APEX
Allied, Scientific and Technical

Interim Career Framework – APEX Analysis Report

Executive Summary

The original purpose of the Interim Career Framework (ICF) was to improve national consistency, given the breadth of salary translations coming out of pay equity and across twenty district health boards merging into a single Designated scale for a single employer. Within this, the aim was only ever to lift the placements and salaries of the 'lowest common denominators' – roles were never going to be mapped lower than they had been translated to.
This original purpose has changed substantially since 2024. Importantly, what we were told about the new process for mapping roles has since proven to be entirely untrue, as we detail in this report.

This report only looks at the variability in processes at a local level because this is what we have evidence of. The data shows that at a local level the variability in this process is significant, including if position descriptions (PDs), role titles, and discussions with operations / line managers were – or equally, were not – considered as part of the mapping.

We have been told regional and national processes occurred and that mapping was adjusted accordingly on the basis of increasing consistency. However, there is no information provided of what occurred or how these regional and national processes impacted outcomes.
By contrast, our evidence shows regional and national attempts at "consistency" have been fundamentally flawed because even where local mapping has been demonstrably inconsistent, this has not been identified and rectified at a national level.

As one example, Senior MITs in Canterbury who were previously on Band B were mapped onto Band A of the ICF, whereas these roles in Waitematā were mapped to a Band C. If anything, Canterbury's mapping made this less consistent. So why wasn't this picked up in national moderation processes, and why were outcomes in Canterbury not adjusted to lift salaries to be consistent with Waitematā?

Put simply, it is our view that the ICF has been a very poorly executed process. It did not achieve its original nor revised purpose. It has left us with glaring inconsistencies across the motu, despite this alleged purpose.
And it continues to have deeply distressing psychosocial impacts on the AST workforce.

Going forward

The reconsideration process must address all sources of inconsistency. Managers and DAHs must undertake to use accurate role information in properly mapping roles against the framework, doing what Health NZ had said it would do in the first instance. The onus here must be on the employer to get it right, not on the employee to prove the point.

There must also be an undertaking from Health NZ to dispense with the hiring of roles (vacancies and new positions) at the lower ICF placements, because the ICF was never an exercise in job sizing so there is no basis for determining these roles are "worth" less.

Finally, it is impossible to avoid the conclusion that the veracity and credibility of AST Senior Leadership has been brought into question because of what this process has uncovered; this must be addressed by Health NZ.

Background to this report

Following Health NZ's roll out of the Interim Career Framework (ICF), APEX has undertaken an analysis of its process and outcomes across districts. The purpose of this report is threefold:

1. To collate and share information transparently, so that members can make an informed appeals submission when the process reopens for APEX.
2. To once again draw to Health NZ's attention the discrepancies between the espoused purpose of the ICF and the reality that transpired – namely that there has been a failure to achieve its stated aims of "national consistency".
3. To consolidate learnings from this process and provide a basis for next steps.

What was supposed to happen with ICF?

ICF was never meant to be a comprehensive role mapping exercise. It was simply meant to be a quick "interim" (as the name indicated) adjustment of roles post pay equity translation, towards national consistency and specifically to adjust the lowest standard deviation upwards. There was never an intention to reduce salaries noting that a full job evaluation process would occur later with 'Career Framework' and the Job Evaluation Tool (JET).

The initial framework tabled by Health NZ was straightforward with roles mapped based on district size: small versus large. At some point, this morphed into a more complex framework, without engagement, which we were told would account for factors such as:

- Working across multiple settings of care,
- Working across multiple sites,
- Working across multiple districts,
- Responsibility / oversight of multiple professions,
- Significant additional responsibilities of the role, and
- Other factors that increased or decreased complexity of the role.

The stated process would now involve:

1. Comparing responsibilities of a role with the overarching role groupings using the ICF Support Tool descriptors.
2. Identify best fit of overarching role grouping.
3. Review considerations of the above factors that add to/reduce role complexity.
4. Determine Tier 1 / Tier 2 status.
5. Regional and national moderation conversations to compare mapping of similar roles.
6. Confirm district mapping.

District and regional Chiefs Allied Health Scientific and Technical (DAHs and CAHSTs) were to lead this work with input from Operations Managers and Line Managers. Role titles were not to be used to determine ICF placement. [1] The end goal was a more nationally consistent placement of Designated roles until Career Framework landed.

It is unfortunate that it has taken over three years for this 'interim' framework to land, that this shambolic process has been deeply demoralising for staff, and that this has now soured expectations around the 'Career Framework' which is soon to kick off its pilot phase.

1. https://apex.org.nz/campaign/career-framework/#interim-career-framework-faqs

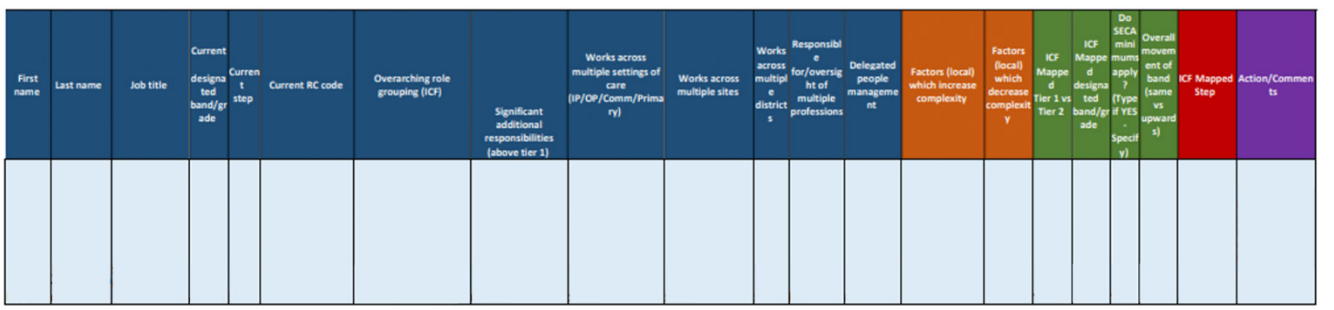
What we believe happened.

APEX's view is informed by discussions with and correspondence from allied leaders within Health NZ and member feedback. Information has been collated below to highlight discrepancies across process and outcomes.

Comparison of ICF process and communications across districts

The table below contrasts the variation in the ICF mapping process across districts, as well as in responses to members' requests for information. We only report in those districts where members have had a response at the time of writing.

What we mean by 'line data': An ICF Mapping Template (Excel spreadsheet) was used by CAHSTs in the mapping process. Within this spreadsheet, each member's role information was consolidated across a single row or 'line', sometimes including comments to justify placement. Below is a snapshot (data removed) of what this looks like.



First name	Last name	Job title	Current designated band/grade	Current step	Current RC code	Overarching role grouping (ICF)	Significant additional responsibilities (above tier 1)	Works across multiple settings of care (IP/OP/Comm/Primary)	Works across multiple sites	Works across multiple districts	Responsible for/oversight of multiple professions	Delegated people management	Factors (local) which increase complexity	Factors (local) which decrease complexity	ICF Mapped Tier 1 vs Tier 2	ICF Mapped designated band/grade	Do SECA minimums apply? (Type if YES - Specify)	Overall movement of band (same vs upwards)	ICF Mapped Step	Action/Comments

District	ICF process	Responses to member requests for information
Auckland	**APEX view of the process in Auckland** Auckland refused to attend a meeting to review ICF process and outcomes. **What members told APEX** • PDs were materially outdated, and in some cases, the only information relied upon. • Managers did not have input into mapping process.	• Line data, with some commentary on factors that increase and decrease role complexity.
Bay of Plenty	**What members told APEX** CAHST has made genuine attempts at promptly responding to and resolving member queries, including overturning lower placements and moving staff up outside of the formal appeal process.	• Line data, with some commentary on role-related information. • Specific PD used as part of the decision-making process. • Redacted emails with Team Leads and Professional Leads as part of mapping discussions.
Canterbury & West Coast	**What Canterbury CAHSTs told APEX in our regional discussions** Mapping was not a role evaluation process but a "broad conversation" around the role against: • Descriptors of ICF role groupings • Organisational structure • "Information at hand" from leadership team (DAHs, Line Managers, Service Managers) Acknowledgement of variation in job titles due to: • 'Business titles' (in the MAX system) used to recruit for a role • Historic titles no longer used • Actual day-to-day role titles Mapping "looked at roles beyond titles". This is counter to what members have told us (see below). As an example with laboratory services, we were told the General Manager and Senior Professional Leads were involved in mapping. **What Canterbury CAHSTs told members in responses to ATA requests** "Chief AHST Office led the process supported by the DAHs Waitaha and Te Tai o Poutini and Service Managers / Operations Managers as relevant to the role. Initial conversations were held with the Operations Managers / Service Managers about the roles that reported directly to them. Comparison of roles utilizing the ICF support tool were made at district and national level." **What members told APEX** At a meeting with staff in July, the Canterbury DAH confirmed: • The information used to assess mapping was just the job tile and did not look at PDs. • They did not use the mapping tool criteria for ICF placement. Staff discussions with their own managers (e.g., in Pharmacy) have confirmed that they had no input into the mapping.	• Line data with no commentary. • Noted where PDs were not available/used at the time of mapping. Where outdated PDs were used, also noted and attached.

Counties Manukau	**APEX view of the process in Counties Manukau** Counties Manukau refused to attend a meeting to review ICF process and outcomes. **What Counties Manukau CAHST told members** "The role mapping hasn't been done using titles (because titles vary across comparable roles)" however, when member sought further information, they were asked about role title information and whether they had any "formal title changes". **What members told APEX** • PDs were materially outdated, and in some cases, the only information relied upon.	• Line data, often with no commentary. • References minimums noted in the Collective Agreement, where applicable. • References discussions with Managers (i.e., "Laboratory management") but no evidence of discussions provided
Hawke's Bay	**APEX view of the process in Hawke's Bay** Multiple issues with ICF notifications: • Letters sent out earlier than dates indicated to unions. • Letters incorrectly referencing PSA agreement. • Letter sent to member in a non-pay equity profession. • Member placed higher on ICF, then received payroll notification that this was an error "following a subsequent review", with overpayment refund sought (case ongoing). • Several delayed letters, sent to members months later.	• Line data provided, sometimes with commentary. • For MIT roles there is reference to "mapping reviewed with service leadership". • Timeline of events / mapping history provided.
Capital Coast & Hutt Valley	**What members told APEX** Based on member feedback, issues in these districts have largely been about compliance with placement on minimum steps outlined in the relevant collective agreements. CAHST has been responsive in remedying issues. **What CCHV CAHST told members in responses to ATA requests** "Chief AHST Office led the process and either one or two members of that team were involved in all mapping conversations for CCHV. Initial conversations were with Ops Managers or Service Managers about the roles that reported directly to them. We asked Ops Managers or Service Managers to then identify whether they could speak directly to other roles (i.e. Roles for which they are the two-up manager) or whether we needed to consult direct line managers".	• Line data provided with some commentary. • Reference to PDs being sourced prior to mapping and PD provided in response. • Reference to Operations Manager consulted for AT roles.
Northland	**APEX view of the process in Northland** Some delays in ICF notification within this district. **What members told APEX** • Role titles appear to have influenced placement, despite this not being part of the assessment. • Some members did not have a PD. • For some professions (e.g., Physiotherapy) Team Leads / Line Managers did not have input into mapping, with communication gaps.	• Line data provided with some commentary which indicates "moderative conversations have taken place to confirm placement with other comparable districts". • PD used to inform mapping attached.

Waikato	**What Waikato CAHSTs told APEX in our regional discussion** PDs were not predominant driver of mapping. They looked at: • PDs, • Role titles, and • "General" discussions with Operations Managers around where roles fit within team structures. Where role titles in HRIS system did not align with staff role title, they "tried where possible to line up the two". Recognition that some districts "may have given more weighting to the PDs". "Further work" to be done in region around service design and designation/ recognition of advanced practice roles (e.g., Physiotherapy). **What members told APEX** Despite assurances that the process will consider individual roles and with input from Managers, this has not happened. Most designated staff have been mapped to the lowest band. Where PDs were relied upon, these were materially outdated. Several delayed ICF notification letters.	• Line data provided with some commentary. • PD used to inform mapping attached. • "Discussion with Operational Manager" referenced.
Waitematā	**APEX view of the process in Waitematā** Waitematā refused to attend a meeting to review ICF process and outcomes. **What members told APEX** Some PDs were materially outdated. The CAHST has been responsive in remedying some issues informally outside of the appeals process.	• Line data provided with no commentary. • PD used to inform mapping attached. • Reference to other information considered in mapping: "Knowledge of service" and "Org manager/ chart available via StaffNet".
Southern	**APEX view of the process in Southern** District CAHST has been responsive to reviewing and updating PDs, where this has not existed, to inform updated placements. **What members told APEX** Several members have confirmed that the CAHST had asked to check all ICF notification letters prior to being sent out. Letters were sent out anyway (unchecked) while they were on leave, without the CAHST review. Members believe no mapping was done and that (inaccurate) data was simply pulled from payroll. Some members also did not have a PD.	• Line data provided with no commentary. • Payroll information (around role title) sometimes provided.

Note: *If your district does not appear on this table, and you have not yet lodged your Authority to Act request, please do so immediately so are aware of what is happening in that district.*

Comparison of ICF placement outcomes across groups

Unsurprisingly, the variability in the process has led to significant discrepancies in mapping outcomes within and across districts. Our analysis of these discrepancies is informed by data members have provided to us. Where we do not hold data, or where there are too few people in the role to provide placement information without compromising their identity, we have not provided this information.

ATs

We have insufficient data across members and districts to identify significant discrepancies, except to note that Specialist Practice ATs have been generally placed at A and Team Leaders at B.

Dietetics, Occupational Therapy, and Social Workers

We have insufficient data across members and districts to identify placements nor discrepancies.

Clinical Physiologists

Across 9 districts:

Role	Placement on ICF
Renal Physiologists	Ranging from A to C (at the transplant centres) and C (at some non-transplant centres)
Respiratory Physiologists	Ranging from A to D
Cardiac Physiologists	Ranging from B to D
Charge / Team Lead Cardiac	Ranging from B to E
Section Heads	D

Medical Laboratory Workers

Across 6 districts:

Role	Placement on ICF
Technical Specialists	All on A
TB/PC3 Scientists	Ranging from A to B
Scientific Officers	Ranging from B to D (some within the same district)
Section Head	B or D

MITs

As far as we can tell, MIT mapping has been based solely on the minimum bands outlined in the Collective Agreement. However, it is worth noting:

Role	Placement on ICF
Senior MITs	A in Canterbury, C in Waitematā

Pharmacists

Across 4 districts:

Role	Placement on ICF
Senior Pharmacists	A or B
Specialist Pharmacists (e.g., nephrology, medicines information, ICU, etc.)	All on A
Pharmacist Prescriber	B or D
Advanced Pharmacists	B or C
Team Leader	Ranging from B to D

Physiotherapists

Across 3 districts:

Role	Placement on ICF
"Senior" Physiotherapists	All collectively on A (Waikato)
Section Head	A or B
Advanced Clinician	Ranging from A to C

RTs

As far as we can tell, RT mapping has been based solely on the minimum bands outlined in the Collective Agreement.

Why was there a difference?

If role titles were variable, position descriptions outdated or entirely unavailable, and little to no input from operations and line managers into the mapping process – how could CAHSTs ensure consistency of mapping decisions across roles? And if local, regional, and national 'moderating' conversations occurred, as stated, then why weren't these major inconsistencies picked up?

It is our view that the absence of a rigorous and reliable process at the district level has allowed a huge degree of subjectivity to seep in, influencing mapping outcomes. [2]

Why for instance, have members in some districts been able to resolve placement issues through informal conversations with their DAH/CAHST, whereas other DAHs/ CAHSTs have been evasive and deferred to the reconsideration process even before this was paused?

Why have some DAHs been forthcoming about the fact that only role titles were used for mapping, whilst others remain committed to upholding the façade that this has been a rigorous "nationally consistent" process? We have also seen such variability across service/line managers and professional leads – some supporting and even directly encouraging members to appeal, whilst others letting their own personal agendas interfere, going so far as to dissuade members from appealing. In at least two districts service managers have raised concerns about preserving their own pay relativities when members have sought to have discussions about appealing their placement. In one instance, there was an implied threat of a member's workload being increased if the outcome of their appeal resulted in a higher placement.

The evidence points to an incredibly inconsistent ICF process, where the personal views have been allowed to influenced staff placement, and ultimately, the extent to which their roles are "valued" by the organisation.

What can we take away from this?

If the entire purpose of ICF has been about "national consistency" and not about determining the value of the role – which is what 'Career Framework' is about – then we would expect to see consistent outcomes across roles. Yet, the data tells a totally different story.

Further, while there has been a reversal of decision to 'freeze' staff whose roles were mapped lower, should these roles become vacant recruitment will be against the lower placement. Again, since ICF was never intended as a job evaluation system, on what basis has it been determined that these roles are "worth" less and should be placed lower?

We suspect this has simply been a means of cutting pay and holding down budgets – something that managers have alluded to in conversations with our members.

2. It goes without saying that if inconsistency existed at the local level, regional or national attempts at consistency were only going to exacerbate issues. We do believe that the process at regional was more one to drop to lowest common denominator, so the local discrepancies simply occasioned the opportunity for more disadvantage.

What must happen going forward.

So, what needs to happen now?

For APEX members

The information provided in this report should give you an indication of how ICF mapping occurred in your own district, against others, including what information was included or omitted as part of this process. You may also get an indication of where broadly comparable roles have been mapped.

However, you should not have to spend hours rewriting PDs or proving your "worth" to fix what has been an incredibly flawed process by Health NZ. We will be releasing guidance on how to use this information in your own appeals (or amending previously submitted reconsideration forms) once the reconsideration process has been agreed with Health NZ. We are also providing this report to Health NZ to facilitate the reconsideration process for APEX members as smoothly as possible.

For Health NZ

We are conscious that members have already had to provide significant role information:

- First, in 2024 during the translation phase.
- Then, in preparing and submitting reconsideration forms. Many members have already submitted this in the vacuum between their notification and receiving a response to requests for information about their own role.
- Then again, when the reconsideration process officially re-opens for APEX.
- And once more, when engaging with the JET and 'Career Framework' process. For some this process is happening in parallel through their involvement in the pilot.

This is unacceptable. We are here because the ICF rollout has been plagued by a fundamental and unilateral change in purpose, and widespread procedural failures, as evidenced in this report. Health NZ must therefore take responsibility for fixing these outcomes. If the ICF process has not been transparent, consistent, and rigorous, let the appeals process be so at least.

Once the reconsideration process has been agreed for APEX members, Health NZ must:

1. **Assess reconsideration forms in good faith.** The burden of proof should not be on employees to pull together information to "prove" the worth of their roles. Health NZ must be open to reviewing all placements, with the onus on the employer to demonstrate that the role was mapped correctly using robust criteria, rather than requiring staff to prove where errors occurred. Where mapping relied on outdated PDs, incorrect job titles, or occurred without operations/line manager input, CAHSTs must actively work with line managers and staff to verify actual responsibilities in finalising appeal decisions.
2. **Abandon the position of lower-band vacancy recruitment.** We can all agree the ICF mapping process has been flawed. Since it was never intended as a comprehensive job evaluation exercise, roles must not be "downgraded" prior to the full 'Career Framework' rollout.