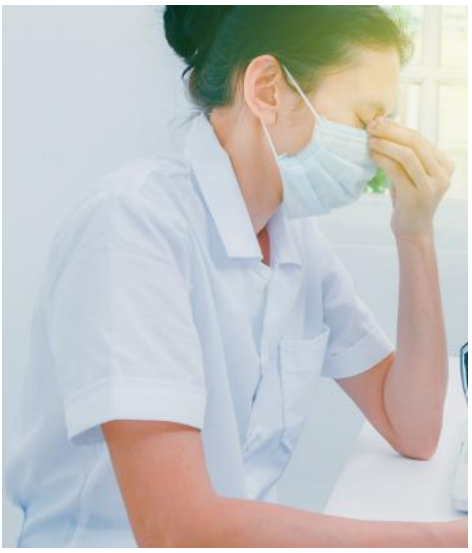
APEX

MIT news

Medical Imaging Technologists' News December 2020

We hope you are keeping well during this whirlwind of a year we are experiencing.

Since the end of the COVID-19 lockdown, delegates have been busy continuing implementation of the fatigue risk matrix/ on-call roster review, and the working groups on Merit Progression and MRI/Nuc Med Recruitment and Retention.



DHB FATIGUE RISK MATRIX/ON-CALL ROSTER REVIEW

As part of the MIT MECA bargaining, we reached agreement with the 20 DHBs on a new process to monitor on call rosters for fatigue risks and to implement shifts where the on-call roster is too demanding on MITs.

We devised a points-based risk matrix system for assessing relative fatigue risk. There are three fatigue risk levels (low, medium, high) set for days, evenings, and nights on call. The more points, the higher the risk.

Low risk means continue monitoring. Medium risk means the DHB needs to take further steps to mitigate fatigue. High risk means the DHB must consult with the affected employees on implementing a shift, or otherwise reduce the level of on call activity and fatigue in that on call roster.

Delegates have put a lot of work into assessing on call rosters in DHBs and then implementing shifts to combat these identified risks. The increase of FTE has often been considerable (up to 10 in one medium sized DHB) but worth every penny. Replacing on call with shifts has made a real difference to the work life balance, health, and safety of our members. Notably, where the MITs themselves have formed roster committees, we have been very successful in ensuring a smooth implementation.

However not all DHBs who have agreed to recruit the FTE have done so willingly, with some deliberately dragging the chain.

We have had to threaten to file for mediation, while another has taken several meetings (including a stop work), and very active delegates to implement. Well done to those delegates, however – champion work!

We have not had communication from a few DHBs. Do get in contact with us if you are continuing to work a high frequency of call outs or you have not been reviewed.

Ongoing monitoring and reviews of the impact of on call rosters shall be completed at least annually, so this is something we will continue to monitor and bring shifts in if needed.

DHB MERIT PROGRESSION AND MRI/NUC MED RECRUITMENT AND RETENTION WORKING GROUP

We have had three working group meetings since July on MRI recruitment and retention, the criteria and process for Merit step progression.

In MECA bargaining we tried to advance recognition of advanced practice and a career pathway. We were not able to reach agreement on this in bargaining and we agreed to defer it to a merit working group. We envisaged achieving clearly defined process and criteria for merit progression. MITs like prescribed criteria, want to know that they will be recognized, and be renumerated for taking on extra duties and responsibilities that benefit the DHB.

We wanted the MITs to be achieve merit for performing duties or roles outside of the core role of an MIT and for advanced progress.

These could, amongst other things, include achieving merit steps for doing the following;

- NG/NJ tubes
- Colonography
- Drug administration
- Consenting patients
- Accessing ports (e.g. PICC hickmans)
- Cannulation
- Ability to manipulate original images e.g.
- Advanced Image
- Reconstruction Technology
- Fusion Technologies
- Ultrasound guided cannulation
- Able to escalate priority review of urgent clinical findings
- Gatekeeping (in the absence of a radiologist)
- Advisory research – new technology advances and subsequent introduction to service (e.g. New Shunts, spine/femur stitching).

For Nuc Med and MRI we discussed that the DHBs need to ensure appropriate workforce planning, train the future workforce, ensure that they retain their existing staff and not lose them to the private sector. A means to do so, is through a career pathway in which advanced practice and salary step advancement occurs.

The first day of the working group was productive and there was a meeting of minds between the APEX team of delegates and the DHB service managers. However, things started to change when we were not around the table. After the 1st day the DHBs team went away and came back with a proposal for us to consider.

Unfortunately, it was a framework that resembled the merit criteria framework of another union (CASP of the PSA), with vague domains. This was sent out to delegates for feedback and the response was overwhelmingly negative (bin it). We passed on this feedback to the DHB team, prior to our 2nd meeting. When we expressed our dismay that they had proposed merit from another unions MECA, worse still one that was a proven failure. CASP is well known for very few achieving merit, and that the framework sets up people to fail. Managers retain control and if they don't want you to achieve merit (i.e. the budget is prioritized instead) you don't. We continued in good faith to make suggestions on defined process and provide clear examples of what could be undertaken within the proposed domains (the domains included: advancing technical knowledge and or practice, advancing clinical knowledge and or practice, leadership, service development, professional development, and cultural competency).

Despite our misgivings, we put considerable work into this. Our thoughts were that it would be better to reach compromise and an agreement on a merit framework

that could be trialled prior to MECA bargaining in 2022.

The DHB team took away our amended proposal for consideration. At the third meeting we were told that the Allied Health Directors were not agreeable to our proposal as they did not want to include our examples because they did not consider them to be what they would deem meritorious. This feedback was conveyed by the one Allied Health Director in the working group (Roger Lysaght from Lakes DHB). To say our team was livid was an understatement. The Allied Health Directors were not involved in our working group and should not be calling the shots. This felt like bargaining deja vu (those not at the table scuttling agreements reached). We informed the DHBs team in no uncertain terms they had wasted our time. Working groups are bipartite and not only determined by the employers. If we do not have the ability to reach agreement in working groups on matters of importance to the MITs, then the only recourse to the MITs, is the blunt instrument of collective bargaining and all that can entail. They clearly understood what the implications of this were. We ended the meeting with a request that they reconsider what we have proposed and come back to us with a new proposal for our team to consider. We specifically said if they do not think our examples constitute what they consider "meritorious" then they at least need to explain the reasons why.

We hope to have a response from the DHBs soon. From this we will know if a merit framework can be achieved or it will be on the agenda for MECA bargaining in 2021.

We will keep you posted.

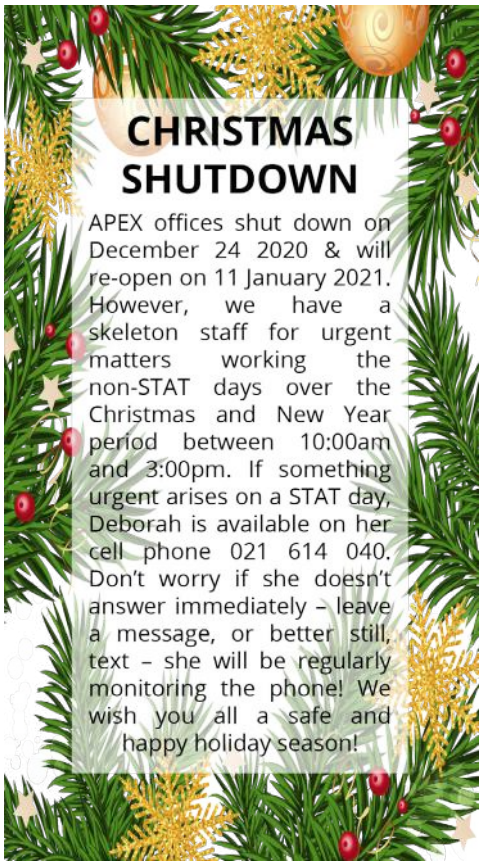
CENTRAL OTAGO HEALTH SERVICES LTD (COHSL).

We will commence bargaining for the MITs and Sonographers at Dunstan Hospital in Clyde shortly. COHSL is contracted to Southern DHB. In previous years COHSL had automatically passed on what we had negotiated to the MITs and Sonographers. After the last bargaining round this stopped, without any explanation given. After learning that the MITs at Waitaki Trust (Oamaru Hospital) had successfully concluded their collective agreement, they decided the time was right for them to bargain theirs. We believe that as they are providing a public health service, that it is only fair that they get paid the same and receive the same conditions of employment as their DHB colleagues.

HOLIDAYS ACT COMPLIANCE

Compliance with the Holidays Act continues. APEX has had advocates present in DHB steering committees and the national bipartite Holidays Act Working Group that is making recommendations on Holidays Act Compliance. Several DHBs have completed their audits and are now in the stage rectification of the pay roll systems and ensuring compliance going forward. We expect the last stage of remediation, where you will receive any underpayments owed to you from 2010 to processed next year.

We will keep you posted.



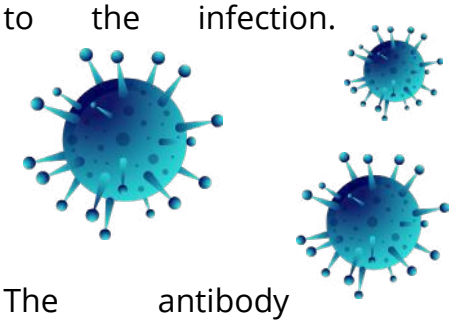
COVID-19 ANTIBODY TESTING

Covid is a virus that is new to humans and so everyone can be considered naïve in immunological terms.*[1] Naïve simply means that there is no immunological memory to speak of and therefore without any behavioural controls the virus would circulate unchecked until it reached it's natural limit. The cost of that occurring would be enormous in terms of loss of life and other indirect financial effects.

New Zealand's response to Covid is appropriately to keep the virus out and has relied on viral detection methods to achieve this to date. The virus is circulating vigorously overseas and will continue to do so. Should a vaccine become available it is important to note that the best available will have been through a truncated approval process and some of it's characteristics may not be fully known. This presents NZ with some risk that the unknown characteristics of a putative vaccine will carry unacceptable risk in NZ populations. Examination of the immune responses to Covid infection should therefore be coordinated in NZ laboratories that have the expertise and are accredited to do so.

Immunity to Covid

Immunity is broadly divided into cellular and humoral (antibody) immunity. Immune responses involve the presentation of virus particles to the immune system through specialised antigen presenting cells. T cells and B cells broadly speaking respond by proliferating into specialised cells capable of killing virally infected cells and producing specific antibody respectively. Humans can produce 5 classes of antibody, IgM, IgA, IgG, IgD, IgE and different amount of these antibodies normally circulate in blood naturally. IgM, IgA, IgG typically respond to infection with an increase in detectable antibody specific to the infection.



The antibody response in humans to Covid as is the case for most infectious agents, typically induces the production of IgM antibodies in the first instance[2] which can be relatively less specific and happens a few days after infection at the earliest. IgG and IgA antibodies typically follow on and they are more specific for the target virus and can be neutralising. Neutralising antibodies typically bind to portions of the Receptor Binding Domain (RBD) for example the spike protein. Non neutralising antibodies can also be formed. Both types of antibodies will wane over time although non-neutralising antibodies such as to N proteins are noted to wane more quickly while neutralising antibodies that can be detected for many months. It is at this point that immunologic memory is important and tests that can infer that or measure it directly are relevant. The corollary to this is the measurement of anti-Tetanus IgG antibodies to infer protective immunity[3] at levels measured against an international standard.

There are a multitude of laboratory assays that measure Covid antibodies. Not all assays measure the same types of antibodies. Some measure total antibody, essentially the combined total amount of IgM, IgA & IgG. Others measure antibodies to multiple targets or neutralising antibodies solely or any combination of these.

While there is no coordinated serum bank of Covid proven positive cases in NZ, there is stored blood in various places. Diagnostic medical laboratories are uniquely placed in NZ with capacity and ready access to sample material from infected patients and sample material

[1] There are four human coronaviruses – 229E, NL63, OC43 and NKU1 that account for ~15% of common colds in humans which may confer some cross reactive immunity, although relationship to Covid is unclear..

[2] There are reports of IgA antibodies being detected first.

[3] Tetanus antibody levels considered to confer protective immunity extrapolated from LD50 experiments in mice.

from those who do not have Covid infection that can be used to validate these tests. Ordinarily patients' sera can contain antibodies that can confound antibody tests. The format of these tests can make them susceptible to negative results. To date the number of assays that have used healthy controls to define the false positive rate (specificity of the assay) is significant and not appropriate. Other assays do not specify sufficient detail of control material used in evaluations in order to judge their efficacy.

Evaluation of these assays has been largely left to individual laboratories and as a result an array of different solutions is now being investigated. Assays fall into different types which all have specific issues. If the country moves to a different phase of Covid response or a vaccine is in place antibody assays will become an essential tool. They will be invaluable as an adjunct to tracing and also in evaluating immune responses. They can also identify convalescent individuals from whom donations of sera can be produced to aid in treatment of seriously ill patients. Withthewindowoftimeavailable now Medical Laboratory Scientists in diagnostic medical laboratories around NZ need to coordinate their efforts and expertise to ensure that the most effective antibody test(s) are being offered. Specific forums need to be enabled as this will likely reduce national duplication of effort and more quickly result in proper validations. Nationwide antibody testing consistency and harmonisation and therefore greater public confidence would be the natural output.

Current Issues for Consideration

Standardisation/ Harmonisation of assays -

- **Validation process**
- **National/International Standard Sera**
- **Assay formats**

Quality assurance -

All assay validation documents for assays to be made available to all.

Send us your thoughts: mit@apex.org.nz

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