APEX
New Zealand's Specialist Union
Allied Scientific & Technical

TO THE POINT

December 2018

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Divisional Newsletters

From the President

Well, another year is nearly gone. What a busy year it has been with phenomenal levels of activity. I'm sure many of you can relate to that. 2018 has been full of promise, with expectations that years of neglect of the Allied Health sector would be addressed. The appointment of Martin Chadwick as the new Chief Allied Health Professions Officer reporting to the Director General of Health is hopefully a positive sign.

A number of critical issues have arisen this year, apart from the obviously important bargaining ones that many of our APEX divisions are involved in at the moment. However, I would like to concentrate on just one: bullying.

The individual cases are horrendous in their own right. However, I want to talk about how we collectively create an environment where bullying is unacceptable. That no matter who you are, you are confident to say "No, Stop it." Not just if you are the target, but even if you observe it happening to someone else.

Unfortunately there are very real fears that people commonly report for not coming forward.

- It could get worse.
- You will become the target instead.
- Career retribution, which can be active or passive, but never benign.

The common feature of this is repeated deliberate intentions to undermine.

Insidious

How do you know it's happening to you? This might seem obvious but while some behaviour is overt it is just as likely to be covert. Bullies tend to be secretive, although power and control can be maintained by overtly creating an environment of fear amongst those who witness it. Some of the things that may point to you being bullied are things like:

- being given deadlines that are unrealistic
- overburdening with excessive tasks compared to colleagues (setting someone up to fail)
- frequently changing instructions without explanation
- allocating tasks beyond an individual's ability with the deliberate intent of undermining confidence
- blocking promotion by refusing to endorse a pay rise
- excluding the target from discussions about their work or responsibilities
- micromanaging with the obvious implication of incompetence.

Who is the target, and why? The short answer is that it could be anyone. Some people become targets because the bully perceives they are weak or lack confidence, others because they are popular and/or are perceived as a threat.

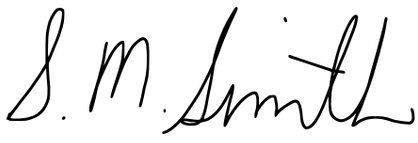
I am at a loss to understand why employers allow situations like these to develop and then do nothing about them once they are identified. It is a collective blindness that perniciously blights many of our workplaces. There are significant consequences to being bullied, ranging from feelings of loss of control and being unable to carry out usual tasks without coming under threat, to serious health concerns including PTSD. It results in lower productivity, increased sickness, and is clearly contrary to an employer's responsibilities to provide a workplace that is free from harm. Inaction on the part of an employer to address this type of activity effectively condones it, as there is no feedback to the perpetrator.

What can you do?

Talk about it with your work colleagues. If you are being bullied or think you might be, keep good records. Bullying is described as repeated behaviour, so a pattern will need to be established. It is important to prevent further psychological damage as soon as possible, so get advice and tell someone you trust – a delegate is a good start. If someone else can observe the same behaviour you are in a far better position.

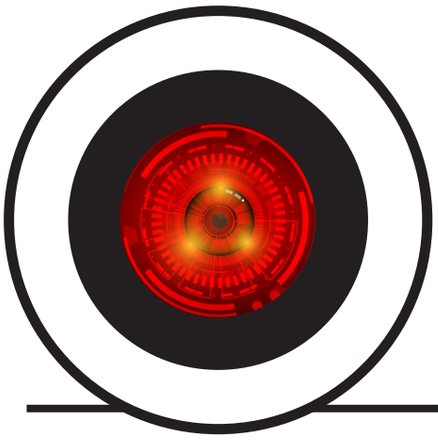
Remember that you are not at fault. There is no shame attached to being bullied: that belongs entirely to the bully. They may well have been bullied too, but that's no excuse for perpetuating knowingly harmful behaviour.

On that note I'd like to wish everyone best wishes for the holiday season and hope you all have a safe and enjoyable time. See you next year.



Stewart Smith

APEX President



APEX Feature
ARTIFICIAL INTELLIGENCE

A conference on Artificial Intelligence (AI) in healthcare, organised by the Royal Australian and New Zealand College of Radiologists (RANZCR) was held recently in Sydney. Congratulations to the college for taking the initiative.

There is much hype around AI and its potential effects on healthcare, including risk to job security. This conference sought to put some perspective on what is happening now, as well as future gazing. Importantly, it sought to give better understanding about what is involved in making AI work for us, and what good as well as risks might arise.

We are largely focusing here on the subsets of AI, mainly machine learning (ML), a little deep learning (DL) and to some extent neural networks (NN). There are other acronyms that you'll come across too, including ANI (artificial narrow intelligence, which describes AI that can perform only a narrow range of specific tasks), AGI (artificial general intelligence; AI with human-like transferable intelligence and problem-solving) and ASI (artificial superintelligence; AI whose intelligence substantially exceeds that of the most gifted humans).

Dr Jordan Nguyen is on the "speakers tour" and has an interesting website (see www.drjordannguyen.com). He is an electrical engineer by training and, amongst other things, has worked in the disability field. Some of his work has involved linking occipital (visual cortex) lobe electrical signals through a head band, to the cloud, to a computer in a car to enable a young man with cerebral palsy drive using his eyes – and only his eyes. Dr Nguyen also showed us passenger drones that are transporting people now (in China at least) and an electric car that autonomously drove around a racetrack at 260kph – again in China. The stuff that may previously have been in the realm of fantasy or sci-fi is here already.

Dr Nguyen's point is this: we can't stop change. The Luddites smashing machines in the industrial revolution didn't stop the revolution.

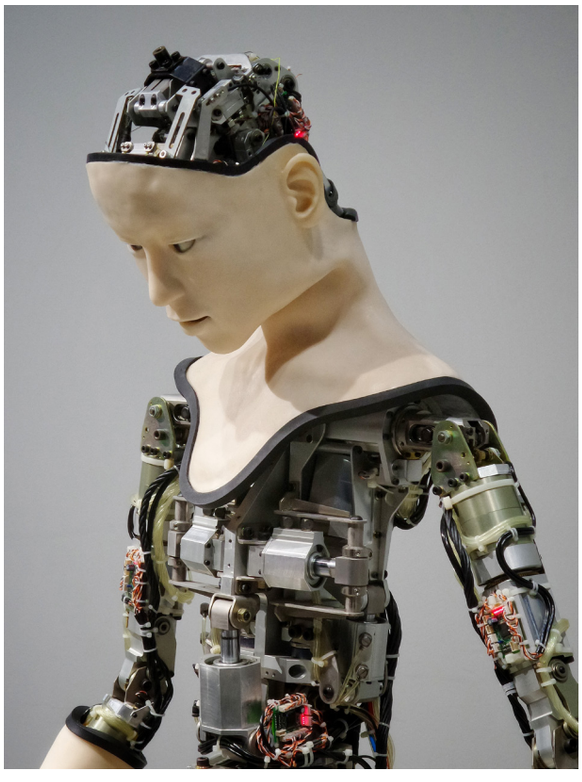
The Luddites were an early 19th-century group of English workers who destroyed machinery, especially in cotton and woollen mills, as a means of protest against industrial development. Whether this is a true representation of what the Luddites were all about (see the end of this article) or not, the term Luddite has since become synonymous with a person opposed to increased industrialization or new technology.

Stephen Hawking said, "Intelligence is the ability to adapt to change." And many have noted that innovation for some is disruption to others. We need to recognise what's coming and make active decisions about what and where we should harness the new technologies. We need to think and plan for what will happen to changing roles. A big question in my mind is what impact AI will have on future job security. How will the displacement of jobs happen? Will they simply disappear? or will we change to do other things?

Examples are already with us. Bank tellers lost jobs when ATMs were introduced. But we still crave the human experience, so we kept (some) tellers and just changed what they did. Smart gates at immigration hasn't removed the need for human beings in the airport. In labs, we may have machines reading bugs and cells for us, but we will still need people to help patients and clinicians understand their results, and more big data population-based work to prevent disease or respond better to microbial threats.

We have an ever-increasing volume of work, so will having technology that screens for "normal" allow the remaining workforce to concentrate more productively on the abnormal?

Dr Nguyen noted that those who enjoy the hype around AI are often those for whom it's core business – and those who seek financial benefit. Those who buy healthcare services, however, won't want to pay any more than they do now. There is a risk, therefore, that savings will be sought from existing areas to allow the introduced of new technologies. Given that staff represent 70% of cost of healthcare, looking at shifting money



TECH ALREADY EXISTS

- 24/7 ECG that recognises impending MI and dispatches an ambulance before it happens.
- Medical data gathered from sweat, detected through clothing or a wearable patch, available in real time.
- Retinal screening that can predict cardiac disease. (So, can voice recordings of emotional speech detect, well . . . ?)
- Ultrasound (instead of mammography) of breast screened by AI, leaving the negatives to look at.
- A machine that can take a scan and quantify the size and volume of anatomical features.

from the human workforce budget to an AI-based workforce is going to be tempting.

We've all heard that "The role of the radiologist will be obsolete in 5 years." Such comments have been around since 2010, when the potential of AI became apparent. Yet here we are: radiology remains a key discipline, and we have a workforce shortage – not just radiologists by MITs and sonographers as well.

When new technologies are introduced, they are not always entirely fit for purpose. Early AI has over-promised and under-delivered. One example is in labs, where a machine can now tell us the classification of bugs – but only if they aren't anaerobic. And AI requires big data which we often simply don't have access to in our little world. More on these challenges below.

But we must not lose sight of the fact that technology is an enabler. In pathology, a machine learning model is reducing the number of slides pathologists need to review. Whilst the machine identifies more disease than is there, it is very good at identifying when there is no disease. This has in one instance halved the number of films pathologists need to read, allowing them to get through more work. It is also a good example of how working with AI will enhance what we do.

To harness the good, we need to define our purpose and act. And we must be prepared to innovate or be disrupted. There will be change, and some of it will be rapid. We need to see a shift in focus from intervention-centred to patient-centred care. And, perhaps most importantly, we need to make decisions, and not let the decisions be made for us.

It's here already, and more is coming. We need to make some decisions about how and what, and lead the change.

What's holding AI back?

AI in its simplest form is pattern recognition; but if the pattern changes, the machine can no longer recognise it. For instance, developing facial recognition technology using the faces of thousands of white males enabled accuracy to a 1% margin of error. However, accuracy fell to 35% when confronted with the face of a black female; the pattern changed, and the machine could no longer be relied upon to get it right. And can we trust what it is that the machine has learnt?

In the case of a machine learning the difference between a wolf and a dog, the machine learned the difference to 1% accuracy until someone realised a picture of a dog in snow was being categorised as a wolf – the machine had learnt what snow looked like.

AN EXISTENTIAL THREAT?

The Terminator. The Matrix. Ex Machina. We love to speculate about whether AI will turn against us, or turn evil. Will AI become an existential threat to our species? What do the experts say?

> The real worry isn't malevolence, but competence. A superintelligent AI is by definition very good at attaining its goals, whatever they may be, so we need to ensure that its goals are aligned with ours. Humans don't generally hate ants, but we're more intelligent than they are – so if we want to build a hydroelectric dam and there's an anthill there, too bad for the ants. The beneficial-AI movement wants to avoid placing humanity in the position of those ants.
>
> — The Future of Life Institute

OTHER CHALLENGES

- Disease versus disorder: At autopsy 60% of dementia cases were found to be due to Alzheimer's, but only 10% had *only* Alzheimer's. For reliable AI we need to learn from those who have only Alzheimer's if that is what we want to diagnose on MRI. And of course, if you look closely enough, everyone is sick.
- Not all data always exists
- Frequency of data collection can be variable.
- Prevalence may be an issue. Only a few people who suffer X disease limits the ability to machine learn, hence the focus on normal rather than abnormals.
- Huge datasets are required due to the huge variability between people. Genetics, environment (including nutrition), education and physical environment vary.
- Having many data sources also brings in variability in both quality and quantity.

AI cannot perform contextual reasoning. For example, if presented with the sentence, "The councillors rejected the demonstrators' permits because they advocated violence", 99% of people understand it's the demonstrators advocating violence, not the permits. However, the sentence confuses machines built to comprehend language because they lack the contextual reasoning to make sense of the ambiguity. (Or, perhaps we should say they *currently* lack the intelligence. Whether general (AGI) and super (ASI) intelligence in machines is even possible is a matter of debate amongst the experts in the field. What they do tend to agree on, however, is that if AI with contextual reasoning arrives at all, it is decades away at least.)

Cost is always a factor. Healthcare costs continue to increase despite successive governments trying to cap spending. Who will improve medical practice, healthcare providers or consumers? If medicine charges what it thinks the value of our work is, we might be in for a surprise. Value-based payment pay systems for outcomes, not interventions. To determine outcomes, you need data – which we are now collecting. For example, machine learning could create an order of merit from the sum of patient data, practitioner data,

hospital and environmental data, which can then provide a pattern of behaviour and outcomes identified down to the individual practitioner. This will bring value-based medical systems to our front door.

To learn, AI needs huge datasets, millions of parameters, known "ground truth" (is it a dog or a cat? is it a normal chest X-ray?), and enormous computing power.

Machine learning requires a data set. It takes thousands of images for a computer to be able to recognise a human, and thousands of chest X-rays to recognise a normal one. But, images are not all the same: machines need to learn to identify the limits or parameters of "normal". This is easier for some applications than others. Group A streptococci have a narrower range of normal than human chest X-rays.

The datasets are on their way in radiology: ImageNet has over 15 million labelled high-resolution images, in 22,000 categories. But getting enough radiologists to decide if the images are normal or not – to determine ground truth – is a sizable task and a rate limiting step. There is also the question of whether the information is in the data. For example, is an X-ray alone enough to make the diagnosis?

Enigma is another initiative. Enigma involves 300 scientists from 185 institutions in 33 countries gathering data from more than 30,000 subjects. Genetic and imaging data are being gathered through systemic methods to generate longitudinal data. Biobank is also gathering big data.

But despite all these challenges, thousands of people are working to overcome them. We now have auto machine learning where, alongside the direct machine learning described above, the machine itself learns more from the learning already done. We have "models" that a machine can learn from – it doesn't have to be real data, just data that will get to ground truth.

Privacy Problems

Every time we use a cell phone, swipe a credit card, get caught on CTV, or Google something, data is created. And we need a dataset for machines to learn from: but what if this data is "sensitive".

London Underground collected data from individuals' cell phones to map crowd movements. This was thought to be acceptable use because the data was de-identified or anonymised – or so people thought.

Anonymisation requires the removal of identifying features. However, this is not sufficient. Deidentification needs to add some "noise" to the data; for example, changing date of birth to age by decade. But conventionally de-identified data is increasingly being able to be identified – and publicly released. The question is: how private is our data?

Long story short – it isn't. Current anonymisation protocols are inadequate to guarantee that personal data is safe. De-identification protocols are 20 years old now and no longer fit for purpose.

There is a trade-off between utility and privacy. We want to use big data, but we will have to decide the value of privacy over the benefits derived from big data. Not collecting or using big data is not an option – there is too much good that can come from it.

In 1930, we found that 12 points on a fingerprint could identify a unique individual. What does it take to de-identify a person in today's dataset world? How many individual points of data (use a credit card, a Google search, appearance on CTV) do we need to have to uniquely identify an individual from a large dataset?

The answer is surprising – and perhaps frightening. In a data set of 1.5 million people carrying cell phones in a 1 km area, just 4 datapoints will identify any individual 95% of the time. In a dataset built from 1.1 million people paying by credit card at a restaurant, 3 datapoints were 90% successful at identifying an individual.

If we make the spacial and time information less precise i.e. Greater area and wider time frames, will that additional noise help? The answer is only to a point; one trial found this only extended the number of points to re-identification by 2.

Standards and Control

AI ignores boundaries and borders. Our legislators are slow, our regulators slower. It is unlikely these mechanisms are fit for purpose in this new era. How we might solve these challenges is only just starting to be thought about. International work is underway on providing standard terminology, big data reference architecture and governance of big data and AI. But this is a global responsibility, not just the concern of a few people in a back room.

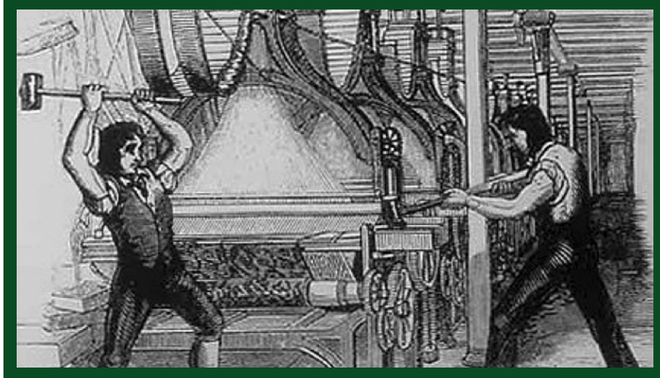
Progressive Luddites

The follow is an excerpt from the Smithsonian Magazine from March 2011, written by Richard Conniff.

Despite their modern reputation, the original Luddites were neither opposed to technology nor inept at using it. Many were highly skilled machine operators in the textile industry. Nor was the technology they attacked particularly new. Moreover, the idea of smashing machines as a form of industrial protest did not begin or end with them.

British working families at the start of the 19th century were enduring economic upheaval and widespread unemployment. A seemingly endless war against Napoleon's France had brought "the hard pinch of poverty," wrote Yorkshire historian Frank Peel, to homes "where it had hitherto been a stranger." Food was scarce and rapidly becoming costlier. Then, on March 11, 1811, in Nottingham, a textile manufacturing centre, British troops broke up a crowd of protesters demanding more work and better wages.

That night, angry workers smashed textile machinery in a nearby village. Similar attacks occurred nightly at first, then sporadically, and then in waves, eventually spreading across a 70-mile swath of northern England from Loughborough in the south to Wakefield in the north. Fearing a national movement, the government soon positioned thousands of soldiers to defend factories. Parliament passed a measure to make machine-breaking a capital offense.



One technology the Luddites commonly attacked was the stocking frame, a knitting machine first developed more than 200 years earlier by an Englishman named William Lee. Right from the start, concern that it would displace traditional hand-knitters had led Queen Elizabeth I to deny Lee a patent. Lee's invention, with gradual improvements, helped the textile industry grow—and created many new jobs. But labour disputes caused sporadic outbreaks of violent resistance. Episodes of machine-breaking occurred in Britain from the 1760s onward.

As the Industrial Revolution began, workers naturally worried about being displaced by increasingly efficient machines. But the Luddites themselves "were totally fine with machines," says Kevin Binfield, editor of the 2004 collection Writings of the Luddites. They confined their attacks to manufacturers who used machines in what they called "a fraudulent and deceitful manner" to get around standard labour practices. "They just wanted machines that made high-quality goods," says Binfield, "and they wanted these machines to be run by workers who had gone through an apprenticeship and got paid decent wages. Those were their only concerns."

So, if the Luddites weren't attacking the technological foundations of industry, what made them so frightening to manufacturers? And what makes them so memorable even now? Credit on both counts goes largely to a phantom.

Ned Ludd, also known as Captain, General or even King Ludd, first turned up as part of a Nottingham protest in November 1811, and was soon on the move from one industrial center to the next. This elusive leader clearly inspired the protesters. And his apparent command of unseen armies, drilling by night, also spooked the forces of law and order. Government agents made finding him a consuming goal. In one case, a militiaman reported spotting the dreaded general with "a pike in his hand, like a serjeant's halbert," and a face that was a ghostly.

In fact, no such person existed. Ludd was a fiction concocted from an incident that supposedly had taken place 22 years earlier in the city of Leicester. According to the story, a young apprentice named Ludd or Ludham was working at a stocking frame when a superior admonished him for knitting too loosely. Ordered to "square his needles," the enraged apprentice instead grabbed a hammer and flattened the entire mechanism. The story eventually made its way to Nottingham, where protesters turned Ned Ludd into their symbolic leader.

The Luddites, as they soon became known, were dead serious about their protests. But they were also making fun, dispatching officious-sounding letters that began, "Whereas by the Charter"...and ended "Ned Lud's Office, Sherwood Forest." Invoking the sly banditry of Nottinghamshire's own Robin Hood suited their sense of social justice. The taunting, world-turned-upside-down character of their protests also led them to march in women's clothes as "General Ludd's wives."

They did not invent a machine to destroy technology, but they knew how to use one. In Yorkshire, they attacked frames with massive sledgehammers they called "Great Enoch," after a local blacksmith who had manufactured both the hammers and many of the machines they intended to destroy. "Enoch made them," they declared, "Enoch shall break them."

People of the time recognized all the astonishing new benefits the Industrial Revolution conferred, but they also worried, as Carlyle put it in 1829, that technology was causing a "mighty change" in their "modes of thought and feeling." Men are grown mechanical in head and in heart, as well as in hand." Over time, worry about that kind of change led people to transform the original Luddites into the heroic defenders of a pretechnological way of life. "The indignation of nineteenth-century producers," the historian Edward Tenner has written, "has yielded to "the irritation of late-twentieth-century consumers."

The original Luddites lived in an era of "reassuringly clear-cut targets—machines one could still destroy with a sledgehammer," Loyola's Jones writes in his 2006 book Against Technology, making them easy to romanticize. By contrast, our technology is as nebulous as "the cloud," that Web-based limbo where our digital thoughts increasingly go to spend eternity. It's as liquid as the chemical contaminants our infants suck down with their mothers' milk and as ubiquitous as the genetically modified crops in our gas tanks and on our dinner plates. Technology is everywhere.

The original Luddites would answer that we are human. Getting past the myth and seeing their protest more clearly is a reminder that it's possible to live well with technology—but only if we continually question the ways it shapes our lives. It's about small things, like now and then cutting the cord, shutting down the smartphone and going out for a walk. But it needs to be about big things, too, like standing up against technologies that put money or convenience above other human values. If we don't want to become, as Carlyle warned, "mechanical in head and in heart," it may help, every now and then, to ask which of our modern machines General and Eliza Ludd would choose to break. And which they would use to break them.

APEX 2018 BARGAINING ANALYSIS

The formation in late-2017 of the Jacinda Ardern-led Government stirred up a real confidence in union members, particularly in the health sector, to start tackling issues that Labour had campaigned on – stagnant wage growth, pay equity issues for predominantly female-occupations, and under staffed public health services. The sentiment of "Let's do this", which had supercharged Ardern's rise in political popularity, quickly heated up the arena of collective bargaining. People's expectations were rising.

Nurses' Strike

In early December 2017, the 27,000 nurses, midwives and health care assistants covered by the New Zealand Nurses Organisation multi-employer collective agreement (MECA) with District Health Boards, rejected an offer of 2% pay rises for three years.

And although DHBs and NZNO headed to mediation in early 2018, another offer was rejected by members in March. An independent panel and a new offer failed to avert a 24-hour strike on July 12. But in early August 2018, NZNO members accepted a fifth offer to address concerns around pay, equity and staffing. The main benefits were three years of 3% increases and additional steps in the salary scales, as well as commitment to implement pay equity by the end of 2019 and a safe staffing system (known as CCDM) by 2021.

Flow On

The traditional pattern of bargaining has been that whatever the NZNO MECA settles for will be delivered to the Public Service Association Allied and Nursing documents, as well as to midwives covered by MERAS. This is known as flow on.

So as soon as NZNO had settled, the PSA rode the coat-tails of the nurses' settlement with nearly mirror-image settlements for their nursing and allied health MECAs. At the same time, we were beginning to hear rumours of increased control over DHB bargaining from a group of four cabinet ministers: Grant Robertson (Finance), Iain Lees-Galloway (Workplace Relations), Chris Hipkins (Education), and David Clark (Health).

Industrial Action Kicks Off

In September, APEX advocates were told the nurses' settlement would not flow into the nearly two-dozen collective agreements that were being bargained on behalf of pharmacists, anaesthetic technicians, physiotherapists and others around the country. As a result, APEX members, beginning with perfusionists at ADHB, began to ballot for industrial action. Quickly we saw a change in negotiating tack, and APEX members began to be offered salary increases in line with the nurses' settlement – all clinical documents were being offered the same. But the offers were being tightly controlled by central government. The DHBs seemed unable to make offers that were even a little bit different to what had been offered to PSA members in the same professions.

In October and November some APEX groups settled for the standard deal, but other groups boxed on, particularly the (industrially powerful) anaesthetic technician groups, who began regular and sustained strike action at Lakes, Hawke's Bay and Northland DHBs. Despite the disruptive effect of industrial action, DHB negotiators began complaining the four Ministers were refusing to allow them to make any offer

A spectacular breach

MERRY CHRISTMAS!

APEX wishes you a very merry Christmas and a safe and happy new year!

The APEX office is closed from December 24 until January 14.

However, we will have an advocate in the office between 10am and 3pm on the non-stat days to deal with emergencies.

If you have an emergency on a stat holiday, please call Deborah on 021 614 040.

beyond the standard deal.

Strike action spread beyond APEX. In late November 2018, more than 1000 midwives covered by the union MERAS issued 540 strike notices to get the DHBs to make an offer beyond what had been offered to NZNO's midwives.

2019 – Wellness for Us

Through 2018 DHB employees and unions leveraged favourable political conditions to improve their salary and conditions. But the increased Ministerial control of bargaining has imposed barriers to tailoring collective bargaining outcomes at an individual DHB level for professions like anaesthetic technicians and pharmacy.

And where professions are split in a substantial way across two unions, the DHBs have not shown any mood to allow different sets of conditions in different areas across the same profession. Instead, DHBs have sought to settle an agreement with one union and use that as leverage to force the other to accept identical terms. The Government has also begun demonstrating an increasing resolve to wait out industrial action – not just in health, but in other parts of the public sector – classrooms and courtrooms.

The increased control over collective bargaining by the Ministerial Quartet leaves health professions with a single *de facto* employer – the Ministry of Health. At law the DHB is the employer, but this is supplanted in reality by tight control from Wellington. This magnifies the inequality of power in the employment relationship and erodes constructive collective bargaining at the DHB level. The effect of this on the future of collective bargaining remains to be seen.

As we head into 2019 all of the APEX MECAs – radiographers, radiation therapists, physicists, sonographers, psychologists, laboratory workers, physiologists are all up for negotiation. At the same time as the Government promises a 'wellness Budget' in 2019, it will be negotiating with some of the hardest working, least recognised, most essential health professionals in the country. The government will have to practice what they preach. Wellness for the public begins with wellness for us.

LAKES DHB LOSES FACILITATION APPLICATION

Lakes DHB applied to have the Employment Relations Authority (ERA) grant the right to have our anaesthetic technician bargaining referred to facilitation. That application was opposed by APEX, and successfully so. The decision is worthy of a read, but for those who think legal decisions are less interesting than paint drying (and yes I can see that point of view), here are the key points.

What is Facilitation?

Facilitation is a provision of the Employment Relations Act (ERA) that is rarely used but allows for parties to a dispute to have a third-party determination about a bargaining outcome. The parties may or may not accept the determination: i.e. it is not binding on the parties.

Why is it not often used?

A basic focus of the Employment Relations Act is "the parties". The provisions of good faith, direct bargaining etc all provide a platform underpinned by the responsibility of the parties to resolve issues and progress the employment relationship. Mediation supports that focus, but facilitation, where a third party offers up a settlement, does not.

And, in fairness, most parties agree with this focus. When a third party settles an agreement, neither party "owns" it, which in turn means the deal often isn't cemented in and the same issues arise again on renewal. Given the Act prioritises the relationship between the parties, getting to facilitation is not easy. The ERA assesses against legislated criteria; the view of the ERA in the Lakes situation is detailed as follows.

Criteria for facilitation

Against this background, the ERA looked first at whether the bargaining had been unduly protracted, whether extensive efforts had been made to reach settlement and whether there are serious difficulties necessitating facilitation.

Lakes did claim the bargaining had been unduly protracted, but the ERA found that "unduly protracted" has both a temporal (timing) and activity (how much has happened) element, and was also mindful that 'unduly' meant exactly that!. Whilst the ATs at Lakes had initiated bargaining over a year before this case came to be heard, there was also effectively an abeyance to bargaining of some 5-6 months due to the DHB's focus on the NZNO dispute. Once APEX and Lakes reconvened, there had in total only been 4 days in bargaining and one day in mediation – hardly unduly or protracted.

"Extensive efforts"

The ERA also considered whether "extensive efforts" had been made to resolve the difficulties between the parties, and noted that this required a "wide scope, far reaching or comprehensive . . . range of activities". APEX felt if we couldn't get back to bargaining, strike action would be necessary, but we also maintained that our goal was to get back to mediation to seek settlement. The ERA found that only one day of mediation didn't meet the threshold of "extensive" efforts.

As for serious difficulties, the ERA noted the parties' differing opinions around what a salary package might look like. Whilst an important issue for both parties (as the money usually is!) the ERA didn't feel "serious" related to how genuinely the parties held a view but how difficult it might be, what hurdles might need to be overcome, to reach agreement. They also noted that such a hurdle might lie in LDHB's refusal to release financial information surrounding their position. Obviously the more we know about the basis (financial or otherwise) of an employer's position the more we are able to maneuver to find a settlement – without that we are negotiating in the dark. The system has long recognised that negotiation without information is like breathing without oxygen – it is essential if a good outcome is sought.

The ERA also noted that LDHB felt the APEX claim would disadvantage Lakes in attracting at least some ATs given the fierce labour market we have for this specialist and essential workforce. The ERA therefore noted that further fruitful discussion between the parties must be possible when so much opportunity to find middle ground existed.

Onto the next criteria which might allow facilitation: That during bargaining there has been one or more strikes or lockouts; and that they have been protracted or acrimonious.

Yes there had been 4 days of strike! But was it protracted? The ERA noted strikes can continue for weeks and even months,

LAKES DISTRICT HEALTH BOARD

albeit not commonly in Health. Four days in 8 months of bargaining was not felt to be protracted by the ERA, nor were they acrimonious as the manner in which LPSs were agreed and provided attested to.

Lastly

Finally, that a party has proposed a strike or lockout; and if it were to occur, it would be likely to affect the public interest substantially. At that time our members had not instructed us to take further strike action, so none was proposed, and on that basis the ERA member declined to rule on this criteria. It was not therefore necessary for the ERA member to rule on "the public interest", but did helpfully refer to Judge Perkins of the Employment Court who said:

"The whole purpose of the strike action . . . is to cause . . . inconvenience and it is a valid bargaining tool where carried out in accordance with statutory requirements . . . The rights to strike lock out are part of ensuring a balance to the relative negotiating positions of the parties in industrial bargaining. Any steps to reduce their effectiveness is not to be taken unless there are sound principled reasons for doing so."

In summary, the ERA ruled against Lakes DHB on all points and referred the parties back to negotiations, including with the help of mediation, and through using good faith provisions such as the access to financial and budgeting information.

CONGRATULATIONS MARTIN CHADWICK

APEX congratulates Martin Chadwick on his appointment to the new role of allied health lead at the Ministry of Health. Martin was previously the allied scientific and technical lead at BOP DHB and before that CMDHB. He has also chaired the National DAH group and lead the radiology workforce group.

APEX lobbied hard to have this new role at the Ministry of Health established, sitting alongside the Chief Medical Officer and the Director of Nursing in what is now known as the "clinical cluster" at the Ministry. We were doubly pleased to see the position go to someone who is both familiar with the NZ scene and passionate about allied scientific and technical practitioners, our role and the benefit we bring to the care of patients.

We anticipate Martin may shake a few things up in his new role. As NZ's specialist allied scientific and technical practitioners union representing over 4000 members, we look forward to working alongside Martin and progressing the challenges we already have – and any he may throw at us!!

EMPLOYER STALLING TACTICS

The motivation behind stalling tactics for employers is simple – the longer bargaining drags on, the more likely it is that their workers will cave and accept unfavourable terms of settlement, or even give up on reaching a collective agreement at all.

One of the most frequently asked questions we get from our members is 'why does collective bargaining taking so long?'

As our analysis of this year's APEX bargaining shows, members across many of our divisions have found themselves frustrated with how long it is taking many DHBs to make offers capable of settlement. This year, microscopic oversight of collective bargaining by central government has been one reason for delaying settlement; in many cases, our members have had to threaten or follow through on strike action simply to get an offer on the table. Anaesthetic technicians have had a particularly hard time of it.

The duration of bargaining for any particular collective agreement will of course depend upon all of the surrounding circumstances. For instance:

- how many members there are
- whether the collective bargaining involves multiple employers
- whether it is the parties' first such collective agreement
- how contentious the claims are, and
- what the current and historic state of the employment relationship is like.

But, whatever the exact circumstances, there is always the risk of the employer, or employers stalling bargaining in an attempt to frustrate members.

What does it look like?

Over in the United States, for example, it is very common for employers to 'starve out' fledgling collectives. 52% of unions are unable to settle their first collective agreement within a year, and 25% aren't settled after more than 3 years. In New Zealand, the most notorious example is AFFCO, a major meat processor that was taken over by Talley's Group in 2010.

Since 2010, AFFCO has prevented union meetings from taking place at work, locked out union organisers, closed on-site union offices, banned union newsletters and t-shirts, sought to stop its workers from criticising it online, and even held unlawful lockouts of workers while at the same time aggressively targeting union members with offers of individual employment agreements. Collective bargaining has dragged on for years, beset by litigation that has cost the Meat Workers Union $500,000 a year in legal fees.

In the words of the Court of Appeal, it was "obvious" that "the company's purpose was to fragment the future bargaining strength of the workforce by isolating individual workers" and that AFFCO did so by "[taking] advantage of the inherent inequality of its relationship" with its workers. As a result, union membership at AFFCO-run sites has plummeted, dropping from 95% in 2010 to only 10% in 2017.

Delaying and refusing to meet for bargaining

The most common and frustrating stalling tactic is when an employer refuses to meet and bargain in an efficient and timely manner with the union bargaining team.

The trouble is that there is no hard and fast rule or time limit on how quickly employers must meet with us to bargain. Of course, outright refusing to meet is illegal, but beyond that, it's murky.

The Code of Good Faith in Collective Bargaining only provides that "the parties must meet each other, from time to time, for the purposes of bargaining. The frequency of meetings should be reasonable and consistent with any agreed bargaining arrangements and the duty of good faith". But what frequency counts as 'reasonable'? The New Zealand courts have not directly addressed this question yet, so we do not have a clear-cut answer. Australia and the US have an analogous requirement to "meet at reasonable times" but the Australians

also lack clear legal guidance.

In the United States, the National Labor Relations Board's decision in El Paso Electric Company v The International Brotherhood of Electrical Workers discussed the issue. The El Paso Electric Company was found to have breached its obligations because it had:

- Delayed meeting for bargaining a full two months after initiation.
- Met with the union to bargain on average only once a month.
- Refused employees unpaid time off to attend bargaining.
- Only agreed to meet in the evening and on weekends without reasonable grounds.
- Arbitrarily and repeatedly cancelled planned meetings.
- Repeatedly refused the union's requests to meet.
- Bad faith bargaining strategies

Even once bargaining has begun, employers have tactics that can drag out negotiations. 'Surface bargaining' and 'positional bargaining' are two types of bad faith bargaining strategies which routinely frustrate and stall union efforts to reach a collective agreement with employers.

Surface bargaining tactics may include knowingly making proposals that we could never accept, reneging on agreements, taking inflexible or unreasonable stands on issues, raising new issues at the eleventh hour, breaching bargaining process agreements, and/or refusing to offer alternatives to proposals.

Surface bargaining is where the employer merely 'goes through the motions' of bargaining without seriously intending to engage and compromise with the union bargaining team. An employer is surface bargaining when they attend bargaining meetings, but they do not take the union's concerns seriously and they do fully not participate in the give-and-take of the collective bargaining process. Other surface bargaining tactics may include knowingly making proposals that we could never accept, reneging on agreements, taking inflexible

or unreasonable stands on issues, raising new issues at the eleventh hour, breaching bargaining process agreements, and/or refusing to propose alternative solutions.

Positional bargaining is where the employer comes to the bargaining table with a fixed agenda and effectively attempts to turn collective bargaining into a form of haggling. They will have a private position as to what they are willing to settle for and instead of meeting the union's claims they will fight to settle for the lowest amount possible at each step of the process, thus dragging bargaining on for months. 'Take it or leave it' offers are one extreme example of a positional bargaining tactic.

For example, recent bargaining between APEX Anaesthetic Technicians and certain DHBs arguably reflect an underlying positional bargaining approach. DHBs across the country have been refusing to budge from a one-size-fits-all deal. The main strategic goal of this tactic appears to be limiting the overall costs of settlement, but the DHBs are so fixated on matching outcomes that they will not even agree to creative and low or neutral costing policies that take into account local circumstances.

Solutions

For members, especially if you're a delegate or part of a group seeking your first collective agreement, you need to be highly attuned to the kind of tactics employers are likely to use to demoralise members and undermine bargaining. This encompasses bad faith bargaining strategies, stalling tactics, bypassing APEX, bad-mouthing the union to non-members, and much more. Fortunately, in New Zealand we do have the option of seeking damages against especially hostile employers for such breaches of good faith.

Delegates need perseverance and resilience. Not all employers will intentionally delay bargaining, but we have the primary responsibility to our members to ensure employers do not make bargaining drag on needlessly. It is our responsibility to keep the pressure on employers and ensure that times are set to meet and bargaining progresses. This will help to keep employers on their toes and will also provide a useful paper trail if there is so much undue delay that we decide to take a case against them for undermining bargaining.

Industrial Action

Industrial action remains our single most powerful tool. A strong and staunch membership can move mountains, even if it is only inch-by-inch. In 2018, many of our groups have had to threaten or actually strike simply to get an offer on the table. The fact that this has been necessary is a real pain, but it also reflects the power of workers to use industrial action to progress bargaining. The following APEX groups have had to take industrial action just to get the DHBs to provide an offer:

- **Anaesthetic Technicians** at Hawke's Bay, Lakes, MidCentral, Nelson Marlborough, Northland, and Southern DHBs.
- **Perfusionists** at Auckland DHB.
- **Physiotherapists** at Waikato DHB.
- **Pharmacists** at Nelson Marlborough DHB.

Delaying tactics during bargaining is going to remain a problem with employers for the foreseeable future. A combination of active and engaged members, industrial action and vigilance in detecting these tactics is our best strategy.

A HISTORY OF SMOKO

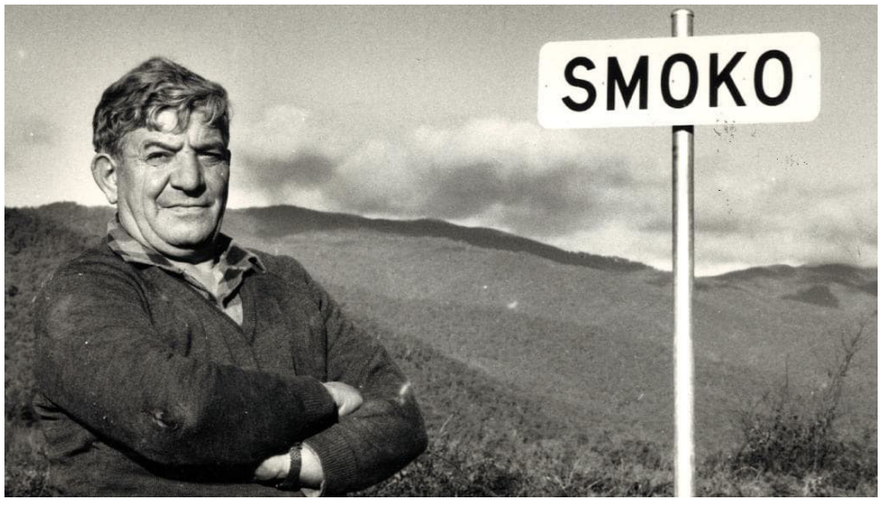
The Employment Relations Amendment Bill currently before Parliament will, if passed, restore in statute the right of employees to take regular meal and rest breaks through the day.

The Bill will provide for one ten-minute paid rest break between 2 and 4 hours of work, a thirty-minute unpaid meal break between 4 and 6 hours, and another ten-minute paid rest break between 6 and 8 hours.

The legislative changes are a continuation of the struggle between workers and bosses over the right to decent breaks during work. Rest breaks, or "smoko" as it has often been called in New Zealand and Australia, is a fairly old custom that goes back to the gold-rush days.

There's even a town called Smoko in alpine north-eastern Victoria, Australia. Lore has it that in the 1850s gold miners on the way to the mountains would stop there for a rest and a smoke – from there the town got its name. Over here on the west coast of the South Island, a small creek called Smoke-Ho runs down from the mountains towards a small mining town with a big history – Blackball.

To figure out how the Smoke-Ho creek got its name you have to go all the way back to 1908, when miners who worked underground got 15 minutes for lunch



and no morning or afternoon tea. When the miner's union voted to support 30-minute lunch breaks, the next day one miner, Pat Hickey, kept eating his pie past the 15 minutes, with the mine manager standing over his shoulder. Ordered to return to work, Hickey said "I haven't finished my pie yet." At which point Hickey was fired, setting off a successful 11-week strike – the workers won their right to 30 minutes for smoko and Hickey and six other miners were reinstated to their jobs. The strike also led to law changes around industrial action to requirements workers in essential industries to give advanced notice of strike action that still have an impact on APEX members today.

By the 2000s, most workers covered by awards and then collective agreements had some form of rest breaks provided. And smoko breaks were enshrined into law for all workers in 2008 under the Clark-Government. But they were repealed under the Key-government in 2014.

The return of legislative rest breaks to the Employment Relations Act and the specification of what compensatory measures have to be provided to workers in essential industries who cannot be given their breaks may have quite an effect on contractual obligations. The new provisions will require additional payments and/or additional periods of time off work when


Smoko-Ho creek waterfall

employee's are required to work through their breaks. What this will be will have to be negotiated between employers and unions in coming months.

The right to a decent smoko for workers in essential industries has always corresponded to the degree of organisation and strength unions have at the coal face. Making sure we get enough time to eat our pie or panini is still is as important to our health and wellbeing as it was back in Blackball a hundred and ten years ago.

WORKPLACE SUPPORT for victims of DOMESTIC VIOLENCE

Back in July, Parliament enacted the historic Domestic Violence Victims' Protection Act 2018, making New Zealand the first country in the world to enact paid domestic violence leave as a universal right.

What does the Act do?

From 1 April 2019, every employed person in New Zealand will be entitled to 10 days of paid domestic violence leave per year to support them in dealing with the effects of domestic violence. In addition, people affected by domestic violence will be able to urgently request variations to their working arrangements (place, days, and hours of work).

Why is this such a big deal?

New Zealand has the worst rates of domestic violence in the world.

Enacting this law provides the victims of domestic violence with greater financial and employment security; factors that can be crucial in breaking free from the cycle of domestic violence. These substantive provisions are themselves a huge victory.

But the Act also represents the culmination of a major shift in national consciousness.

As a country, we are collectively recognising that domestic violence doesn't stop at the workplace door and are putting our money where our mouth is to help those affected by it.

What's the evidence around these policies?

This is a world-first, but there are research-backed reasons to believe that these policies will be a win-win-win for employees, employers, and society as a whole.

1. Domestic Violence is a workplace issue. Right now, the effects of domestic violence on employees are estimated to cost employers in New Zealand around $400 million each year. Secure employment is also a key pathway out of domestic violence, providing those affected with a way to maintain domestic and economic stability.
2. Research from Australia indicates that only around 1.5% of female employees, and around 0.3% of male employees, are likely to utilise paid domestic leave provisions in any given year. Made proportional to NZ's population, this rate would cost employers a total of around $20 million per year, as against the whopping $400 million in lost productivity due to domestic violence. The policy will probably pay for itself.
3. Abusers don't stop at the workplace door either. Victims may be stalked and harassed in their workplaces or sabotaged from attending work or performing in their jobs by their abusers. The Act sets up a process for securing victims in their workplace and varying their terms of work. These kinds of workplace safety strategies have proved critical; in at least one Australian case they have successfully prevented an employee's husband from abducting their son and murdering her.

What is APEX doing about this?

As always, APEX's plan is to stay one step ahead. We are introducing a new 'support for victims of domestic violence' clause as a standard claim for all of our collective agreements.

This new clause goes above and beyond the Act, by taking effect immediately instead of after 6 months of employment. It also ensures that affected employees can go to whichever manager they feel most comfortable confiding in, and it stresses the importance of treating any related discussions and requests with the utmost confidentiality, including keeping no record of personal information disclosed in these conversations without express consent.

WELLBEING & BULLYING
STRANGE BEDFELLOWS

— By Dr Deborah Powell

I was at bargaining for the MITs recently – a forum in which the issue of wellbeing in very real terms is on the table.

Demand

The demand for radiology services continues to grow, and the number of MITs fails to keep up. Previous work practices, such as on call systems, are no longer safe for many of the staff and inevitably impose negative health impacts, not just from fatigue but the myriad consequential impacts the "stress" of work has on our physiology.

On call is fine when the call backs are of an occasional nature, but where call backs effectively become on-duty, and remembering call is in addition to the normal working day or week, we are inevitably seeing MITs on a day shift and back at the hospital that evening and overnight. Likewise, having finished a 40-hour week, MITs are at the hospital multiple times at all hours over the weekend days, effectively working a 12-day stretch.

MITs not alone

MITs are not alone: nurse staffing issues were front and centre of their industrial action in 2018. The government pledged an additional $300M to help, plus promising a CCDM system (Care Capacity Demand Management; a nursing "correct" staffing level system) to be implemented by 2021. SMOs (senior doctors) are facing huge levels of burnout as their workload outstrips their numbers.

And, of course, RMOs went on strike to get safer hours of work – which required more RMOs to be employed – in late 2017. ATs are in short supply, psychologists are fighting to maintain appropriate caseloads: the list goes on.

Bullying

And during this we have the ongoing and relentless bullying culture that we don't seem to be making much, if any, traction on – despite considerable efforts. I believe these issues are linked. The link is not direct: we know two people in stressed environments can react differently – one becoming a bully and one not. The stressed environment in and of itself is not the cause. But it is an environment within which bullying can flourish, and I believe is an environment supported through management culture and behaviours.

MIT bargaining

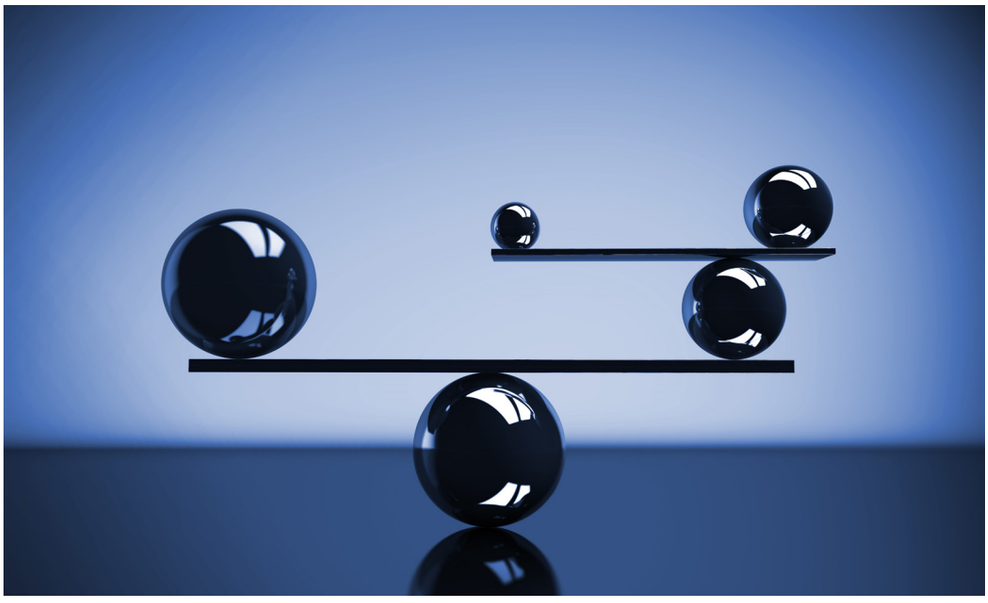
Back to the MITs bargaining – it was early days. We had met for a day in prebargaining and this was our first actual meeting formally at the bargaining table. It was a pleasant two days. Things were relatively low key as is normal at the outset. We were tabling claims (but hadn't got to money yet), and the parties shared several key concerns: fatigue, wellbeing, demand 24/7, recognition and reward. The employers' advocate made two statements, however, that are pertinent to this issue. First, in the context of how we assess the implementation of shift work rostering to meet demand, he said:

"The DHBs don't want any more restrictions (in the MECA); if we are moving to more shifts there

is no point in restricting the number of weekends MITs can work."

But hang on: isn't staff wellbeing one of our principles, and doesn't that include consideration of work-life balance for the staff? And what the employers see as "restrictions" to us are protections, and ones we have always needed, because without them delivering to demand would be the only driver. We challenged the employers to think more broadly than just demand and service delivery, to balance that by also valuing the wellbeing of the staff and their right to a happy workplace – as well as a happy life outside of that. The employers readily agreed. Yes, wellbeing is important. And on day 2 the advocate reiterated this when he said, "Wellbeing is a high priority". However, he went on to say:

"And of course directly related to improved patient safety."



Again, we had a moment to pause. Is our wellbeing only important if patients get better/more care as a result? Is our wellbeing in and of itself not a valuable enough goal?

Culture

Which takes me to management culture and behaviours. I have always said that the role of the employer is to care for the staff: the staff will care for the patients, students, and clients. And, goodness, we see how far staff will go to ensure those in their care do get the best. Staff are notorious for putting themselves out, and going the extra mile, even when that may negatively impact on themselves. So, I believe it is imperative employers look after staff first, including protecting staff from their own altruistic behaviours where these can cause harm.

But management culture is too far from this goal: the language is all about service delivery, meeting demand, flexibility. Staff wellbeing has become a "work stream" with a website constructed to house resources we can tap into. We are now having to deal with the consequences of not attending to wellbeing; we do not have happy healthy workplaces, and we do not have members who can achieve a healthy work-life balance.

Grass roots

And with that we have a bullying culture. At grass roots level, team leaders and service managers have one objective by which they are measured – service delivery. Scant if any concrete concern is shown for staff wellbeing from those to whom they report. I am not saying they do not care; however, I am saying we need to talk about it – in real terms. This is not what drives us: staff are a tool to meet demand, and the more we deliver the better our stats. And our managers are not taught people skills – skills I believe are mandatory in today's workplace for those with staff responsibilities. How much support do our managers get for reflective practice – reflective of how their own behaviours are impacting on those around them, especially when their drivers are productivity, not staff wellbeing?

Confidence to act

Speaking up for safety programmes will not work if staff do not have confidence that speaking up will have benefit, let alone being worth the risk. Whilst managers continue to turn a blind eye, focusing instead perhaps on the relentless daily business of service delivery, this will not change. Maybe the means to find cultural change around bullying lies in the same sphere as standing up for our right to have wellbeing. Maybe DHB drivers have to be changed to measure and value staff wellbeing at the same level as throughput?

GET IN TOUCH

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COLLECTIVE AGREEMENT RATIFIED @ MoE

A multi-union collective agreement with the Ministry of Education and NZEI was ratified by APEX members at the end of November.

The collective agreement comes after 9 months of bargaining and a 12-week partial strike by APEX psychologists who used industrial action to bring in safe caseloads. Strike action by APEX and NZEI members was the first industrial action during collective bargaining in the history of special education.

The collective agreement is for three years and includes:

- A minimum 7% increase on all printed salary rates;
- An immediate 12% increase in the starting salary for new graduate psychologists;
- A new top automatic step of $96,000 for psychologists from 1 January 2020;
- A simplification of the process to access Skill Progression Pathway;
- A new clause to provide for external supervision;
- A new professional development clause with guaranteed 2 days study leave per annum;
- A working group to determine guidelines on safe caseloads and workloads for all professions.

The agreement is APEX's first collective with the Ministry of Education; although gains were modest, the new clauses in the collective agreement mark a substantial improvement in psychologists' working conditions at one of the country's largest employers of psychologists.

Not all of our claims were met during bargaining – protected professional development money, reimbursement of professional association fees and financial recognition for those who work on traumatic incident teams were not agreed by the Ministry.

The agreement is one small step for APEX, and a giant leap for Ministry of Education.

CTRL-C CTRL-V

HOW THE DHBS PREPARED THE 2018 PSYCHOLOGY WORKFORCE REPORT

The DHBs pre-bargaining report shows the psychologists no longer want to work at District Health Boards, but the national agency responsible for health workforce planning has copy and pasted their analysis of the 2018 workforce from a 2016 report.

In the last two years, contracted psychology FTE has dropped 0.7%, and FTE per 100,000 population has dropped 4.1%. Sick leave usage is up 6.3%. Turnover is up 18.9%.

There are currently 73.8 FTE vacant across the country: 11.4% vacancy rate. The vacancy rate has doubled in less than 2 years.

Despite the fact that in the last two years vacancy rates have doubled, and turnover is up by nearly 20%, the DHB's 2018 workforce report has "copy and pasted" from its 2016 report a summary of the profession:

The analysis of the Psychologists Workforce within the DHBs has resulted in the classification of a Transitional Occupation. This classification highlights that service demand is progressively increasing with some supply issues around the number of Maori and Pacific psychologists and with particular areas of specialisation. There are emerging sector requirements to begin looking at alternative models of care and roles for this workforce, as greater flexibility is required. The psychology profession deserves better than a recycling of the 2016 analysis. Unless District Health Boards are prepared to seriously think about, problem solve, invest in, and develop the psychologist workforce in 2019, then the problems the report identifies are bound to get worse and not better.

Read the report here: Psychology Workforce Report

DHB MECA BARGAINING

CLAIMS, BARGAINING TEAM, MECA BALLOT

A set of claims for DHB MECA bargaining has been provided to DHB psychologists to vote on claims ahead of the initiation of collective bargaining on 30 December.

Because we are seeking to expand the MECA from fifteen to eighteen District Health Boards to include Southern, Tairawhiti and Wairarapa DHBs the law requires members vote on whether they are in favour of a multi-employer collective agreement with the new parties included.

Members are being asked to vote on the claims and the proposed expansion of the MECA before 1600 on Friday 14 December.

Bargaining will be initiated on 30 December and begin in February.

The APEX divisional executive has also appointed the following delegates to the Psychologists' MECA bargaining team:

- Siaan Nathan, Northland
- Emma Edwards, Waitemata
- Iris Fontanilla, Auckland
- Chris Murray, Counties Manukau
- Simon Waigth, Counties Manukau
- Oloff Arnold, Bay of Plenty
- Amber Barry, Midcentral
- Peter Robertson, Capital and Coast
- Annmaree Kingi, Canterbury
- Anna Chesney, Canterbury
- Mike Parkes, Southern

DHB MECA ISSUES

In our claims survey to the DHB members, we received a set of responses that, rather than suggesting a need to change the MECA, raise issues of whether the employer is complying with the current provisions of the MECA and other sources of employment law. Below are some of those comments, and some advice from us in italics.

"Increased commitment from employer to provide up to date ICT." – Clause 13 of the MECA already requires employers to provide "suitable office space with computer and telephone facilities" including "up to date test material, software...".

"Firm time frame around merit step, as it's more like 12 wks min than 6." – Clause 9.3.3 requires employers to process applications within 6 weeks "where practicable". If a DHB is not meeting this timeframe, this suggests there is not enough FTE at the decision-making level (i.e. professional leader) to enable these decisions to be made in a timely manner.

"Long service leave can be taken as normal leave not just in a 5 day block all at one time." – Clause 17.2 reads, "Wherever practicable long service leave is to be taken in periods of not less than a week." If you want to take a day or two, that would be a conversation to have with whoever approves the leave within your DHB, and you would need to explain why it was not practicable to take a week's long service leave at a time.

"CPD to be included in pay rather than seeking approval." – A large amount of psychologists expressed their satisfaction with having a protected CPD budget and that we not remove this budget. Including it in pay, will reduce it significantly in real terms as it would be subject to income tax.

"My employer informed me "An offshore parent cannot be classified as being dependent on the staff member [for the purposes of sick leave]" – This is wrong advice from your employer. Determination of dependent status is based on whether they depend on you at the point they become ill, not at the point they have been living independently whether overseas or across the street.

"Clear guidance on implications of parental leave on CPD and eligibility to apply for salary steps." – Parliament has provided us with clear guidance on this matter already. Section 43 of the Parental Leave and Employment Protections Act 1987 states that rights and benefits conditional on unbroken service, for example salary steps or CPD are not affected by taking parental leave.

"I missed out on merit progression this year as there was no students or peers to supervise." – Clause 9.3.7 requires a psychologist be a supervisor unless agreed "this is not an appropriate component of the employee's job"; which if there is not one to supervise it is hard to see as appropriate.

"Include allowances to attend patient funerals as part of work, eg paid employment" - This should be taken as bereavement leave.

APEX

MIT news

Medical Imaging Technologist News OCTOBER 2018

BARGAINING BARGAINING BARGAINING

NATIONAL MECA BARGAINING is now front and centre for our many DHB-employed colleagues, with an initial 'pre-bargaining' day with the DHBs now imminent – November 13 – while the first round of formal bargaining is scheduled for 10-11 December.

Key proposals besides across the board pay rises include:

- Getting ahead of the rising tide of technological changes: shifting from a pay-scale which rewards work across modalities outright in favour of one which rewards a wide range of qualifying duties and responsibilities.
- Enhancing work-life balance: 1:6 weekend frequency.
- Reducing the risk of fatigue through smarter rostering.

As always, the devil is in the detail and final claims to be brought in to bargaining remain hot topics. Your advocates and APEX delegates have been impressed with the high level of engagement, consideration, and feedback received so far. Keep it coming!

PRIVATE SECTOR BARGAINING: MITs working at **Bay Radiology** across the Bay of Plenty concluded a successful round of collective bargaining back in April for the period 9 April 2018 to 12 April 2020. Bargaining began in February and APEX MITs walked away with some big wins:

- A 5.1% pay rise in the first year, with a further increase of CPI plus 0.5% in April 2019;
- A new theatre on call roster with a $10/hr on call allowance on top of T2 call backs;
- 1.5 extra days of annual leave just for APEX members!

MITs at Pacific Radiology Group (PRG) in Wellington have been highly proactive and got the ball rolling on reaching a **National Collective Agreement with PRG.** Bargaining is set to begin on 21 November 2018 and key claims are for weekend penal rates, weekly overtime, and a clearer salary step system with an across the board pay increase.

The more PRG MITs participate the better, so if you work at PRG be sure to get involved and encourage your colleagues to join the union.

MIT vs MRT: What's in a name?

You probably will have noticed that this newsletter has been referring to MITs as opposed to MRTs.

This change puts us more in step with the New Zealand Medical Radiation Technologists Board's defined scopes of practice and also with the reality on the hospital floor. Technological change has already required most of you to begin working across modalities and beyond radiography. This trend looks set to continue, if not accelerate.

Like APEX on Facebook

Talking about Medical Imaging Technologists rather than Medical Radiation Technologists is therefore a logical change for the profession. It is more inclusive and reflects the reality that collectively you are experts at providing top-quality medical imaging across a wide (and widening) range of modalities. Visit the MIT page on the APEX website here.

Systemic Under-Staffing

One of the major bones of contention for DHB MITs heading into MECA bargaining is the chronically low staffing levels the DHBs have allowed to persist despite the ever-increasing demand for medical imaging services.

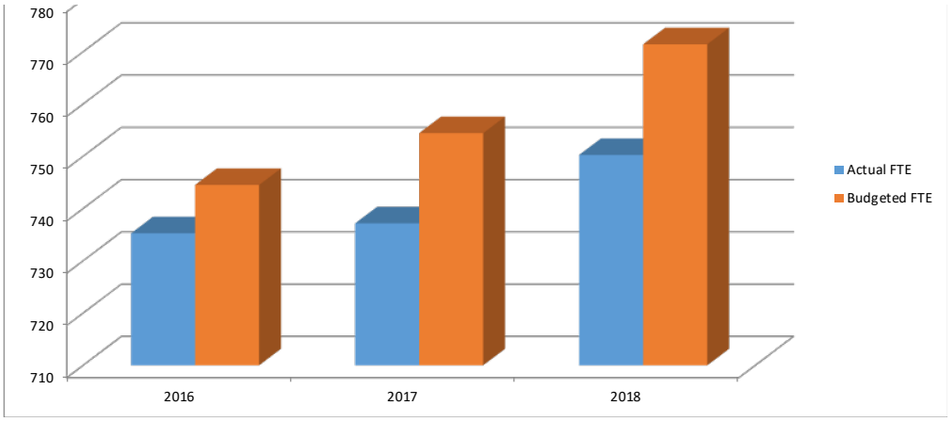
There are a whole slew of reasons for the increase in demand: more frequent MRI requests, technological advances such as intra-theatre cone-beam CT and angiography machines, a growing population, demographic changes and higher numbers of acute presentations, the list goes on…

So, nowhere near enough MITs and Trainee MITs are being hired and retained to keep up with demand. How did it come to this?

The reality is that the DHBs have been systematically adding fuel to the fire by prioritising short-term savings over planning ahead to anticipate future needs and to meet the growing demand.

- APEX has repeatedly warned the DHBs that MITs will soon face a workforce crisis if the DHBs don't drastically up their game on staffing and make sure that jobs are being made available for new trainees to step into the public health sector. They have taken no bold action.
- Faced with constant growth in demand for MIT examinations, the DHBs have been increasing their FTE budgets on paper but still hiring under-budget to save money.
- To meet growing demand with chronically under-staffed departments, the DHBs have turned to squeezing as much productivity as possible out of current employees – this has driven the years-long upward trend in total examinations per FTE despite major under-staffing.

Hiring has not kept pace with FTE budgets



What are the results of all these flaws? You and your colleagues are working more for less, feeling the extra pressure on the hospital floor, and being put at greater risk of fatigue and burn-out.

This is why the APEX Bargaining Team will be fighting fiercely for better hiring practices, safer staffing, and, most importantly, paying MITs properly for the extra work they are already doing!

Wait Times for CT & MRI

The NZ Herald's recent article "Increased demand prompts surge in delays for CT and MRI scans at Waitemata DHB" is just the tip of the iceberg when it comes to growing waitlists for CT and MRI.

The number of referrals for CT and MRI exams keeps growing and this means that the status quo around staffing and rostering is rapidly proving to be unsustainable. The prime example may be Capital and Coast DHB, where an additional MRI scanner has been installed, but they simply lack the staff and duties necessary to keep all of their machines in use. With multiple DHBs already hitting wait times of several weeks, and some with months-long wait times, change is needed to avert a full crisis.

This is why a significant part of our DHB MECA bargaining will be focused on raising staffing levels across the board, maintaining our competitive levels of remuneration, and ensuring that we are funnelling New Zealand trainees into workplaces with tutors who are valued for their work under the new pay scale.

In saying that, the reality is that the compounding growth in demand is so huge that techs should be readying themselves for DHBs looking to add night and weekend duties to their rosters to keep up.

Send your suggestions on how any new night and weekend duties for CT/MRI should be recognised under the MECA to mit@apex.org.nz.

BARGAINING ON THE BOIL

There's a lot happening at the moment with APEX Anaesthetic Technician bargaining across the country. Let's take a look across the DHBs and see just what's going on.

The DHBs' Stance

Many of our sites have been negotiating for almost a year now. During bargaining the DHBs consistently told us the nurses' settlement would flow on to us. We have been patient and waited.

Unfortunately, the DHBs now tell us they can only offer a settlement based on the nurses' second offer – a total annual cost of 2.43%. This compares poorly against a nurses' deal, which included 3% pay increases and extra automatic steps, meaning most nurses would receive increases of 12% to 15.9%.

It should be noted, too, that the 2.43% offer for ATs includes the increases in on-call pay, which means the actual salary increases would be less than that.

"Promises and deadlines come, and then they go."

We've told the DHBs this is unacceptable: our members expect the same offer as the nurses. The DHBs now repeatedly tell us they cannot agree to this, and as a result we are discussing options for industrial action.

Industrial Strength

Anaesthetic Technicians in New Zealand are in a strong position. There has been a chronic shortage of ATs for some time now due to (among other factors) poor attention to training by the DHBs.

The problem is particularly acute at the moment. A search of seek.co.nz in mid-September found 19 advertisements for ATs – with more than one employer looking to fill multiple vacancies. We have had it confirmed that there are 57 AT vacancies nationally.

"We have had it confirmed that there are 57 AT vacancies nationally."

Northland DHB is 4 FTE down at the moment, and have been unable to recruit to fill these vacancies. And, as reported by Stuff on 14 September, Auckland DHB has 117 budgeted AT roles, 34 of which were vacant, being covered by overtime, additional shifts, or agency cover.

"There's never been this number of AT vacancies in New Zealand before."

Meanwhile, advertisements are directly targeting UK-based practitioners, a clear sign that something is broken with the system in New Zealand.

The Private Sector

The AT landscape is complicated by the effect of the private sector. Kensington Hospital in Northland is reportedly paying ATs $80,000 pa as a started rate, some 15-30k above the DHB salary. Kensington also offers a 3k retention bonus for ATs. This salary and bonus scheme is a direct response to the difficulty they face in recruiting and retaining people in this specialised and critical role. Meanwhile, Southern Cross Hospital in Rotorua has just agreed to a pay increase for ATs of 6.4% for a 1-year agreement.

Nurses Covering ATs

In some DHBs, nurses are working in AT departments as ATs, either as regular practice or to cover shortages. It's hard to see how the DHBs can agree to pay nurses around 77k (the top of their automatic steps after their new settlement kicks in) to do this job while refusing to match this rate for ATs.

Straight Talking?

As mentioned already, APEX has been told that the government has not agreed to flow on the parameters of the nurses' settlement to other professional groups in healthcare. However, a recent communication from the PSA has claimed that their members will be getting the "same or similar" settlement to the nurses.

Precisely what "same or similar" means in reality is unclear, but the implication is that the DHBs and the government are not dealing equally and honestly with the different unions operating in the healthcare sector.

"The day that I heard about the communication from the PSA I was in bargaining at Lakes DHB, where I was being told there would be no flow on."
— Luke Coxon, APEX Advocate

This is unacceptable. What we've been told in bargaining is quite different from the apparent reality. It's time to start taking action.

Welcome Mercy ATs!

Welcome to anaesthetic technicians at Mercy Hospital, Dunedin, most of whom have joined APEX in the last week and are getting ready to negotiate a new collective agreement.

Compliance Issues

Footwear for theatre

The Health and Safety at Work Act and our collective agreements require employees be provided free of charge by their employer all protective clothing, footwear and equipment. Working in theatre we are often exposed to blood, bodily fluids, needles and other potentially dangerous bits and pieces dropping on our feet. Because of this, it is important the employer provides you with suitably protective and washable footwear at no cost to you.

On duty during meal breaks

The standard clause in collective agreements for meal breaks states that if you are unable to be relieved from the workplace for a meal break you shall be entitled to have a meal while on duty, and this period shall be regarded as working time paid at the appropriate rate. It is commonly the case that anaesthetic technicians must remain on duty during times when other staff would ordinarily be able to take unpaid meal breaks and leave hospital grounds. If this is the case for you, then your employer may owe you backpay for hours spent on duty but for which the time was treated as an unpaid agreement.

How to raise issues

If you have not been provided with footwear or are not being paid appropriately during meal breaks, raise the issue in writing with your charge tech and delegate in the first instance, and direct with us in the second by emailing at@apex.org.nz.

facebook.com/APEXUNION

Across the country

Along with the action being taken in Lakes DHB, there is also activity across the rest of the country for ATs.

Northland

In Northland we were promised an offer in line with the nurses: it hasn't come through.

"Northland DHB has cancelled 12 surgical lists due to lack of ATs in the last 2 months."

We've deferred stop-work meetings twice already after promises from the DHB Chief Executive that we'd receive offers in accordance with the nurses', and would also deal with recruitment and retention issues. However, it was disappointing that an offer of only 2.43% came through.

The Northland stop-work meeting went ahead on Friday 14 Sep, with the decision to begin balloting for industrial action.

"Northland had to cancel four elective surgery lists to accommodate the AT stop-work meeting. Is there any clearer sign of how central ATs are to

Nelson-Marlborough

We have a roster review process underway in Nelson-Marlborough DHB at the moment. ATs there are understaffed, and are having to work unsafe rosters. This is ongoing, and we will be back in bargaining on Oct 1.

Mid-Central

We had a bargaining conference call in early September. They confirmed that they would not be matching the nurses' settlement for ATs, but they said if the parameters had shifted they would be back in touch. We have another call scheduled for Monday 17 September to confirm what's happening, and we will update you on the outcome of that meeting shortly afterwards.

Canterbury

We've asked for bargaining dates in Canterbury DHB, and are waiting for these to be confirmed.

Hawke's Bay

In HBDHB we've had two days of bargaining, and the DHB was adamant that all they could offer was the annualised cost of settlement of 2.43% we've been hearing so much about. Hawke's Bay said they would give us an offer this week: again, this hasn't come.

Regardless, the 2.43% does not meet the members' expectations. We've had a look at how we might restructure their pay scale, but we've gone back to them since we've heard about the PSA communication: we await their response.

Southern

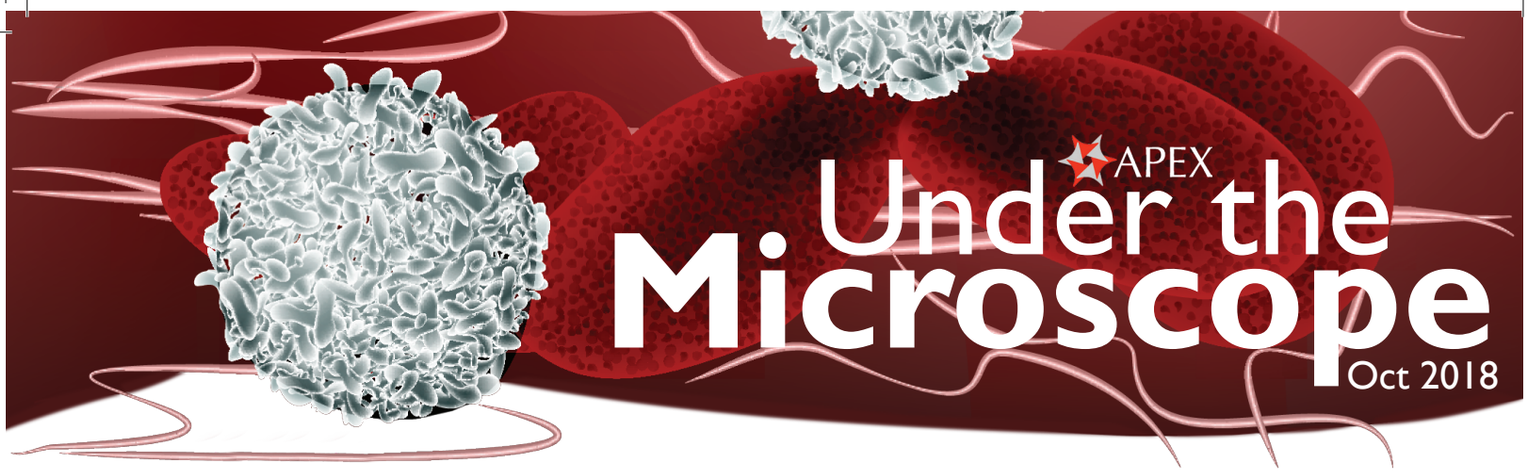
Dunedin ATs will have a stop-work meeting on Tuesday 2 Oct at Dunedin Hospital (08:00 to 10:00), and Invercargill ATs will meet on Wednesday 26 Sep (time to be arranged).

Show Your Support

With industrial action looking likely in several locations, please send notes of support and solidarity for your AT colleagues through to luke@apex.org.nz. If the ATs achieve a breakthrough, it will be better for all members across APEX.

On the move

The bargaining landscape for ATs is changing rapidly: things are on the move. Also on the move is Luke Coxon, APEX Advocate for ATs. In the last week he's visited four DHBs to discuss their specific issues, which means that at the moment he's often not in the office. He remains available by email, however. And, as always, you can go directly to your local delegate with any questions or concerns, and your delegate will be able to get in touch with Luke if there is something urgent.



SCL & Pathlab Lakes Bargaining

Two of our major private-sector laboratory employers have been in bargaining recently. Both collectives expired at the end of June this year.

We have met with both sets of employers and had constructive negotiations. In each case it was important from the outset to set the tone that we are in a 'new world' of bargaining. Now that the long-running NZNO dispute over the nurses MECA has been resolved, the parameters for bargaining have opened up a little: there are now justifiably higher expectations amongst other health sector employees for much bigger pay settlements than has been the case over the last decade. The reasonableness of these expectations has been confirmed by the announcement of a similar settlement of the long-expired PSA collective agreements with DHBs.

However, DHBs are trying to push back. At the time of writing it appears that although they are prepared to make offers on APEX collective agreements broadly similar to those for nurses and the PSA, they are refusing to acknowledge the flexibility required to settle our profession-specific documents. Nowhere is this more clearly demonstrated than with the current disputes over anesthetic technician bargaining. APEX is not about to sit back and allow settlements with other unions dictate the shape of settlements for the groups we represent.

Pathlab and SCL are both private sector employers so there is even less reason to have to conform to a particular shape of settlement arising from other unions' settlements with DHBs.

At SCL it took the threat of a one-day strike to bring the decision-maker to the table and then to make an offer that could be considered by members. That offer included a straight 24-month term with backdating, 3% increases for each 12 months, the application of T1.5 between 8.00pm and 6.00am across all members, and 5 weeks' annual leave after 8 years' service for everyone (noting that some parts of the business get 5 weeks and/or 4.6 weeks earlier than 8 years' service and this remains protected). Whilst those are important breakthroughs, and the proposed settlement has now been ratified by SCL members, there is still work to do. The issue of being stuck at the top of the automatic steps, and there being little movement beyond that into merit payments, remains a work-in-progress during the term of the new Agreement.

Meanwhile at PathLab an offer of a 28-month term with 3% at the beginning and a further 3% halfway through has been rejected by members and we are waiting on a revised offer from the employer.

The SCL bargaining team. From left to right, front row: Spencer Walker, Justine Young, Mandy Moore; 2nd Row: Natalie Dick, Lynda Hampton, Anna Behringer; Back row: Adrian Joshi, Grant Cook, Brice Thomson.

MEDICAL LABORATORY WORKERS

DIVISION OF APEX

MedLab News

Medlab Central

Welcome to Medlab Central lab workers who have joined APEX and are in the process of organising delegate representation across their workforce. We are aiming to meet with members at the Palmerston North hospital based laboratory in mid-November prior to initiating bargaining for their new APEX collective agreement.

Taranaki Medlab

Taranaki Medlab members are set to hold a stop work meeting on the 23rd October to discuss proposals for bargaining process arrangements and to finalise their claims to take to bargaining with their employer for their first APEX collective agreement.

Pay Equity

As you may be aware, APEX has raised a pay equity claim for a subgroup of Medical Laboratory Pre-analytical Technicians (MLPATs) – phlebotomists – during bargaining with Southern Community Laboratories (SCL). We will continue to raise this claim for other APEX laboratory collectives as they are bargained. However, there may be still more to be done for Medical laboratory practitioners across the board.

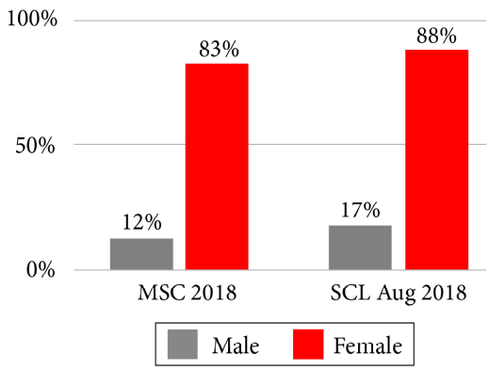
Pay equity has been firmly on the political agenda since the 2014 Court of Appeal decision in Terranova versus the Service and Food Workers Union. That decision held that the Equal Pay Act 1972 not only provided for equal pay between men and women doing the same work but also for pay equity between occupations doing work of equal value. After the decision, the government set up a joint working group on pay equity principles to establish a procedure for workers and their employers to use to resolve pay equity claims.

Since then, unions representing workers in a number of occupations largely staffed by women, such as education support workers, carers and mental health and addiction support workers, have successfully made pay equity claims to win pay increases.

However, pay equity is still a widely misunderstood concept. The following points hope to clear up some basic facts around the concept so members understand our pay equity claim for phlebotomists.

- A pay equity claim is a potential way of improving pay for all workers, irrespective of gender, in jobs where women have traditionally made up the majority of the work force.
- Research shows that occupations where most workers are women are typically underpaid in comparison to work of equal value in occupations where most workers are men. Pay equity is the concept that work of equal value deserves pay of equal value.
- Workers who believe their work is underpaid because it is work largely done by women can have their union make a pay equity claim. When workers make a pay equity claim their employer must respond and negotiate with the union to resolve it.
- Pay equity claims are mostly resolved when employers increase the pay of workers in the female-dominated occupation to bring it into line with higher pay enjoyed by workers in occupations of similar value (similar level of qualifications, level of responsibility, etc) in which men make up the majority of the workforce.
- If the claim is not resolved in negotiation it may go to the Employment Relations Authority – which can make a determination to ensure pay equity.

Gender Distribution of Med Lab Technicians including MLPATs



Whilst the data are currently insufficient for us to ascertain precisely the number of MLPATs, and among them the number of phlebotomists, the above chart clearly indicates that the medical laboratory technician profession in New Zealand is predominately female-based.

Technician Salaries

	Pay equity	Min wage	Pay equity	Pay equity	Min wage
Years of service	1 July 2018	1 April 2018	1 July 2019	1 July 2020	1 April 2021
12+ or level 4	51107		53193	56322	
8+ or level 3	46935		47978	52150	
3+ or level 2	43806		44849	47978	
Less than 3	41303	34419	42763	44849	41720

Pay rates for care and support workers after achieving pay equity versus minumum wage, projected over time.

Medical Laboratory Technicians (MLTs) are paid a qualified technician rate of between $42805 and $46194 with an ability to move automatically up the salary to between $49565 and $51128 – depending on who you're employed by. Work conducted by SCL with ARA (Institute of Technology – Canterbury) was presented at recent bargaining, and has placed the MLT qualification at Level 6 on the NZQA framework and the MLPAT qualification at level 5. When compared with the recent pay equity settlements for care support workers, mental health support workers and Oranga Tamariki social workers, we can see that current qualified technician entrance salary rates are very close to the minimum wage and the entrance rates for unqualified workers, and for a level 4 qualification the rates are comparable now but will become higher than the top of APEX technicians' (after at least 3 years qualified) automatic steps by 2020.

Where to From Here?

Over the coming months we will be gathering the research and documentation required to make the claim, and then ensuring we pursue a pay equity claim in bargaining for the APEX collective agreements that cover phlebotomists.

	DHB MECA	SCL MECA	NPL	PathLab Lakes	Pathlab	TLab	PSA WSCL
	7 Sep 2018			1 July 217			
Supervising Technicians	60422						
	58303			61483			
	56446			59206			
	7 Sep 2018	1 July 2018	1 July 2017	1 July 2017	20 Jan 2018	6 Sep 2018	1 Sep 2018
		62008					
Technician Merit		59286				58017	59877
	54068	56568			55,418	55696	56552
	51816	53843			53,107	53375	52652
		51128	Range of rates: min $1k increases	50098	50,798	51053	50702
Technicians Autos	49565	49497	$47,973	47821	48,490	48733	46804
	45057	47866	$45,307	45544	46,181	46412	43680
	42805	46194	$42,749	43266	43872	44,092	

Pay rates for MLTs on various collective agreements.

Welcome!

In addition to APEX's *TO THE POINT* journal, we thought it would be of value to you if we generated a semi-regular Physiotherapist Division Newsletter. So, welcome! If you have any questions or comments please email us at physio@apex.org.nz – we would love to hear from you.

2018 Workplan

From now up until the end of the year (which is fast approaching…) negotiations are the priority (see below for bargaining updates). This is where our energy will be focused. However, APEX also wishes to increase our engagement with Physiotherapists – these targeted newsletters are a good place for us to start. It is important that you are empowered as employees, and to assist with this we are in the process of creating a SECA (Single Employment Collective Agreement) FAQs section on the Physiotherapist Division of the APEX website. This will be a great place for your to go to get clarification around your entitlements and to find quick answers to common questions and problems. So watch this space! Another piece of work we are going to do is a general comparison of our three current collectives (Northland DHB, Bay of Plenty DHB and Waikato DHB). We will carry out a preliminary investigation into a pay equity claim for Physiotherapists – this is not a straightforward matter by any means, but will be worth looking into.

Bargaining Update

Northland DHB

The NDHB SECA is currently in term and is not set to expire until October 2019. However, APEX has recently requested a variation to the agreement to help address the issue of increasing workload in the weekends, and the impact this is having on work-life balance of the Physiotherapists as well as being able to respond to service demand and patient care imperatives. We are in touch with members about amending current hours of work and associated provisions. We will have more to report in the next newsletter.

Bay of Plenty DHB

The BOPDHB SECA expired on 26 July 2018. We have met with the employers for bargaining twice now. We are set to meet for negotiations again next week on 3 October at Tauranga Hospital, and have scheduled a meeting with the members (face to face and via video conference) afterwards, during which we will update you and discuss where to from here. We have yet to receive a formal offer from the employers.

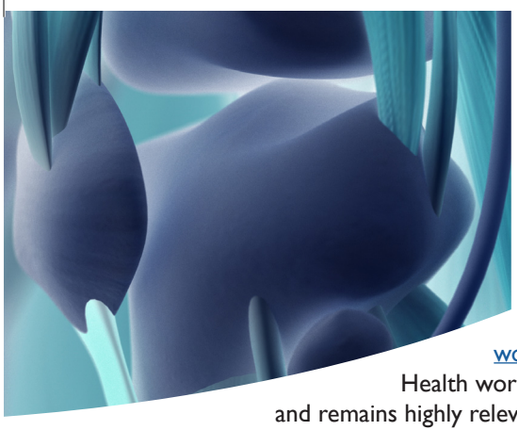
Waikato DHB

The Waikato DHB SECA expired on 28 April 2018, and we have met with the employers for bargaining twice since then. We had a meeting with members following the last round of negotiations at Waikato Hospital to provide an update. We have not received a formal offer from the employers and we have a third date for bargaining tentatively set.

SECA FAQ: Sick Leave

DO I NEED TO PROVIDE A MEDICAL CERTIFICATE IF I TAKE SICK LEAVE?

You may be required to provide a medical certificate or other evidence of illness to the DHB. However, if you are sick/injured for less than three days and you are asked for proof then the DHB covers the cost of getting the proof e.g. visit to the doc. If you have queries about this let us know.



Workforce Assesssment Report

We're taking a look at the key findings of New Zealand's first ever Physiotherapist workforce assessment. Even though Physiotherapists make up one of the largest DHB Allied Health workforces, Technical Advisory Services Ltd (TAS)'s April 2017 report was the first of its kind and remains highly relevant. Key findings of the report are given below.

The (slowly) changing face of the workforce

- We remain a majority female workforce (87.8% at April 2017), but there is an increasing number of males among new entrants and newly enrolled undergraduates.
- The under-representation of Maori and Pacific practitioners at only 2.7% remains an issue. The general population figures are around 22.5% and growing.

Growing demand

- Demand continues to grow, driven by an aging population presenting with a higher frequency of complex conditions, co-morbidity, and chronic illnesses. In particular, demand for community-based care and pre-surgery assessments and physiotherapy as alternatives to orthopaedic surgery is growing.

Long-term shortages of experienced/specialist physios

- Compared to 2011, the mean length of service is up from 5.4 to 6.2 years.
- However, the DHBs (and especially the regional DHBs) report difficulty in recruiting experienced and specialist physiotherapists. This is a significant challenge given the demographic forces driving chronic conditions, complex trauma and neuro-rehabilitation.

Operational flexibility

- DHBs are also reporting a rise in inter-discipline substitution as physiotherapists, particularly in community settings, take on tasks traditionally performed by occupational therapists and nursing staff. Likewise, we are seeing some low-level physiotherapy work being conducted by allied health assistants.
- This will be a space to watch – delegating more low-level physiotherapy tasks to allied workers could be one way in which the DHBs seek to free up specialist physiotherapy care to meet rising demand amid the ongoing long term skills shortage.

We look forward to hearing about your own experiences of change in your workplaces. Please contact us at physio@apex.org.nz

Delegate Interview: Nikki Laker

Your delegates do a fantastic job and APEX could most definitely not function as well as it does without them!

Nikki Laker, a National Executive member and delegate, recently spoke about leadership at the APEX delegate training held in Auckland. She is a natural leader and a true advocate for Physiotherapists. If you have any questions for Nikki please do not hesitate to get in touch with her.

Where do you work and what do you do?

I have worked at Waikato Hospital for over 20 years as a physiotherapist. I work in acute paediatrics in the Neonatal Intensive Care and Paediatric Medical and Surgical wards. I work with babies through to 16 year olds. Mostly my focus is respiratory physiotherapy; however, I also provide mobility and rehabilitation interventions.

How did you become a Physio?

When I was in school I volunteered to help run a community programme working with children who had difficulties with co-ordination and physical activities. I really enjoyed working with these kids, and pursued this in my career. Although the majority of physiotherapy training and rotations as a new graduate involve working with adults, I knew that my long-term aim was to work with children.

What do you enjoy most about your job?

Working with children is challenging but so rewarding. I have a respiratory focus, and some of the children I work with are extremely unwell. It is a real privilege to work with families of these kids, and feel that my input can make a difference to them. Children are so resilient, and we can learn so much from them.

How did you come to be a delegate?

A small group of us took it upon ourselves to lead the change from "another union" who we were dissatisfied with. We knew that APEX represented the MRTs at Waikato and that they may be an option for us. We approached APEX, Dennis came to talk to us, and we became the first physios to join APEX. As someone driving the change, I naturally fell into a delegate role and also that of division president. I have changed from full time to part time in that time and have considered stepping down from the role but I care about the staff's rights too much to do so.

What is bargaining like?

I have been involved in many rounds of bargaining, and I enjoy the process. Because we are a SECA, we as delegates get to contribute quite a lot to this process. Over the years APEX has worked with us to better our terms and on the whole we have had positive outcomes. Our current contract has expired and with the climate as it is this may be a different story this time around! However, in saying that I'm sure we will work to present as favourable an outcome to our members as we are able.

What issues will the Physiotherapist workforce face in the future?

The main issue is the push towards a 7-day service in some inpatient areas. This is already happening in many DHBs, and with any new services or wards being opened, the expectation is for more allied health staff working longer hours across 7 days. Unfortunately, there continues to be a huge problem with staffing shortages throughout NZ, and so the push is being made without the staff to support it. As for so many professions in health, we struggle to provide a traditional Monday to Friday service. It's hard to see what the solution is to this problem – but more money would help, hahaha!

Thanks Nikki!

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