, CEO. We are repeatedly told we'll have the new offer within days, but after a month it hasn't materialised. This is simply not good enough."
- **8-15 April - Lakes DHB, seven-day strike –** "The primary reason for this strike is due to Lakes DHB rescinding its agreement for adequate rest breaks between the start and finish of work."

Lakes DHB ATs give notice for a 48-hour strike on May 27 & 28, and have voted in favour of issuing notice for another three 48 hour strikes in June!

The historic struggle for Lakes DHB ATs' 12-hour break continues! Stay tuned for updates.

## REST AND MEAL BREAKS: NEW RIGHTS FROM 6 MAY

The law changed on 6 May 2019 and this may affect your rights to meal and rest breaks.

The new provisions specify when rest and meal breaks are to be taken. If you work an 8-hour shift, the law specifies that so far as is reasonable and practicable:

"(a) a rest break halfway between the start of work and the meal break; and

(b) the meal break in the middle of the work period; and

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Because some of the work we do is essential where continuity of work is critical to public safety, and we may not be able to be relieved from work, sometimes it's impossible for us to get our rest and meal breaks as normal.

In those cases, the new law states that we should have agreed with our employer, "compensatory measures" such as financial compensation, time off work at an alternative time, or both time off at an alternative time and financial compensation.

If you're concerned about whether you're correctly getting your breaks, and at the right time, and whether compensatory measures have been agreed – get in touch with your delegate.


# IMPORTANT YEAR AHEAD FOR MEDLABS

We are now well into what promises to be a very important year for medical laboratory workers. The DHB's MECA expires on 6th September 2019 and we will need to be prepared for a very firm campaign in pursuit of significant improvements toforlaboratory workers in New Zealand. By September it will have been quite a length of time 'between drinks'. Since the last agreement was settled in 2016, there have been significant changes in the Health Sector and employment environments generally.

When we settled previously, Jonathan Coleman was still the Minister of Health, the NZNO DHBs MECA had not even begun it's renewal process, and there was still no pay settlement arising from the TerraNova pay equity case in the Aged Care Sector. Since then, a Labour Government has been elected with a new Minister of Health David Clark (more on the new Minister later), pay equity settlements have been made in the Aged Care sector which are flowing to other care workers, NZNO settled their DHBs MECA with a range of 3% per annum pay increases, the minimum wage has moved to $17.70/hr and the 'Living Wage' has been increased to $21.15. These developments expose severe under-payment and under-recognition of employees in the medical laboratory sector that must be addressed.

In this newsletter, you'll see that we continue to make good progress in private sector medical laboratory bargaining, that we are well down the road in preparation of a pay equity claim for laboratory technicians and that planning is in hand for the DHBs MECA renewal. What we do here in the office is all very well, but we are going to need you, our members, to be very active this year in the various campaigns.

So, back to the Minister of Health. It is fair to say that insofar as the needs of our APEX members are concerned, he has been a disappointment. David Clark appears undisturbed as he presides over a sector that has seen every DHB slip into deficit on his watch. We also know that aside from not reversing the years of under-

funding during the time of the National Government, that he and his Ministry are so far unprepared to release additional funding to settle Allied, Scientific and Technical collective agreements. This must, and will, change. The DHBs laboratory MECA will feature in that as are other APEX MECAs.

Please feel free to contact us here in the office with your thoughts and issues as we continue the campaign. Your Senior Advocates for Labs are Denise Tairua and David Munro, assisted by Associate Advocates Tamara McConnell and Deepana Ponnampalam. Omar Hamed, Senior Advocate, is also in the mix.

Kia Kaha

MEDICAL LABORATORY WORKERS

DIVISION OF APEX

# NEGOTIATIONS IN PROGRESS

## Taranaki Medlabs

After two days of bargaining, Taranaki Medlab negotiations are almost concluded for their first-ever collective agreement, with the employer and union still to finalise how workers will transition onto the union negotiated salary scales. Taranaki Medlab workers provide medical laboratory services to Taranaki community health providers.

Already agreed benefits of the new collective agreement, which will have a term to 31 January 2020 include five weeks' annual leave for employees with seven or more year's service, merit progression, professional development, redundancy protection and requirements to agree changes to hours of work. The collective agreement will help provide a good structure for working conditions at the lab, where workers pay and conditions had been left behind in the absence of a union contract.

# PAY EQUITY AND TERRANOVA CASE

A pay equity claim is centred on challenging wider societal assumptions and norms. These assumptions and norms have, over time, become engrained into the laboratory workplace.

### Equal Pay Amendment Bill

The new Labour Equal Pay Amendment Bill was introduced on Women's Suffrage Day. Eugenie Sage, the Acting Minister for Women, said that "this bill is one piece of the puzzle" to continue to close the gender pay gap.

Raising a successful claim means to prove that the work is predominately performed by women, that the work is currently or historically undervalued and that this claim is arguable. This "arguable" threshold has been changed from the previous "of merit" threshold that was in the National Employment (Pay Equity and Equal Pay) Bill.

### Historical examples of the underevaluation of women's work

The marriage bar – the practice of restricting married women from employment. Therefore, when a woman gets married her employment is terminated.

Temporary placeholders – during both World Wars women entered the workforce as 'temporary placeholders'. When men returned from war they would take back their old jobs from the women placeholders.

Fixed minimum wages – the Minimum Wage Act 1945 had fixed minimum wages for females at 60% of the male rate during this time.

Private versus professional sphere – women exist in the private sphere whereas men exist in the professional sphere. Any income earned by women was supplementary and to be spent on non-essential items.

Horizontal segregation – this is the fact that men and women generally work in different occupations. This type of occupational segregation can be solved by pay equity.

All of these practices and attitudes still remain in societal norms in one way or another.

### The TerraNova case in brief...

**Why did Kristine Bartlett bring the case?**
Caregiving for the aged dominated by female workers and therefore workers were paid less due to the industry being substantially dominated by females. Considering that the majority of workers are female they are therefore paid less than if the industry wasn't substantially dominated by females.

**What did the Court say?**
The Court of Appeal found that the Equal Pay Act required equal pay for men and women doing different work that is of the same value, ie pay equity.

**What was the settlement?**
The $2 billion settlement covered 55,000 workers and the new wage

structure has been in effect since 1 July 2017.

**Why is it so important?**
It is the first example in New Zealand that acknowledges that in some female dominated industries, wages are lower because the work is done by women. The Government made it clear that the settlement was not to act as a precedent however there have been several successful settlements post Terranova.

### What does this mean for Labs?

Patient specimen collection services, technical processes and ethical considerations are all a part of the phlebotomist's toolkit. Phlebotomists are responsible for direct patient care which often requires a high level of customer service, empathy and patience. These innate skills have long been viewed as simply "part of the job". Traditional job evaluation schemes have continued to discount these skills and the residue of this practice still affects the modern perception of the phlebotomist.

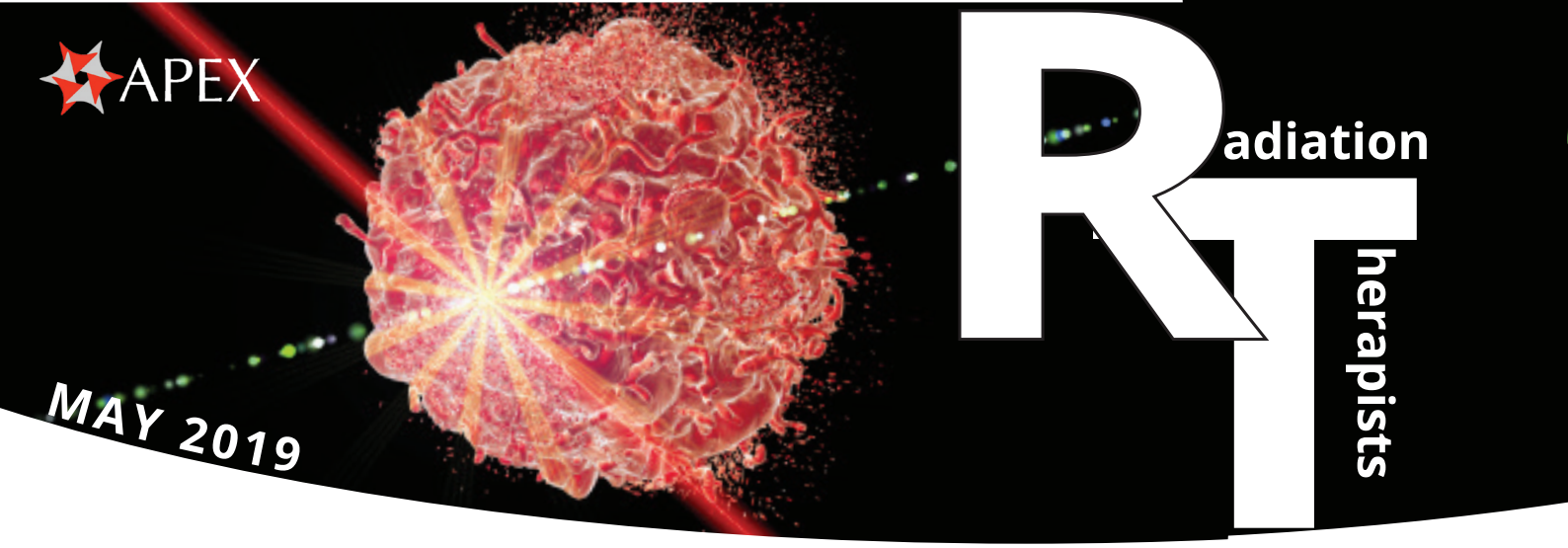
# A MESSAGE FROM BRYAN RAILL, PRESIDENT OF MEDICAL LABORATORY WORKERS DIVISION

With new groups having recently joined APEX I will introduce myself, my name is Bryan Raill, I work in the Biochemistry department at Counties Manukau Health Laboratories (Middlemore Hospital).

Firstly, a warm welcome to Taranaki Medlab members who have joined APEX and for whom we are bargaining their new APEX collective agreement.

Easter is over and we head into the start of winter, where the colder wetter months invariably put pressure on the labs. I have just had my tenth annual flu vaccination which is a combination of several things; my age almost (!), respect for and protecting myself, my colleagues and our patients – as influenza is a significant public health issue in New Zealand. Healthcare workers are twice as likely to acquire influenza than non-healthcare workers, and healthcare workers can transmit influenza without knowing they are infected. I encourage you all to make a habit of it also.

The current Health Minister has said no to contracting out of Taranaki (what lab?), which comes after APEX prevented the plan to simply hand off the Taranaki DHB service to a private provider. We also understand that the Minister has also said no in Hawkes Bay DHB. It is interesting that the round of lab privatisation, which began in 2005, has come to a halt and it is hard to tell whether this is representative of what is to come. While your employer may depend on the winds of political ideas in fashion we advance and protect the interests of our members, whether working in the public or private sphere.




# CANCER CARE IN THE SPOTLIGHT

**Back in February, dozens of national and international experts met in Wellington at the 'Cancer Care at a Crossroads Conference', the largest cancer conference held in New Zealand for over 15 years.**

The over-arching purpose of the conference was to discuss how to achieve high-quality, equitable, sustainable, and nationally-consistent cancer care for all New Zealanders.

A wide range of pressing topics were discussed, ranging from research priorities and global challenges in cancer control to the impact of new technological developments and the role of primary care. The conference also shone a spotlight on some major flaws with the provision of cancer treatment in our public health system.

There are pronounced inequities in outcomes based upon geography, ethnicity, and socioeconomic status. Geographical inequities are primarily driven by unsafe delays in treatment. The graph below is produced from Ministry of Health data and provides a snapshot of DHB performance over the past 12 months.

After a decade of health funding not keeping pace with population growth, inflation, and the rising costs of treatment, the foremost issues for radiation oncology are under-staffing and under-resourcing.

As the Minister of Health, Dr David Clark, put it:

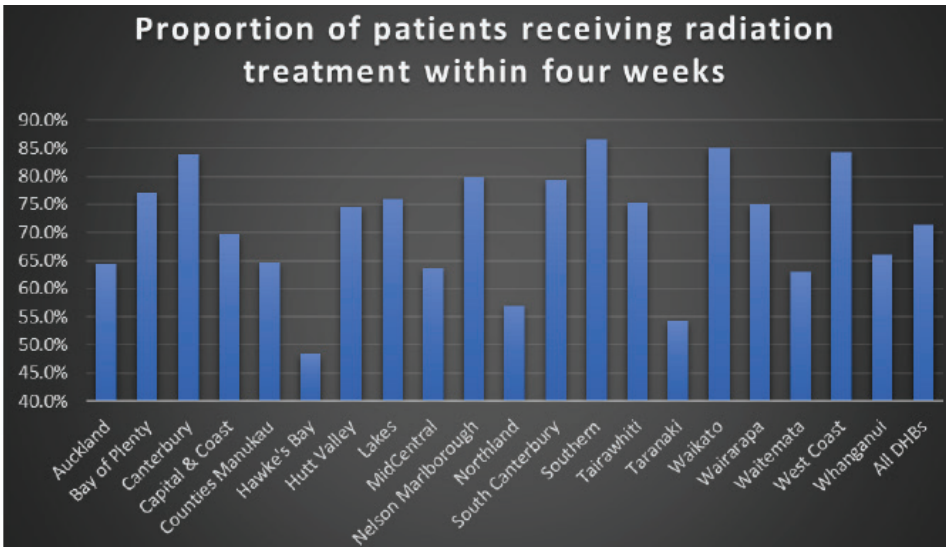
**"There is an acknowledged shortage of these staff...and that's not something that can be addressed overnight...that will take years to fix."**

The DHBs will have to live up to the Minister's words at bargaining if they are serious about improving recruitment and retention for radiation therapists and other cancer care professionals.

**"Those staff, of course, take five to ten years to train depending on how specialised they are but it is something we are determined to put more money and effort into."**

This is cause for hope. However, the only way to achieve these goals will be to deliver better pay and terms and conditions of employment. The way to do that is through the collective bargaining process.

At the Conference, the Minister announced that he was fast-tracking a new cancer action plan to address the lack of co-ordination and consistency of care across New Zealand. That process is now underway and will include specific goals for DHBs to be accountable to around standards of care, access, timeliness, patient experience and clinical outcomes. The interim plan is due this month.



# RADIATION THERAPISTS NEWSFLASH

## Satellite Sites

APEX understands that investigations into building 2-3 new satellite radiotherapy sites across New Zealand are underway and building steam, although no formal proposals have been made yet.

This approach could go some way to addressing regional inequities in cancer outcomes.

However, it would also raise major considerations for staffing arrangements with any DHB seeking to implement a satellite system needing to reach agreement with APEX and the affected RTs.

## MECA AND ADHB SECA BARGAINING UPDATE

The DHB bargaining teams have been disorganised and were unable to meet to begin bargaining throughout April and May. We are awaiting confirmation for dates in late June.

However, we have received a promise that the first salary increase should be backdated to the day after expiry.

## FLASH: the future of radiotherapy?

Earlier this year, it was reported that medical physicists and biomedical engineers in Sweden have developed a way to modify a conventional linear accelerator for FLASH irradiation — and to rapidly restore it for clinical use without interfering with cancer patient treatment schedules.

FLASH radiation therapy employs ultrahigh dose rates from 40 to over $10_6$ Gy/s, at least a few hundred times higher than conventionally used in radiotherapy, in milliseconds-long bursts.

The potential treatment advantages are significant. The impact of patient motion during irradiation would be significantly minimised, reducing the need for target margins and thereby the volume of healthy tissue being irradiated. With fewer treatments, the problem of inter-fraction motion could be minimised or eliminated. Fewer and faster treatments would also allow radiotherapy treatment rooms to accommodate more patients, significantly expanding their utilisation.

FLASH-RT may be ready for clinical testing in humans in three to five years.

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