2019 ANNUAL GENERAL MEETING

SECRETARIAT REPORT

Welcome to the 2019 Annual General Meeting of APEX.

MEMBERSHIP

APEX membership has continued to grow.

APEX strongly supports the right of employees to choose who should represent them. Providing information to enable an informed choice is our goal when approached. Ultimately, taking the step to join requires a decision and action, both on behalf of an individual and usually a group of people: this is not as easily achieved as it might sound. We often find something is needed to precipitate increased motivation that otherwise would not have been strong enough to make the change happen.

This year we have welcomed members of the trades group in Waikato DHB: this group have some alignment with our biomedical engineers. Psychotherapists have also joined us this year as have more DHB based pharmacy groups and anaesthetic technicians and we have had our first PHO members join us from Mahitahi Hauora in Northland. Whilst we have also met with Southern PHO members, they to date have not progressed joining up.

A number of new private sector sites have joined from the laboratory area including Medlab Central in the Manawatu-Whanganui region as well as Taranaki Medlab. Biomedical engineers and dietitians also from the Manawatu-Whanganui region employed by Spotless have also joined us as have anaesthetic technicians from Acurity (Wakefield, Royston and Bowen Hospital) and MITs in Bay Radiology, PRG and Northland amongst others.

Conversely in July 2018 the Radiation Therapist member's at Capital and Coast decided to leave APEX and join the PSA. The PSA did not suggest that they could do better in the negotiation of terms and conditions of employment than APEX. To their credit they

acknowledged how successful RTs had been with APEX and did not suggest they could improve on that. A potential impact of this decision however could have been the fragmentation of the RT MECA, a matter the Wellington RTs were aware of at the time. In 2019 we subsequently negotiated two collective agreements for radiation therapists: one for Auckland RT members and a second one for Southern, Canterbury, Midcentral and Waikato members (more about this in the divisional reports).

BARGAINING

As we wrote last year *"… has been punctuated by on-again-off-again frustration of bargaining as the NZNO DHB MECA dispute dragged on and on. Whilst now the subject of strike action, for almost a year we have been subjected to many negotiations being negatively affected by surface bargaining (going through the motions) on behalf of the employers. APEX has had 22 collective agreements "held up"."*

NZNO did finally settle, but not without some fallout a topic we will briefly review in the next section. As far as bargaining was concerned, whilst this progressed once the NZNO settlement occurred it was still very slow and dogged by an employer's position that "one size fits all".
We also faced a view at government level that there would be no "flow on" out of the nurse's settlement. How this view came to exist is not known to us, but it doesn't stand even the most casual of scrutiny from an industrial perspective.

The PSA was next to settle, and for all intent and purpose for the same as NZNO. However, the PSA also picked up gains we had made within some collective agreements; the most notable being the DHB Laboratory MECA. During term of this agreement within the Lab-DHB partnership programme we had worked to improve salaries for our technicians and others. These improvements had been implemented during the term of the agreement, but the variation required a slightly longer term being applied. During bargaining with the PSA these benefits were passed on without any requisite downside.

This "preferred" treatment of the PSA has been an ongoing feature of our bargaining for some time: from handing over the improved terms and conditions of many of our settlements, in some cases such as the Physicists holus bolus, to this year attempts by the DHB to drag back better terms that we had secured to the (lesser) PSA "standard" in for instance our Anaesthetic Technicians and Pharmacists SECA bargaining.

The DHBs basis for their position was a desire to have the same terms and conditions across the entire DHB sector for the same group of workers. The lesser terms and conditions were preferred by the DHBs where they thought they could achieve such – as in SECA bargaining. If this position continues as we expect it to, we will need to look to MECAs for our divisions, so the same terms and conditions do prevail – but the better ones. Both ATs and pharmacists will be pursuing this objective in 2020 and others may join them.

As for the benefit of partnership, if the Laboratories experience is anything to go by (and we suggest it is) we must approach ongoing constructive engagement with caution as far as DHB employers are concerned. When the result of such is disadvantage for our members, we will have to withdraw.

Following on from the PSA settlement however flow on to our outstanding agreements was still not a given. Over the summer of 2018/2019 Central TAS on behalf of the 20 DHBs sought permission to flow on the settlement parameters to APEX – this process took 3 months. The culmination resulted in immense frustration for our membership and inevitably boiled over into strike action.

At the same time the competence of the DHBs advocacy team suffered. Experienced advocates left to be replaced with new advocates some of which came from the DHBs and whilst good people the step up to national bargaining under such constrained conditions made life very difficult. Even the remaining experienced practitioners started to buckle under the strain.

Our relationship with the employer's advocates is a professional one as it should be. We both have a representative job to do and that job is all the easier when both parties have the authority and support at the table to undertake the task. As the employers advocates increasingly found themselves tied up with multiple lines of accountability to report to and from, bargaining became more and more of a shambles. The worst example saw the employers do a complete U turn in MIT bargaining after 8 months of constructive bargaining and when we were (we thought) close to settlement.

Having competent practitioners on "both sides" is critical to efficient, informed and effective processes. What should have been simple matters have increasingly turned into prolonged disputes as we faced more of an "any excuse to say "no" approach, than reliance on the plain

meaning of the words (in the case of agreement interpretation) or legal precedent in the case of disputes of right or personal grievances or just common sense or even a concern to do the right thing.

We have none the less caught up with outstanding bargaining and continue to progress disputes and defend members. The stress of the past year has however taken a toll on both members and advocates as well. Trying to ensure advocates get breaks from the relentless stress of bargaining in such an adversarial environment, whilst having said same bargaining dragging on has been challenging and has required other advocates to cover for periods. Whilst disruptive this cannot be helped if we are to ensure our own representatives are well and able to perform to their best. There have regrettably if understandably been some frayed tempers during the year which occasional have spilled over in bargaining itself.

Outside of DHB bargaining however, things have progressed more smoothly. We now have non DHB sector agreements for anaesthetic technicians, dietitians, biomedical engineers, MITs and laboratory staff. We will embark on our first PHO collective agreement in Northland shortly.

Whilst some MIT employers have been deliberately obstructive and undermined our efforts to secure collective agreements for members, most negotiations are productive. Improved conditions over the DHB sector such as T1/2 night rate in private laboratory agreements, are agreed in a more pragmatic approach as often employers respond to workforce and workplace pressures.

APEX STRUCTURE

Before we review the discussions, this year surrounding our own structure, a quick consideration of the issues affecting NZNO are in order. Internal NZNO conflict marred their bargaining in 2017/2018. A review of the bargaining conducted by Ross Wilson referred to:

- Members feeling distanced from the bargaining so much so they became concerned that their union was “too close” to the employers and not representing the members interests. NZNO had come to believe that communication with members during bargaining breached an obligation of good faith to the employers as a result of the Health Sector Relationship Agreement (to which all CTU health unions are party alongside DHBs and the Ministry of Health). This agreement talks of constructive bargaining and relationships with the employers.

- A lack of effective communication saw members taking to social media including some vicious personal attacks being made.
- 5 offers were put to the membership and rejected, 2 despite NZNO endorsement and the process of decision making at meetings felt to be a deliberate mechanism by NZNO to get settlement despite what nurses wanted. NZNO only moved to electronic balloting in the latter stages of the dispute.
- A failure of NZNO to adapt their model of bargaining in response to changes in environment including the employers position, and a failure to prepare for strike action resulting in contingency planning for life preserving services providing more nurses during the strike than would necessarily have been on duty in the absence of strike action.
- A failure of NZNO to respond to members concerns about CCDM that were apparent from the 2015 bargaining and continued to grow in the subsequent 3 years.

NZNO also suffered a divide between the elected president of the union and the industrial team and Board which as this report is finalised is heading to a special general meeting of NZNO to decide whether the president should be removed from office.

The leadership conflicts NZNO suffered as well as their approach to bargaining has left this union with considerable rebuilding to achieve. The lessons from their bargaining a timely reminder of how important it is to get the fundamentals right and importantly the role of the union to effectively communicate with and represent its members.

In 2018 (and unrelated to NZNO) consideration started to be given to our own structure and whether it was effectively supporting strong democratic process and efficient, nimble functioning.

Our divisional structure is a fundamental strength with each division holding a degree of autonomy over their activities. Each Division has a President and a Secretary (collectively known as the divisional executive) elected from amongst their members: The Presidents sit on the National Executive alongside the 4 nationally elected office holders. The day to day functioning of the division is largely left to delegates in conjunction with their advocates.

This has resulted in the National Executive which is responsible for the functioning of the union between AGMs comprising up to 28 members.

Our challenge is that as APEX has grown, we have been struggling with ensuring efficient decision-making in a timely fashion of what is now an organisation of significant size and complexity.

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

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

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

Whilst there is no question these people are doing an outstanding job it is quite a responsibility for which more immediate support would be valuable and ultimately from a good decision-making perspective, appropriate.

A proposal emerged to form a new structure (the National Divisional Council or NDC) comprising both divisional presidents and secretaries in a council type setting and chaired by the National President, that would meet twice a year to discuss in depth the broader trends and bigger picture issues affecting us or likely to affect us. This would also give the opportunity for the different divisions to share knowledge and improve communication and our collective knowledge base. This group would be central to forming and confirming

APEX's strategic plans, evaluating performance against those strategies and plans and of course adapting as necessary.

The national executive would be responsible for implementation and day to day decision making and would be pared back to 10 members:

- The current 4 nationally elected positions (National President, Vice President, Executive Secretary/Treasurer and National Secretary) elected from the membership as a whole for a 2-year term, with 2 of the 4 coming up for election in alternate years to provide continuity.
- 6 members of the NDC would be elected to a national executive. These individuals would not operate on divisional representative lines for the purposes of their national executive role, rather provide a spread of views and skill sets that could manage those operational and decision-making issues that arise during the year. Support to the President and Treasurer in particular with respect to allocation of funding and investments, would be provided by this group but the NDC could also refer matters to the executive for consideration.
- We suggest a three-year term for these positions and that no division could hold more than 2 positions on the national executive at any point in time to ensure breadth of participation.

This proposal was circulated to the membership in early 2019 and is the subject of a motion to the AGM to progress.

COMMUNICATION SYSTEMS

Effective communication is vital in any union. This year we employed more communication resource and revised our platforms with a new website commencing operation earlier this year.

Our facebook page whilst slow to get going, we hope will gain further traction with members as we advance initiatives in this space. A new journal format and regular update videos have also been introduced. Whilst the videos were started as a quick mechanism to update members on all the bargaining that was ongoing, with bargaining settling down, the success of the video's has demanded they continue but looking to more general big picture issues that members might want to think about or simply catch up on. In recent video's we covered such topics as the launch of our eco-friendly cups for members, the remediation and rectification of the Holiday's Act noncompliance in DHBs and the Health Sector Review findings (leading to recommendations in March 2020).

We are also working on mechanisms to provide more information and support to students in the various tertiary education programmes that produce our future colleagues.

INDIVIDUAL DISPUTES

We successfully engaged with ADHB this year to ensure MIT students were paid as per the MECA for their work. This has led to a wider discussion about the use and employment of students in the MECA bargaining so that going forward, clarity around what is supervised training and what is work and therefore entitled to payment, will exist.

The biggest individual success APEX achieved in 2018 was an outcome to for Kerryn Glasson. Kerryn is a cardiac sonographer working at Southern DHB. The DHB preferred to pay Kerryn as a physiologist; we contended that as a sonographer she should be paid as such which equated to a considerably higher salary.
We were proven right but not before we had to traverse mediation, an Employment Relations Authority hearing and finally the Employment Court.

Kerryn stayed strong and committed to the case throughout; no mean feat given how long it took, the number of hearings she had to preserver with and evidence against her she had to endure. We all owe members like Kerryn a vote of thanks; without individual members prepared to take a case, we are sometimes hamstrung at getting compliance.

And for all those cardiac sonographers who now benefit from the decision, possibly an even bigger thanks.

These types of cases are expensive; however, they are important to take. What is the point of a union that can't enforce a member's collective employment agreement let alone the right to a healthy and safe workplace free from discrimination, sexual a harassment and the like?

Which takes us to bullying. This plague continues to impact on members but possibly more so a "toxic workplace environment". Health practitioners are very accommodating and forgiving. You focus on patients and put up with management refusing to comply with your rights, let alone fostering a safe and healthy workplace. We still have far too many toxic workplace environments where members put up with, or maybe more accurately don't feel able to stand up to, poor management behaviours.

The fact that the DHBs don't have enough money but they still want more and more service delivered is somehow made staff's responsibility to address by working harder, for longer, seeing more patients than we can reasonably cope with or at least while also taking care of yourselves. The DHBs latest concern about wellbeing is because we have lost that component of our working lives largely as a result of the DHBs own behaviours. And wellbeing responses to date have lacked resource or focus on why we lack wellbeing. An ambulance at the top of the cliff approach, putting the wellbeing of staff as a number one priority and as I often say, ensuring we care for staff so they can care for the patient, is sorely needed.

NATIONAL BIPARTITE ENGAGEMENT GROUP (NBAG)

We continued to engage at NBAG this year. Most recently we have faced a challenge to our purpose if, despite reaching agreement between the DHBs and unions, individual DHBs refuse to adopt the decision.

NBAG can't override the sovereign nature of the DHBs legal role; but having committed to NBAG there must be some onus on them to recognise its work and if not comply then tell us why they decide not to.

One of the most frustrating issues this year has been the use of Gmail (and other IT systems of communication) by members and particularly union delegates in the workplace. This stemmed from ADHB shutting out all access to Gmail preventing a significant number of delegates from accessing important union resources and support. Our workplaces are open 24 hours a day, 365 days a year so it was our view that enabling staff to easily access technology for reasonable personal use, and for discharging their obligations as employees under the Health Sector Code of Good Faith, is appropriate and in keeping with a modern 24/7 work environment was appropriate.

Accessing workplace technology is offered in recognition of a mature, respectful relationship between employer and employee as a requirement of the good faith employment relationships, and as a benefit (not a right) in respect of reasonable general personal use.

We agreed 3 principles:

- **Open Access:** that the DHBs will open up workplace technology to employees, with as little restriction as is practicably possible including
    - Local intranets
    - The Internet

    - Social Media
    - Third party e-mail providers
    - Wireless internet access for personal devices where this is available.
- **System Security:** we recognise that DHBs have a responsibility to maintain the security and integrity of their IT systems. This means that from time-to-time when a DHB faces a significant IT security risk, or any other unanticipated threat, there may need to be an immediate response that restricts access. In those cases, employees and unions will be notified as quickly as possible and normal access will be communicated on and restored as quickly as possible.
- **Consultation:** All organisational policies relating to the appropriate use of workplace technology should be developed and reviewed in consultation with staff and unions. Where security is not at immediate risk, any changes to workplace technology access should involve consultation with employees and unions, with as much notice as possible.

Ironically perhaps, the DHB whose actions started this process (ADHB) and despite their GMHR being a member of the NBAG subgroup that developed this policy, still refuses to comply.

On a related matter we also looked into the issue of DHB support for stop work meetings. Again, the rights of employees to freely associate and to attend stop-work union meetings were acknowledged as fundamental. And it was noted that by their very nature stop-work meetings will be more or less disruptive to the employer's business, but they are called from time to time because they are essential to empowering and enabling all union members to participate in the decision-making processes of the union.

Whilst a union will do its best to provide as much advance notice of any planned stop-work meetings as possible, we do so in good faith and in the expectation that employers will reciprocate this gesture by proactively working with the union in a responsive and communicative manner, as is required of them under s 4 of the Act.

It was agreed that it is incumbent upon both parties to facilitate the maximum possible attendance at such a meeting and the expectation that only a few, essential staff will therefore be absent from any stop-work meeting. We will monitor this agreement to see if it improves DHBs behaviour with respect to facilitating these meetings.

Other topics being progressed at NBAG (at our instigation) include

- Sexual harassment against staff by members of the public including patients;
- Domestic Violence Leave being applicable from day 1 of employment; and
- Ongoing work supporting vaccinations in the workplace.

REVIEW OF THE HEALTH SECTOR

In 2018 the current government announced a review of the Health Sector. This review excluded mental health which was the responsibility of a second report. We were interviewed by the reviewers early on in their considerations and have been again now the initial findings have been released.

We will not go into all the findings in any detail: for those interested we recommend you read the entire report as the Executive Summary, fails to do justice to the body of the report where the nuances will be found. However, some key messages include:

1. A lack of leadership at all levels.
2. A lack of cohesion and collaboration within services being delivered but also Union and employer relationships. The report noted that the HSRA (the CTU affiliated unions agreement with DHBs and the government referenced in the comment under NZNO above) has failed.
3. Focus on Maori health and rural health.
4. Focus of primary/community care rather than secondary hospital-based care.
5. Serious workforce issues but equally changes to the type of workforce and manner in which we will work.
6. A need to deliver 7 day a week services without the “slow down” of weekends.
7. Potential impacts of technology and AI on health

This review will potentially have far reaching impacts and may well for the basis of the current governments platform on health going into the next election. All members are encouraged to read it and consider its contents.

HOLIDAYS ACT COMPLIANCE

This process continues to drag on. We are now at the stage of rolling out audits in 4 waves, which will be following by rectification and then remediation.

Whilst we have agreement to backpay to 2010, members are still losing use of money owed to them as the DHBs drag their feet in getting this matter resolved.

We hope to be able to report next year that at least some DHB members will have started to receive their owed entitlements. And again by contrast, our private sector employers are all but finished, compliant and back payment made.

PAY EQUITY

It is expected that the government will pass its amendment to the Equal Pay Act to provide for legislated Pay Equity procedures before the end of this year. We have raised a pay equity claim on behalf of phlebotomists at all Laboratory collective bargaining since mid-2018. In mid-2018 Central TAS (Technical Advisory Services; the employers' Wellington based industrial services resource) established a Pay Equity unit staffed with two experienced practitioners seconded from the State Services Commission to deal with pay equity claims in the public health sector. The claims that the unit is dealing with so far include nurses, hospital clerical workers, midwives, and, more recently at time of writing, Allied, Scientific and Technical employees raised by the PSA.

The first three are quite well advanced in terms of investigating the nature of the roles being assessed and identifying appropriate comparators. The PSA Allied claim has not yet got out of the starting blocks and is unlikely to progress without some serious refining and paring back.

We intend to prepare and prosecute APEX pay equity claims with much more attention to detail and careful consideration of which cases will be most likely to be successful. As reported last year we are beginning with phlebotomists.

The principle underpinning a pay equity claim is that an occupational group is low paid not simply because they lack bargaining power and have miserable bosses, but because the group performing the work is predominantly female and that the work performed is perceived as 'women's work'. That being established it is then the systemic tendency of post-industrial society to discriminate against women in employment, and women's work in particular, that is the cause of the low pay.

It is worth remembering that systemic discrimination against women in the workplace has been around for a very long time. And until as recently as the passing of the Equal Pay Act in 1972 it was legal to pay a man and a woman doing the same job a different rate of pay.

That is not that long ago and achieving equal pay was only the beginning of the solution. The pay equity concept seeks to remedy systemic discrimination against 'women's work' by introducing a legal framework for considering the comparison of a female dominated

occupation with a male dominated occupation where the work may be very different but the skills, effort, knowledge, responsibility and working conditions that are associated with the jobs are similar. These factors are often referred to as the pay equity criteria.

At this stage then, with a view to the pay equity criteria above, APEX is investigating a pay equity claim that would compare phlebotomists with scaffolders. At first blush these roles appear to be very close in terms of the criteria, but even if the investigation found that a phlebotomist was equivalent to 90% of a scaffolder, that would imply a huge boost to phlebotomy wages that are currently barely 60% of scaffolders.

We are pleased to have another 'string to the bow' when it comes to strategies for improving the terms and conditions of our members.
The membership profile of APEX is such that the advocacy on behalf of highly skilled professionals who need to be recognised in a competitive international marketplace and who are essential to the running of a world-leading health system will remain the principal method of bargaining success and lifting wages. We do however have a significant membership at the bottom of the healthcare hierarchy who are very low-paid and could enjoy a significant relative boost from the pay equity argument. And it is now the case that 'pay equity is here to stay.'

What we mean by that is that since the aged care and social workers pay equity settlements the 'genie is well-and-truly out of the bottle' and the law which the government expects to pass this year is unlikely to be repealed, or much tampered with, by any future government whether Labour-led or National-led.

We can now expect pay equity bargaining to be a long-term feature of pay settlements and we are already preparing strongly to make sure that APEX members are at the front end of any benefits arising.

DIVISIONAL REPORTS (in no particular order)

The following reports largely provide a snapshot from the year. It is not the intention of this report to provide details of every event, PG or issue that has arisen, unless it is of relevance to the greater membership.

Scientific Officers Division

A relatively quiet year for our scientific officers' negotiation-wise, with our collective agreement running until September 2019. However, at renewal it is envisaged the Scientific Officers SECA will be rolled into the DHB Laboratory Workers MECA.

Social Workers Division

Whilst DHBs have expressed appreciation for the valuable service and role carried out by social workers, for a variety of factors including the diversity and geographical spread they have equally continued to deny them a voice, overlooked them and left to be managed by nurses.

Our social workers are currently in a service-based system with no dedicated social worker manager or advisor, and as such the group could be described as somewhat "adrift" without professional leadership or representation at a higher level. This in turn is depriving the social workers of good leadership which is critical to the professional safety of the social workers as well underpinning as their cohesion and support systems. There has also been a considerable piece of work looking at establishing a social worker department but with no outcome. It is unclear where this work faltered or what the barriers were, but the establishment of a stand-alone social work department would address many of the issues currently encountered by this group.

In the past the social work Advisor role has been described by those fulfilling it as 'a poison chalice' as despite credentials, knowledge and experience, previous Advisors have been unable to support the social work group to effect positive change as they have not been supported themselves. The position has been undermined and undervalued.

Of particular concern is the lack of consultation with either the social worker advisor or any social workers for that matter, when appointing new social workers. This input would not only provide recognition of the value social workers bring to the workforce but also ensures robust and relevant recruitment.

APEX has for some time now also been advocating for social workers to manage leave either through the Advisor, manager or a department as opposed to the current system utilising a nurse. We believe the employment and orientation of new locums should be organised and maintained by a social worker as only they are able to fully understand the profession, its

requirements, necessary self-care in terms of leave, and the requirements in order to retain registration.

To add to this issue is the fact that for quite some time now, the locum cover has been insufficient to allow social workers to take leave when needed or put off social workers from requesting leave when they know their colleagues will be negatively impacted as a result. Locum cover also rarely extends to services such as maternity and paediatrics.

Vacancies within the social work group and the withdrawal of additional winter cover as has previously been added to their compliment, has also occurred adding to the stress this group is experiencing.

As with psychologists, it is a mandatory requirement for social workers to access regular supervision in order to remain registered. Whilst the DHB prefers for social workers to access supervision internally, the reality is there are few "intra-DHB" social workers in a position to provide this, and restrictions on the number that each appropriate social worker can supervise. As a result, some social workers are not receiving adequate supervision

Psychologists Division

It's been an interesting year for the psychology division.

Our focus for DHB members has been renewing our MECA. We initiated for an 18-DHB MECA for psychologists at the end of 2018, up from a 15-DHB MECA, and began bargaining in early 2019.

At about the same time *The Report of the Government Inquiry into Mental Health and Addictions had* concluded, "an immediate priority is to begin building [the psychology] workforce". So once bargaining had stalled over issues of salary, professional development, and staffing, members began taking partial strike action to highlight the mismatch between what we need, and we have got.

First, members put in place an overtime ban for five weeks, from July to the end of August. Second, members stopped running groups and accepting new patient allocations from September to October. Third, strike notices have been issued for a month-long strike during October dropping patient contact time to two-hours.

This has been the first experience of strike action for DHB psychologists and a learning curve for most members, but there has been a generally positive experience and a lot of good publicity for the professional issues the bargaining raises, and the value of psychologists especially responding to mental health issues.

Over the period of bargaining, our DHB membership has grown and we have more delegates than ever before - 28 delegates in DHBs alone. As we move forward during this MECA campaign, we will have to continue to support members in what could be a relatively long struggle for a better contract.

Ministry of Education psychologists settled their first APEX collective agreement in the form of a multi-union collective agreement with NZEI at the end of 2018 for a three-year term. The collective agreement was a good step in the right direction - we gained clauses for supervision, professional development, and a simplification of the merit progression process. It was also agreed to set up a joint working group on caseloads/workloads, which has been meeting monthly this year to determine guidelines on safe caseloads and workloads and begin to tackle other issues at the Ministry including improving retention and recruitment of staff, supporting good professional practice, and ensuring professionals have the resources they need to do their jobs effectively.

We continue to publish a bi-monthly 4-page newsletter to all psychologist members, which includes delegate interviews, advice on professional issues and contract meaning, and reviews of interesting resources and trends.

Casework has been relatively stable, with issues such as supervision, professional development, leave, service, merit progression, etc coming up from time to time, and compliance having to be ensured. We also have had a few disciplinary actions against members, with no adverse outcomes.

The division also submitted a proposal to the Ministry of Health's innovation fund alongside DHBs and training providers for an intern co-ordination service to be set up to improve forecasting of workforce needs and improve the workforce pipeline by streamlining the education to work system. Despite being one of the few proposals to get through to a business case stage it was eventually declined for funding by the Ministry.

The possibility of multi-sectorial representation of psychologists has also arisen in discussions this year as the public system's approach to better linkages throughout all those impacting on the social determinants of health gains momentum; something to watch in the upcoming year.

Biomedical Division

Our biomedical division has continued to grow with biomedical technicians employed by Spotless at Palmerston North and Whanganui hospitals joining at the end of 2018. Waikato Biomed went through bargaining in late-2018 and early-2019 and secured their second APEX collective agreement after two week-long partial strikes. Spotless Biomed secured their first APEX collective agreement after putting in a strike notice.

Waikato trades group have joined in August 2019 and in the interim are covered by the same division, as they include electricians, as well as builders and plumbers. We will be commencing the process of securing a collective agreement for these newest members shortly.

CSSD Division

The CSSD division represents sterile supply technicians at Hawke's Bay DHB. It's a relatively new group and they have benefited in bargaining from an excellent local delegate and are a well-organised site. Hawke's Bay CSSD went through bargaining in late 2018 and early 2019 and secured their second collective agreement after a 24-hour strike which is in term until December 2020.

Dental Therapists Division

Our Waitemata dental members settled their collective agreement at the end of 2018 and are in term until December 2020. Members have been active tackling issues around understaffing of the Auckland Regional Dental Service in their workplaces, and ensuring the service employs one dental assistant for every dental therapist/oral health therapist.

Perfusionists Division

At the end of 2018, ADHB perfusionists led the charge to get the nurses' parameters to flow on to APEX documents. This was successful after the group issued strike notices however the bargaining then broke down over the perfusionists claim for six weeks annual leave. A strike notice was issued, and then withdrawn, and the collective agreement settled, although there was some division amongst this group over this. Since having their document settled the division has been very quiet. Waikato Perfusion is in term until May 2021, Auckland Perfusion is in term until February 2021.

Psychotherapy Division

New division with members at Auckland and Waitemata DHBs, with members currently engaged in a campaign of industrial action with their employer over improving two core parts of their contract – professional development and merit progression. Each DHBs members are bargaining for a local CA and have engaged in one three-day partial strike each.

Physiotherapists Division

Bay of Plenty DHB and Waikato DHB agreements are currently in term and are due to expire in April and July 2021 respectively. Northland DHB is due to commence bargaining in late 2019.

We have had a number of individual matters or have had ongoing scheduled meetings to monitor workload. These instances have been tracking well with APEX's involvement. APEX has also assisted members who have come to us concerned around unhelpful workplace dynamics which we have played a role in, alongside the DHB, to help manage these relationships and look at long term solutions where possible.

We are part of a working group following on from Waikato DHB negotiations to confirm some outstanding matters (such as Merit Processes and Professional Development Leave) that we agreed to work through post bargaining.

All three sites have strong delegates, who make themselves known as the first point of contact for members. With some of our delegates going on parental leave we have had several members step up to the delegate role.

The Bay of Plenty DHB Union / Management Forum which occurred several times a year was put on hold in order to focus on negotiations. However, the collective agreement is now in term and we are due to recommence this Forum in October of this year. This Forum has been effective in resolving issues (often before they become problematic) and enables APEX input into management decision making and strategy. Feedback from members however is that APEX needs to ensure timely and fulsome reporting following on from these Forums to keep everyone informed. We will ensure this is the case going forward.

We have commenced discussions with members around the idea of turning the three SECAs into a MECA. APEX has articulated the benefits this strategic move would provide including being able to pull together our collective strength, improve conditions of employment overall and address the specific needs of the workforce. Thus far members have reacted positively to this concept. APEX will be providing members with more detail around what 'MECA-ising' means and how we would go about this practically speaking.

There is a greater need for APEX to investigate and engage with other (non-APEX) Physios from around the country. Going forward, we will be looking at opportunities where APEX can present to and recruit Physios with the aim to grow our membership.

Dietitians Division

2018 -2019 has seen the growth of the Dietitian division. Members contracted to MidCentral and Whanganui DHB by Spotless have joined APEX and interest has been shown by Dietitians in the PHOs with those in Northland employed by Mahitahi Hauora joining with their colleagues.

The issues faced by this group include compliance with their collective agreements. On the ground long term staff report they are faced with high turnover of staff, and to be constantly training newly qualified staff. Whilst there continues to be an oversupply of new graduates the employers will continue to prefer to employ them as opposed to more experienced candidates who require a higher entry salary.

Both Northland and Taranaki are currently in term, real and actual of costs of CPD will be monitored, and their Dietitian specific merit processes needing testing over the term, this will inform next bargaining.

Spotless dietitians have joined APEX in 2018 and have just recently secured their first APEX collective agreement, which will see improvement in general terms and conditions including overtime as well as them move to salary parity with DHB employed Dietitians by expiry. This is a step in a journey of improvement.

Pharmacy Division

This division has continued to grow West Coast Pharmacy joining APEX and recently settling their first APEX agreement.

Recruitment and retention of both Pharmacists and Pharmacy Technicians across most sites related directly to inadequate remuneration and/or lack of career pathway; this has been a major driver for the pharmacy groups that have moved over to APEX. The widening gap between private and public has been an ongoing issue for both Pharmacists and Pharmacy Technicians.

Recent pay equity settlements as well as increasing numbers of employers moving to become living wage employers has meant that both pharmacy technician and pharmacy assistant (not just isolated to these) salary scales have been devalued and as more DHB's slip into deficit the ability of employers to address this has been limited. Both of these groups will increasingly become more difficult to train and recruit and retain, with a staffing crisis in the not too distant future.

Pharmacists and pharmacy technicians' scopes of practice continue to be extended, with pharmacy technicians' training in the Pharmacy Accuracy Checking Technicians qualification, as well as the new level 6 pharmacy technician certificate. Pharmacists are also keen to take up the opportunity to obtain their post-graduate qualification in prescribing. However, the employers have not been as keen to remunerate for this added value. Adjustments to merit progression will needed to be tested over the term of agreements, however the "proof will be in the pudding".

APEX continues to advise members to seek improved remuneration prior to taking on these new responsibilities. However, we recognise that gaining improved remuneration for the added value these roles bring will continue to be an issue for many and needs support through cementing structures in our collective agreements.
To address the common issues members have indicated that there is initial interest in an APEX pharmacy MECA. APEX pharmacy delegates will be meeting to discuss and explore this option.

PHO

Over the past year there has been interest received from Wellsouth and Manaia and Te Taitokerau PHO's (primary Health Organisations). With the latter two joining APEX after they came under threat during the amalgamation with the new employer Mahitahi Hauora. This group includes administration staff as well as a mix of Allied scientific and technical employees including Dietitians and social workers.

They are still currently employed on IEA's with the new employer which are deficient in basic conditions including redundancy provisions, that their hospital employed counterparts enjoy.

Work is underway to bargaining for their first APEX collective agreement which will be a MUCA (multi union collective agreement) with the New Zealand Nurses Organisation (NZNO). All employees will be seeking similar general terms and conditions, the main differences being salaries and training requirements.

Medical Laboratory Workers Division

Whilst there has been an influx in membership across some employers, membership across the Medical Laboratory division has increased over the past year with Taranaki Medlab and Medlab Central members joining APEX.

Compliance with the terms and conditions of our members collective agreements has increased and continues to be an issue, including the employers attempt to change clauses in bargaining to fit their misinterpretations. These need to be nipped in the bud but can only be sorted when our membership is engaged.

As a result of increasing workload pressure with all labs continually looking for savings and efficiencies, we continue to have members report that they start early and finish late without claiming overtime or payment, don't take breaks and feel stressed at work.
We continue to advise members that while they continue to put through more work with the same number of staff that the situation will not improve, and that they need to ensure they practise safely.

Increasing bullying complaints, with new staff not being prepared to put up with bad behaviour that has been accepted in the workplace in the past, but also with the increased pressures of lack of staffing has seen a lower tolerance for what was once accepted norms.

There has been a lack of delegates in some sites, and therefore the lack of on the ground support for members at these sites. With the move to APEX we look forward to a reinvigoration of our Lab delegates and better integration and support for them with other local APEX delegates.

There has been an increasing level of paucity in HR practitioners, and misinterpretations of provisions by payroll across all employers, with even more education of members and their delegates about the terms and conditions that apply to them

Although two years have elapsed since changes to scopes of practice occurred, employers have continued to struggle with implementation, including giving poor advice to members entitled to grand-parenting, not following up with registration resulting and members not being able to work until registration was confirmed and uncertainty of how provisional registration is applied.

At the time of writing the Medical Sciences Council are undertaking multiple consultation processes including increasing continuing professional development requirements for MLT and MLPaT, reducing laboratory hours for provisionally registered MLT and MLPaT, and changes to supervision and direction requirements. These changes will have flow on effects to collective agreements and we will need to ensure that we update accordingly, however as highlighted in the recent DHB and NZBS MECA bargaining we need to be sure not to just change words because the MSC has and remember the purpose and intention of the clauses.

Southern Community Laboratories (SCL)

The SCL MECA was renewed in early October 2018 following intense bargaining that reached the brink of strike action. Finally, faced with the prospect of strike action the Group CEO flew in to attend the mediated bargaining in Auckland and we were able to achieve a reasonable settlement in accord with the '3% per annum' post NZNO settlement bargaining parameters. There were improvements to a number of other provisions including 5 weeks' annual leave for all members after 8 years' service. It was also very pleasing to achieve T1.5 as the accepted night rate for all members between 8.00pm and 6.00am in all covered labs. The agreement runs until 30 June 2020.

Pathlab Lakes / Whakatane

Both of these collective agreements have been renewed after quite a struggle to get the employer to broadly match the settlement parameters achieved at SCL. Each agreement has moved one day closer to five days annual leave for all members after seven years' service (i.e. up to four days by next year).

The Lakes Agreement will expire two-months after the SCL Agreement i.e. at the end of September 2020 and good progress was made in improving the technicians' scale at

Whakatane by removing steps at the bottom and matching the higher scale from the Lakes Agreement.

TLab, Taranaki and Medlab Central

Employees at Taranaki Medlab and Medlab Central (Palmerston North Hospital) joined APEX in the last year. This is the same company that owns T-Lab (Gisborne Hospital). The first APEX collective agreement for Taranaki Medlab was ratified in July 2019, and negotiations for Medlab Central employees commenced in July and are ongoing. T-Lab members are currently considering a change to their roster to break up the long stretches of duty they complete over weekends. Both sets of bargaining have delivered, or are due to deliver strong improvements in conditions, including additional annual leave for long serving employees, as well as improved pay and allowances. Taranaki Medlab is due to change hands as the contract for Taranaki community work was won by SCL, effective from February 2020.

DHB/NZBS Bargaining

At the time of writing this bargaining was in its third set of meetings, with SCL now leading the market in terms of a majority of provisions, it will be important to lift this agreement to comparable terms and conditions. Early indications are that the employer wishes to hold this group down to the lowest common denominator, something that these members are not willing to accept. As with other MECA's in bargaining some form of action will be required to progress our members interests.

NLEG

The future role of NLEG will no doubt be a topic decided in the current MECA bargaining. Whilst there has been traction on some issues, others have languished due to lack of commitment and consistency from the employer parties. Since the last MECA was implemented there have been multiple changes to the employer party leaving very few participants who were even involved in the last MECA bargaining or previous ones to even have a history or understanding of workstreams and shared solutions. If NLEG is to continue or take on new pieces of work from bargaining genuine commitment and energy will need to be put to reaching resolution on workstreams.

The majority of workstreams have formed claims in the current negotiations in an effort to reach resolution.

Physicists Division

The three-year Physicists' MECA expired at the end of August 2018. Claims for renewing the MECA were raised with members, a bargaining team appointed, and then initiation and setting dates for bargaining were all accomplished in a timely manner. That is at least insofar as APEX is concerned. What followed the initiation was a pro-longed period of 'phony war' as the employers met with us on three occasions before the end of 2018 and each time suggesting that they were not in a position to make an offer pursuant to the 'new circumstances' and that ERSG (Employment Relations Strategy Group) was designing a strategy that would 'cover all APEX bargaining'.

By the time 2019 rolled around and the story from the employers hadn't changed, the patience of the medical physicists not unexpectedly was fast running out. As we headed into March the team was planning a campaign of partial strike action. At time of writing we can report that the partial strike campaign was successful, and the Physicists achieved a good settlement in June. They are also a group that benefited from the government's removal of the 10% deduction for partial strike action that they had suffered from during their strike action in 2016. The renewed Agreement runs until 31 August 2021.

This profession continues to be under stress from unfilled FTE in a period in which most services are commissioning new Linac machines which are increasingly the Physicists' 'second choice' Electa product which whilst cheaper is less reliable. Tensions arising from this are causing ongoing relationship and grievance issues.

Managers/IT Division

The managers covered by APEX are now all on Individual Employment Agreements and the division is providing a home for senior allied, scientific and technical staff where the positions are specialised and the numbers too low to make collective bargaining realistic. An example is the role in DHBs (usually only one) of Fire Safety Officer.

Managers in hospital pharmacies and senior IT roles make up the balance of the members in this division and APEX represents and advises them as required on their individual terms and conditions.

Occupational Therapists

The majority of Occupational Therapists in Northland are members of APEX and now have a collective agreement that runs through till April 2019. At time of writing that Agreement has been renewed and now runs through to 31 October 2020. Work to follow up with OTs at other centres is ongoing.

Clinical Physiologists Division

The Physiology MECA settled in late December 2016 for a 36-month term on the back of having made significant progress in implementing the recommendations arising from the Governance Group (PGG) that had operated during the term of the previous Agreement. From the four work-streams established, substantial progress was made in three. The four work streams established were;

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

At this point in the final year of the MECA planning has already begun for the renewal. The MECA is the last of the major APEX MECAs in the 'current round' expiring on 18 December 2019.

This profession continues to suffer from the considerable dislocation arising from the boundary between physiology and sonography. The process of ensuring echo-cardiography physiologists are paid under the Sonographer MECA is now almost complete.

With the echo situation resolved it becomes a bargaining priority to ensure that cardiac physiologists not participating in cardiac sonography can still have access to higher salaries like their sonographer colleagues. Work is already underway to achieve a reformed physiology scale that will reward the other cardiac specialties.

MITs

MRTs are now known as MITs, Medical Imaging Technologists; reflecting the fact that they are experts in medical imaging both with and without the use of ionising radiation.

The past year has seen significant growth for APEX with private sector MITs joining APEX for individual representation in greater numbers. This includes MITs at ARG, Hamilton Radiology, Mercy Radiology, SRG, and Central Otago Health Services Ltd.

Pacific Radiology Group (PRG) bargaining began in late 2018, arising out of local issues in Wellington and the desire for collective representation. Initial communication between APEX and PRG was positive but after bargaining began it quickly turned frustrating and protracted. PRG became highly defensive about APEX involvement in the workplace.

After we made our claims in collective bargaining, PRG initiated a major remuneration review and handed out significant pay-rises to all staff. At first it was not clear if they would pass these rises on to APEX members, but we pressed them to secure this. In the end, the decision was made to withdraw from collective bargaining since negotiations were stalling and the remuneration review addressed key concerns around pay. We intend to start the process over again in the next year or so.

The Radiology Group (TRG) MITs in Northland have begun the process for negotiating a collective agreement. Key issues include transparency around pay.

MIT MECA bargaining began in December 2018. Taranaki DHB is now back in this MECA after a successful transition from Fulford Radiology.

It has been a very frustrating and challenging process for our bargaining team and our members. We put forward major claims to address critical workforce issues which have been undermining MIT health and safety, recruitment and retention.

From the end of January, the DHBs took a long adjournment from bargaining, as they were 'seeking a mandate'. It took them over three months to come back to the bargaining table. When they did, we made incremental progress towards a new salary scale that would have recognised MITs for building up their skills and taking on responsibilities.

These hopes were dashed in June, when the Chief Executives (via ERSG) over-ruled the DHB bargaining team's efforts to that point and pulled everything previously agreed off the table. There followed a fraught couple of months with a 24-hour strike notice issued to get the DHBs back to the table for mediation and to get a formal offer that went some way to addressing our claims. In late August, after two days of intensive talks, the DHBs finally had an offer and that first strike notice was withdrawn as a gesture of good faith.

But the offer did not address the issues faced by our postgraduate MITs working in MRI, Nuclear/Molecular Medicine and Mammography, it left Students and Clinical Assistants sorely under-paid, and it sought to claw back the 'modality pay' we have for advancing those who train up in additional skillsets, without providing any other means for our more junior MITs to be rewarded as they climb up through the ranks.

The major workforce issues MITs are up against continue to fester:

- **Growth in Radiology demand:** The MIT complement continues to fall further and further behind the relentless growth (7-10% p.a.) in demand for radiology services. As a result, individual MITs are under pressure to work harder and faster to make up for the shortfall in staffing.
- **Staffing crises:** There are pockets of severe under-staffing across New Zealand, concentrated in major urban centres. The 3 Auckland DHBs are reeling from under-staffing; Auckland MRI is in absolute crisis, Counties Manukau X-ray and Waitemata X-ray/CT are at 25-30% vacancy. Hutt X-ray is also in real crisis. Most DHBs are feeling the crunch and many advertised roles are remaining unfilled for months.
- **Limited government response:** We have engaged with the DHBs and Ministry of Health regarding the mounting workforce crisis for MITs to no avail. Despite our active involvement in future workforce planning though the Medical Imaging Workforce Action Group and HWNZ Allied and Scientific Technical Governance Group, the DHBs remain unwilling to take decisive action. Hawkish Ministry oversight on DHB expenditure only makes matters worse.
- **MRI:** The MRI workforce is starved of the resources needed to drive recruitment and retention and is effectively in meltdown. The private sector offers better pay in the main centres, plus better work-life balance. In Auckland, resignations and reduced services are the new normal. Frustratingly, our recent OIA requests to the DHBs show that they are now wasting over $25.5 million a year on outsourcing MRI scans to the private sector. Instead of investing in and rewarding DHB staff, they are adding fuel to the public MRI workforce 'fire' by growing the private sector and incentivising their staff to leave! This is a key sticking point in ongoing MECA bargaining.
- **Safer Rosters and Understaffing:** We continue to have issues with MITs working unsafe rosters due to chronic understaffing. We have put substantial work into this at the MECA bargaining table and the DHBs have agreed to our proposal for a roster review system whereby unsafe on call rosters are replaced by shifts.

After APEX intervention last year, MITs working at Invercargill Hospital and Nelson Marlborough DHB report that their new staffing levels and rosters are working much better for them. By stark contrast Palmerston North has continued to be a hotspot for fatigue and stress. The CT on-call roster is demanding and almost certainly needs to have a shift implemented. This will be on the cards in the coming months. We also lobbied for personal alarms to help keep our CT staff safe when working isolated from the main hospital buildings at night.

The Auckland region DHBs likewise are suffering recruitment and retention problems, exacerbated by the city's high costs of living and continued growth in private sector radiology, fuelled in no small part by DHB out-sourcing. Waitemata has reached a tipping point and over winter, Counties Manukau also hit a crisis. Auckland MRI staffing is critically low, and services have been reduced, with major pressure in other services too. The DHBs are doing what they can to address these issues, but ultimately the only way forward is by funnelling resources.

Student MITs: Unitec changed their Medical Imaging course structure and told the Auckland region DHBs that they no longer need to employ and pay their placement students. Instead of getting in touch with us or looking to the MECA, the DHBs took this advice to heart and decided to stop paying their students. We took ADHB to mediation and achieved a settlement. Waitemata is on notice and is calculating its obligations.

IT/Non-MIT RIS PACS Admins: This year has seen an increase in the numbers of RIS PACS Admins who do not have professional training as MITs – most come from IT backgrounds. Not just any IT person can step into the role – it requires specialist knowledge, skills and talent to do so. It is therefore only fair for these people to be paid in line with MIT RIS PACS Admins. It also prevents DHBs looking to move RIS PACS work away from MITs and towards non-specialist and cheaper IT labour.

And finally MITs who work across two skills sets: The Theatre MRTs at CMDHB work in plain films and perform CT and Angio in the theatre environment. Despite working across three skill sets, they have not received modality pay however, we have successfully achieved a settlement for them which addresses this issue.

Sonographers Division

A relatively quiet year with bargaining not getting underway until 2019.

Auckland management continue to want sonographers to provide more flexibility to work weekends and evenings. The weekends don't pose to much of a problem with a T2.5 penal rate applying, however during the evening there is no additional remuneration on offer making this an unattractive proposition for our members. The employers don't appear sufficiently enthusiastic to pay more so the issue keeps going around in unresolved circles.

A second area that is "hovering" is that of independent practice and specifically reporting. Unless the employers are prepared to remunerate for the additional responsibility (including reimbursement of indemnity insurance as is required for radiologists) of those who take on this

higher level of responsibility, there will remain barriers to enabling the additional flexibility on offer here.

It is probably a lesson for us all: whilst the employers desire for flexibility and extended scopes of practice is real, their preparedness to pay for such labour (largely intellectual) is not as apparent. In the case of sonographers, their hourly rate is a lot lower than that of a radiologists who otherwise would have performed this function. Sharing of the financial benefit however does not appear part of the employer's scheme. The knack is not to do the work until the money is agreed. Once we start doing the work, the employers will simply thank us.
Resolution of appropriate pay for our cardiac sonographers is reported elsewhere in this report.

Radiation Therapists Division

A quiet year here as well with bargaining also not until 2019. A split of the Auckland RTs away from the South of Auckland MECA has occurred however the bargaining itself was performed in tandem.

Auckland also continue to pursue more flexible hours of work as they squeeze a greater spread of hours for treatment from the staff. Recruitment and retention issues and as a result short staffing and exhaustion amongst our Auckland RTs have been an increasing feature.

We also have the spectre of linear accelerators being placed in provincial NZ: Northland, Hawkes Bay, Taranaki and Nelson are all vying for this service. How we will maintain competent physics and RT support for these machines is still to be discussed.

A workforce group met this year and a study on the RT and physics workforce is pending. Key issues included:

- Recruitment from Otago University from 1st year Health Sciences, numbers have fluctuated in recent years, unforeseen dropout rates some years. Clinical placements to Australia halted.
- RT profile amongst school leaver/health science students not good
- Public knowledge of workforce is seen as being minimal and uninformed.
- Feminised workforce that does not fit to part-time mothers. Female RT's at their peak with skill levels and expertise are also having families and can't hold or access Senior Positions as the positions are not part-time.
- Not enough career progression opportunities/steps or advanced practice opportunities. UK advanced practice seen as more patient focussed/patient care roles, whereas NZ seen as a focus on dosimetry, pre-treat. skills.

- Lack of research and development roles.
- MRTB -partial scopes for UK RTs coming to NZ, have deemed UK training not in depth enough to grant full scope. The training burden is significant on NZ Depts to upskill new employees.

Anaesthetic Technicians Division

We have concluded bargaining over the last year in Hawkes Bay, Lakes, Christchurch, Midcentral, Northland, Southern and Nelson- Marlborough DHBs. This included strikes in NMDHB, Northland and Hawkes Bay, that were precipitated by the DHBs bargaining position of “national consistency” in collective agreements/ and salary scales and reversal on claims that had previously been agreed across the table.

Members were generally satisfied with the outcomes. Lakes DHB who went on strike for total of 16 days, were able to gain agreement to important health and safety breaks between duties.

A consensus has developed on the need to bargain a AT MECA in the next year to avoid the employer’s preference for dragging us down to a lesser common denominator as well as to improve terms and conditions specific to ATs and addressing professional issues. We need in the next year to expand membership into other DHBs, build up collective strength so as to be best able to advance the interests of anaesthetic technicians.

Private Sector We bargained two private sector collective agreements: Mercy Hospital in Dunedin and at the start of this year Anaesthetic Technicians employed in private with Acurity Health Group decided to leave NZNO (with their blessing and support) join APEX and bargain their own collective agreement.

Due to the shortage of anaesthetic technicians, Acurity were struggling to recruit and retain staff. Their rates & conditions of employment were no longer competitive within the Anaesthetic Technician labour market.

We were able to address this in bargaining and in addition, we increased the on-call allowance, sick leave and annual leave entitlements, overtime paid at T2, a shift coordinator allowance,

and have a salary scale with reduced automatic steps (3 steps to top of autos) and process going forward to achieve merit step progression,

The benefits of targeted documents to the specific professional class of employees was again demonstrated by this process. It will also provide us with a good basis to expand further into representing Anaesthetic Technicians in the private sector.

Workforce Issues The Anaesthetic Technician workforce continues to be facing a shortage. DHBs do not train enough technicians to cover their services and are dependent on locums to fill staffing gaps. Lists are routinely cancelled in some DHBs, due to not having enough staff. Anaesthetic Technicians can find employment almost anywhere in the country and more attractive pay in the private sector. Locums are paid between $45-$55 per hour and some Locum agencies are now guaranteeing full time employment.

The DHB Anaesthetic Assistant Workforce report 2019 (by central TAS) identified Anaesthetic Technicians as being an at-risk occupation, requiring intervention. The workforce shortage has been created by the DHBs however with only 9 DHBs currently training the future anaesthetic technician workforce. The training model is dependent on the DHBs investing in and ensuring the workforce pipeline needs are met.
A significant risk to the profession is Registered Nurse Anaesthetic Technicians, that are now employed in 9 DHBs. They are not popular with the Anaesthetists who prefer their own assistants but are an easy solution to the current shortage with the DHBs. We have always maintained that the Anaesthetic Technicians should have their scope of practice expanded to be perioperative practitioners. The Medical Scientists Council was proposing this last year, but unfortunately backed off. It is possible this was due to pressure from NZNO. We will need to explore possibilities for collaboration with NZNO and theatre nurses to protect the interests of both professional groups. We will also work with NZATS (the Anaesthetic Technicians Association) on joint strategies to protect the profession and lobby for expanded scope.

There are also proposals to bring in a 3-year degree. While understanding that this is quite a popular proposal with some of our members, we are importantly not opposed to the introduction of a degree program if it existed alongside an apprenticeship training model. APEX is still concerned of possible detrimental outcomes. It would be the preference of DHBs to not have to invest in training and paying for apprentice wages, and the universities would likely see this as another cash cow. Anaesthetic Technicians would become indebted and it

would not attract the same type of applicants we currently have. Further consideration of this proposal is required and imminent.

SUMMARY

This has been a hard year. Public sector bargaining has been frustrated by the employers and Ministry/Government constraints not just on process but outcome also. That in a bargaining round where we have had more money available to settle agreements than in many previous rounds our system has managed to lose any benefit this could have afforded, has not gone unnoticed. The problem lies in the system the employers, Ministry and government are using which unfortunately are outside our direct control. The resulting strike action fallout from a management system that for whatever reason couldn't adapt despite the consequences.

A centralised desire for consistency has seen the ability to be flexible and nimble as to employee groups individualised needs, stonewalled. Workarounds are increasingly becoming prevalent as the ability to centrally control many volatile workforces out strips the control desires of those in Wellington.

We must adapt to circumstances around us: in 2018-2019 the basis of the DHBs position of consistency between the same workers was to drive costs down to the lowest common denominator. This must be met with MECAs and the best for that group becoming the norm.

Outside of the DHBs bargaining has been simpler and driven far more by the pragmatism of the labour market than political philosophy. We have grown in the private sector in 2018-2019 through both groups contracted out by DHBs to traditional private and community sector groups such as PHOs and private hospitals. Colleagues in associated sectors have also joined us such as Ministry of Education and interest from others also expressed.

It is important that we think "whole of workforce" in our work; each professional group has differing workplaces, but the connection is always back to that profession. Intersectoral opportunities for professional groups in the public sector, as well as us all in public and private coverage do exist and have not to date been widely enough utilised. To be effective we do have to take all the opportunities afforded us.

And the pay equity process will continue to gather speed, albeit the baseline for activity is reasonably low. Collaboration between unions as claims are consolidated will also be a future feature of this process.

We have already made a claim on behalf of our phlebotomists. The PSA by contrast has made a claim on behalf of all allied scientific and technical, it would appear regardless of whether any one professional workforce is predominantly female or not. Given comparators as to the work must be decided, how this level of specificity can be aligned with the breadth of AST workforces is unclear. APEX is reviewing each predominantly female workforce separately in this regard to assess the validity or otherwise of a case.

In 2020 the review of the Health Sector will publish recommendations on the back of the findings released recently. The level of collaboration between employers and unions, unions themselves and employers also, will be a matter of active discussion. The experiences NZNO faced in bargaining in 2017/2018 and the fallout that continued in 2019 will continue to challenge us to ensure we are not just independent of the employers but seen to be truly independent.

Our members expect us to represent them, to have their back and rightly so. That is our job and whilst this can make us “unpopular” at times it is nonetheless an important role which improves balance in our system and importantly makes us leaders of workforce in a time when our employers have lost the confidence of those they employ to undertake this role.

It does not mean we cannot collaborate it simply means that all parties need to accept our respective roles as valid, and the relationships we have with our members as precious and something we know best.

A huge thanks to our fabulous delegates. On top of their normal workloads, they take their responsibilities of working for their colleagues extremely seriously, with considerable energy often required. With members’ interests in their hearts, they are a force to be reckoned with. Of course, they are strengthened by the support their members give; we must never forget that each and every delegate deserves the support of each and every member to be effective.

And to our Executive; whilst as a whole we have had little engagement this year, each divisional representative has invariably been available to provide oversight, wisdom and sound counsel with respect to their own profession that is invaluable. And to Stewart, Kevin and Pam also a huge thanks for your wisdom, guidance, oversight and availability in what has been a very busy year.

I look forward to 2020 continuing to strive for a better future for all Allied Scientific and Technical Health Practitioners.

Dr Deborah Powell
National Secretary