

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

Workplace Relations Act 1996

Section 503 referral to Full Bench to make a workplace determination

Health Services Union

and

Austin Health and others

(BP2007/4059 and others)

WITNESS STATEMENT OF JENNIFER KAYE GRATTON VAUGHAN

I, **JENNIFER KAYE GRATTON VAUGHAN**, Executive Director Community Integration / Chief Allied Health Officer, Northern Health at 210 Bell Street, Preston, in the State of Victoria, say as follows:

- 1 I am the Executive Director of Community Integration and a Chief Allied Health Officer at Northern Health. I have held this position since December 2006.
- 2 I am authorised to make this statement on behalf of Northern Health. I make this statement from my own knowledge except where otherwise indicated. Where I make statements based on information provided by others, I believe such information to be true.
- 3 From 2001 to 2006 I held the position of Director of Allied Health at Northern Health. During part of this period, I also held the positions of Acting General Manager for Craigieburn Health Service and Acting General Manager for Panch Health Service.

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4 My qualifications include:

- (a) Bachelor of Applied Science in Occupational Therapy;
- (b) Post-graduate qualification in Rehabilitation Studies; and
- (c) Masters in Management.

5 In my role as Executive Director Community Integration / Chief Allied Health Officer, I provide operational and professional management and leadership for allied health disciplines at Northern Health. I also have responsibility for the overall management of the Craigieburn Health Service, the Panch Health Service and Trans-Cultural and Language Services (which are provided across all services).

Northern Health – Services

6 Northern Health comprises five campuses:

- (i) Northern Hospital (acute care facility with inpatient and ambulatory services);
- (ii) Broadmeadows Health Service (primarily a sub-acute facility with inpatient and ambulatory services);
- (iii) Bundoora Extended Care Centre (inpatient and ambulatory services);
- (iv) Panch Health Service (ambulatory services and a number of programs provided in partnership with Austin Health, Bundoora Extended Care Centre, Darebin Community Health and Mercy Hospital); and
- (v) Craigieburn Health Service (ambulatory services and incorporates other providers other than those of Northern Health).

7 Northern Health's allied health services are structured according to three main programs:

- Acute;
- Continuing Care; and
- Community Based Ambulatory Services.

Allied Health Employees and Departmental Structure

- 8 Northern Health employs approximately 283 allied health professionals across all three program areas. I have operational responsibility for the following full time equivalent (EFT) staff:

Physiotherapy	54.50 EFT
Occupational Therapy	36.33 EFT
Social Work	25.17 EFT
Speech Pathology	12.3 EFT
Podiatry	8.30 EFT
Recreational therapy	0.63 EFT
Orthotics	0.30 EFT
Orthoptics	0.30EFT
Total	137.83 EFT

- 9 The remaining EFT of Allied Health professionals include health information managers (**HIMs**), case managers, cardiac technicians and care coordinators at Northern Health. I do not have responsibility for these areas of Allied Health. I am not responsible for some staff who work in the Hospital Admission Risk Program (**HARP**) because they do not work solely in Allied Health roles. These staff work in more generic roles and may, for example, work as an Allied Health therapist only occasionally. Finally, because our radiology services are contracted to a private provider I do not have responsibility for allied health professionals working in radiology.
- 10 The disciplines of physiotherapy, occupational therapy, social work, speech pathology, podiatry, recreational therapy, orthotics and orthoptics all come under one directorate, for which I am responsible.
- 11 Each discipline operates as a separate department. However some of the smaller departments are grouped together for efficiency, administrative and managerial reasons. These groups have a single HSM who is responsible for several departments. So for example, there is an HSM who is in charge of speech pathology, podiatry and dietetics. These three disciplines also have their own clinical manager who reports to the HSM.
- 12 The physiotherapy, occupational therapy and social work departments each have a Health Service Manager (**HSM**) who leads the department. They also have various clinical managers who run clinical streams within the department and report to the HSM.

- 13 Each HSM is responsible for their department(s) across the whole health service. That is, the HSM is a “cross-program” role which means the HSMs are responsible for their department in each of the 3 program areas across Northern Health’s 5 hospitals. The clinical managers in the smaller departments (such as podiatry and speech pathology) are also cross-program roles. In the larger departments, the clinical managers do not operate across all programs. In occupational therapy, for example, there is a clinical leader in charge of Continuing Care programs, and another who is in charge of Acute and Ambulatory Services.
- 14 This structure was designed to and does meet the current needs of Northern Health. It also provides flexibility to respond to changing needs of the service in the future.
- 15 This structure (except for the department divisions) was introduced in October 2007 following an organisation-wide restructure. Now produced and shown to me and marked “**Exhibit JGV-1**” is a copy of the organisational structure of each department.
- 16 Prior to the restructure, Northern Health had a campus based rather than program based structure. Historically this was because Northern Health comprised only three campuses. Under the former structure, the larger disciplines of occupational therapy, physiotherapy and social work always had site based managers who also had clinical responsibilities. Some of these managers were classified as “Chiefs” and some were classified as “Senior Clinicians”. However, in the smaller departments, the low levels of EFT at each campus dictated that even before the restructure there were cross-campus leadership positions. Since the restructure in 2007, health care services have been aligned to program areas.
- 17 The 2007 restructure was implemented following a process of consultation and conciliation between Northern Health, Allied Health staff and the HSU. The HSU objected to the proposed structure. Ultimately, the structure was determined following a conciliation before Commissioner Cribb.
- 18 Northern Health proceeded to roll out the restructure in October 2007.

Funding

- 19 Northern Health receives annual funding from the Department of Human Services (**DHS**) and it is from this income base (together with other funding sources such as private patient fees) we create budgets. I have responsibility for managing funding allocated to allied health. This funding is then allocated to numerous costs including wages, consumables, equipment and maintenance.

- 20 Northern Health cannot implement projects or provide services that exceed its annual budget otherwise it will operate at a loss. The budget is limited so that when we need to implement a new project, in the absence of additional funding, we need to prioritise and/or reduce services in other areas. These decisions are based upon a number of factors including demand for services,, acuity, patient need and cost.
- 21 In an effort to meet costs within its budget, Northern Health has developed a financial efficiency plan that includes limiting leave cover agreements in various departments in the organisation and even increasing parking fees. If the Commission were to award some or all of the HSU's claims, it would have a significant impact on Northern Health's ability to manage our operating costs and, therefore, our ability to provide health services in the existing range and quality. The claims could not be met within our existing budget and if imposed, Northern Health would need to consider service cutbacks.

HSU Draft Workplace Determination

- 22 I have reviewed the HSU's draft Workplace Determination that was filed in the Commission on 28 May 2008. I make the following comments with respect to certain clauses.

Chief Structure

- 23 The HSU claims in clause 21.10.7 would require Northern Health to appoint a Senior Chief, a Chief at each campus and a Chief of the department.
- 24 There are four key difficulties with the HSU's claim. First, the proposed clause is prescriptive, inflexible and does not meet the needs of Northern Health's service. The clause is somewhat similar to the structure that some of Northern Health's larger departments had before 2007. However, Northern Health moved away from that structure because it did not meet the needs of Northern Health's patient, staff or service delivery programs. It is important that Northern Health be able to determine the structure that meets its needs and service delivery from time to time. To have a blanket and prescriptive clause imposed across all health services and in each department of each campus does not take into account the fact that each health service is a different size, has different staff numbers, different department size, client needs and service requirements.
- 25 Secondly, if the clause were imposed Northern Health would be forced to recruit additional staff to fill the role of Senior Chief and Chiefs or alternatively recruit for vacancies caused by the appointment of existing staff to these roles. I have reviewed two organisational flowcharts, marked as attachments "FH17" and "FH18" annexed to

the amended witness statement of Fleur Harbridge dated 3 September 2008. It is unclear on the face of attachment "FH18" whether the HSU intend that existing staff be upgraded to fill the positions of "site manager" or "clinical educator, grade 4". Even if staff were upgraded, Northern Health would still need to recruit new staff to fill the vacancies that resulted from the upgrade. The structure does not take into account the need to recruit the right people for the right role, nor does it have regard to the practical effect of a site manager reporting to a Grade 4 staff member. A site manager performs a different role (which is administrative and managerial based) and is potentially more senior to a Grade 4 position. The proposed structure could not be achieved without either appointing existing staff to the role of "site manager" (or "clinical educator") and recruiting for those positions which would subsequently become vacant, or recruiting new employees to fill the positions of "site manager" or "clinical educator". The claim would result in an increase of Northern Health's EFT and expenditure of wages regardless of whether existing staff were upgraded or new employees recruited directly to those positions.

- 26 Thirdly, a Chief structure is not appropriate at every campus and in every department. For example, in the smaller departments a Chief is not necessary because the number of allied health employees in those departments is relatively small and there is insufficient work to warrant the role. The current structure of combining departments into groups with an HSM is more appropriate. The existing structure provides appropriate levels of supervision for staff. At the same time it also provides the flexibility for HSMs to tailor needs based upon its program needs and to adopt a complimentary approach to service delivery across several campuses. In this way the current structure is also cost-effective.
- 27 Fourthly, if Northern Health were required to comply with the clause it would increase wage costs. Increased costs would occur due to the recruitment of staff and increased EFT. If existing positions were reclassified at a higher level to meet the claim it would still increase wage costs arising from the need to pay higher salaries. There is no additional funding within our current budget for such costs. If the clause were imposed, in the absence of additional external funding, we could not absorb the increase in costs without make cut backs to the service elsewhere. This would impact on the range and quality of health services provided by Northern Health.
- 28 If approved, the HSU claim (clause 21.10.3) would also require that a manager of a multidisciplinary team be classified as no less than a Chief Grade 2 and be remunerated according to the total number of staff in the team. In addition, a team leader in a department or multidisciplinary team must be classified at no less than a Grade 3

(clause 21.10.4). The HSU proposal, if implemented, would require us to reclassify a number of the leadership positions.

- 29 Northern Health has team leaders in charge of multidisciplinary teams, for example HARP, care coordination managers and case managers in community services programs. These team leaders have program management responsibilities rather than management of the particular discipline in which they work. This means that they manage a multi-disciplinary team, including nurses, doctors and allied health) rather than just physiotherapists, or just social workers. The leader of these multi-disciplinary teams does not have to be an allied health professional. It would be an inequitable result if, when the manager of a team happened to be a physiotherapist the position had to be classified at a minimum of Chief Grade 2, but could be classified (and paid) at a lower level if the position was occupied by a nurse or other hospital employee. If clause 21.10.3 and 21.10.4 were imposed it would increase Northern Health's wage costs which could not be met within our existing budget. Alternatively, it could operate as a disincentive to appoint an allied health professional to lead a multi-disciplinary team.

Senior Clinicians

- 30 The HSU claim (clause 21.11) provides that an employer must employ a full time Senior Clinician Grade 4 for each discipline (including MIT Tutor, Grade 3) on each site and in each "section" of the relevant department.
- 31 Northern Health employs staff based on service need. Existing Grade 4 staff are employed in the larger disciplines (physiotherapy, social work and occupational therapy) as clinical leaders. They are responsible for ensuring the clinical competencies of all staff within their team (eg. staff graded 1 to 3). It is part of the position description for a Grade 4 that they will be involved in clinical governance, ensuring the safety of the service and coordinating services with other program staff. Grade 4 staff supervise more junior staff within their program or discipline and ensure that evidence-based practice is in place in their particular speciality areas (as applicable). Grade 4 staff also have responsibility for quality and research initiatives.
- 32 However, the requirement to have a Grade 4 would not suit all departments. For instance speech pathology does not have an existing Grade 4 because there are only six staff in that department and there is no need for a staff member at this level. The supervision, clinical need, education and administration involved in running that department do not warrant a senior clinician at that level.
- 33 Having a Senior Clinician Grade 4 in an area that only has five staff cannot be justified. The scale would not be right.

- 34 The appointment of senior clinicians should be based on the need of the particular department, its size and the amount of non-clinical work that needs to be done. The existing classification of staff in departments meets the needs of Northern Health, The proposed HSU clause would result in the appointment of additional Grade 4s without any commensurate improvement to health services. The employment of staff should add value to the service we offer, and it would not add value to employ a Grade 4 in departments where there is insufficient work to justify the existence of such a position.
- 35 The HSU claim would also potentially require Northern Health to employ five Grade 4's in each discipline at Northern Health. This is because we have five services that could be described as separate sites. This structure is not viable particularly when, in respect of one site, Northern Health may only have one or two staff in the entire discipline. Northern Health would not have enough quality work or research projects to occupy such staff. A one size fits all approach does not make sense.
- 36 The cost of employing so many additional Grade 4s would also be prohibitive. We could not meet the costs within our current funding structure. If the clause were imposed we would need to seriously consider reducing positions elsewhere. This would necessarily lead to a decrease in the level of service provided to patients.

Clinical Educator

- 37 The HSU claim (clause 21.13) would require an "Allied Health Grade 4 Clinical Educator" to be appointed in respect of departments of 25 staff or more. Again, Northern Health employs staff based on service need. In delivery health care services it is not about the imposition of prescribed numbers and classifications but about the needs of the particular department. For example, if we had to employ a Clinical Educator and there were no graduates or students in the relevant department, there would be insufficient work for the Clinical Educator to do. It would also further increase Northern Health's cost in circumstances in which a Clinical Educator was not required because of the size and service requirements within that department. In other words, it would increase costs but not lead to an improvement in productivity or the quality of services delivered. Further, under the current structure, our education needs are adequately met by each grade undertaking supervision and training of the grade below. This system works well and results in staff having direct and "hands on" training and education from more senior staff in the department.

Staffing Profile

- 38 If approved, the HSU claim (clause 18.1 and Schedule 2) would require Northern Health to appoint a skill mix of health professionals in each department comprising no less than 1/3 Grade 1, 1/3 Grade 2 and 1/3 Grade 3, senior clinician or higher classification.
- 39 As stated previously, Northern Health does not provide services according to campuses; it works according to programs. The grading of our staff is based on service need and that service need is different for each discipline. It is determined by the speciality of work, the level of acuity (e.g. the level of work input required) and the level of complexity (e.g. complex family relationships / cultural differences). The HSU clause prescribes a set profile without reference to the needs of the particular service. There would be insufficient work to justify staff at each grade in each department. That is, some departments require a higher level of senior staff whilst others might require a greater number of junior staff depending upon the needs of the service.
- 40 If the clause were imposed, Northern Health would need to employ additional staff to ensure that it met the profile in each department. In very small disciplines, such as podiatry and speech pathology (which have a low EFT) the prescribed profile is unnecessary and does not reflect the needs of the services in that particular discipline.
- 41 The clause would increase costs (arising from recruitment of additional staff to a particular grade or arising from the promotion of staff) which could not be met within its existing budget.
- 42 In addition, any change to the proposed profiles would be subject to the HSU's proposed organisational change process (clause 18,2 and clause 8). As a health service, Northern Health needs to be able to staff its services as it deems appropriate in order to best meet the needs of the services it provides to the community. The requirement that staffing profiles for new sites go through a detailed organisational change culminating in a determination by the Commission impedes a manager's ability to manage change, ensure delivery needs and quality assurance is maintained and restricts Northern Health's ability to generally manage our health service.

Classification Structure

- 43 If approved, the HSU claim (clause 6.2) will extend the application of the award to proposed new classifications.
- 44 Historically the award has applied to professional allied health employees involved in therapeutic intervention. "Case Managers" and "Team Leaders" do not necessarily

perform such roles. It is difficult to interpret the application of the proposed classifications without appropriate definitions.

- 45 Under the proposed clause the classification (grading) of such staff would be determined by how many people worked in their team. The number of people within a team does not necessarily reflect the complexity of their duties or the program for which they may be responsible. Applying the ordinary classification system to these roles would not be an appropriate .
- 46 The HSU claim (clause 21.1.1.3), if approved, would require Northern Health to classify any post tertiary graduates as Grade 1, Year 4 of experience after qualification. Northern Health generally employs Grade 1, Year 2 as a minimum entry classification level. Paying a qualified rate doesn't mean that these graduates are more clinically experienced. The justification for paying professionals more when they have several years experience is because they are expected to be able to perform their duties more efficiently and to a higher level. Paying a higher rate based on qualifications rather than experience and ability does not reflect the level of service that these people are capable of providing. It would increase costs without any commensurate improvement to the productivity, efficiency or services delivered by staff. Taking into account budget constraints and service need we need to pay staff according to their abilities and responsibilities, not according to their degree. Implementing the HSU claim would also increase the overall cost of employing junior staff.
- 47 The clause would also mean that junior staff would reach the top of Grade 1 more rapidly than if they moved through each level based upon their clinical skill, experience and the needs of the service. If the clause were imposed, Northern Health would need to review (and might need to decrease) the number of graduates it employs to limit the financial cost. This would reduce the career prospects for newly qualified allied health professionals.
- 48 The HSU claim (clause 21.1.3.2) also requires persons who hold a degree of Masters of Science be classified as UG1, Grade 1, 5th year of experience. This clause, like clause 21.1.3.1 above, will impose a significant financial cost on Northern Health. This is particularly given the changes that universities are making towards generic degrees, followed by a professional master qualification (eg the Melbourne model). Everyone in a particular discipline would then graduate with a Masters or Doctorate qualification. However, in reality, these graduates do not have any better clinical skills or experience than other graduates. As a result of these new degrees, students will potentially do less field placements which means that they are potentially even less "work ready" than current graduates. Consequently, it is not appropriate to pay a graduate or post-

graduate clinician at a higher level. There would be no change in their clinical output to justify the additional remuneration and the extra cost to the health service.

- 49 Overall, the proposed classification structures appear to remove an employer's discretion to determine whether an employee is capable of holding a particular position. In my view, the employer is best placed to determine classification based upon factors such as the role and responsibilities of a particular grade, turnover, the clinical and financial needs of the service and the employee's skills and experience. Also we need to be able to structure our departments on the basis of who we need to meet our service. The HSU claim limits our ability to do so.

Sole Employees and Employees Working Independently

- 50 If approved, the HSU claim (clause 21.10.3) would also entitle sole employees and employees working independently to be classified at a higher grade. Northern Health does not currently have any staff who are working in "sole positions". However, the impact of the claim will depend on the meaning of "working independently". At Northern Health, all staff are expected to be able to work independently but with someone supervising their practice on a regular structured basis.
- 51 The claim for additional remuneration is unnecessary because staff are provided with appropriate support and supervision so that they are equipped for their role. The range of support includes direct supervision from senior staff at other sites, having senior staff move between sites to ensure that there is adequate support, supervision and assistance from the HSM.
- 52 The HSU claim (clause 21.10.4) would require sole workers be paid an additional allowance. No one in any of Northern Health's programs works in a "sole position". However, they could be the only person present on a particular site at any given time. The fact that an employee may be the only person present on a particular site does not reflect the complexity of their tasks or their workload. Employees in higher classifications are employed with particular competencies and can be independent practitioners. However, as stated above, additional remuneration is unnecessary as all employees have support structures. The claim would increase costs without any improvements in the productivity or efficiency of services.

Backfilling for certain absences

- 53 The HSU claim (clause 49) requires Northern Health to provide 100% leave cover for any employee who is absent on annual leave for a period of five days or more.

- 54 Northern Health has had to decrease leave cover due to a lack of available money in the budget. Northern Health used to provide leave cover across acute and continuing care services. However, now we only have 50% annual leave cover, ADO cover and professional/conference leave cover for 5 days only in the acute programs.
- 55 The claim would require us to recruit additional staff to cover such absences. Whilst existing staff can sometimes be used to backfill this is not always possible. It would require Northern Health to recruit additional staff to cover such absences. We cannot meet the HSU claim within our current budget. Moreover, even if the costs were not prohibitive, Northern Health would still experience difficulties in obtaining appropriately qualified staff to backfill, at either short notice or for short periods of time.

Fixed Term Employees

- 56 The HSU claim (clause 15) seeks to restrict fixed term employment to periods of 12 months, after which these positions will convert to permanent positions. Similarly, the employment of temporary employees will be restricted to three months.
- 57 Northern Health uses fixed term and temporary employees to backfill for long service leave, extended sick leave and for specific projects if we receive grant money for a project that would have a finite timeframe.
- 58 Sometimes we have projects that exceed 12 months. Under the HSU claim we could not extend contracts without ending up having to employ the person permanently. In these circumstances we would need to recruit someone else on a fixed-term basis at the end of the first 12 month period. This would have negative implications for the continuity of the project. Alternatively, if we had to keep the original person on as permanent staff we would need to obtain additional funding from some other part of the service to sustain the position and there would also be insufficient work for that person after the project finished.
- 59 If we have a permanent staff member who leaves, we advertise and we try to get interest through an agency or through informal contacts (i.e. casuals who have previously worked at Northern Health) to recruit to that position. We do not have resources to manage a bank of staff. For this reason we use temporary employees to cover the work until we are able to recruit a suitably qualified person for the role. The claim relating to temporary employees would limit our ability to do so, particularly in circumstances in which a person was required for 4 or 5 months.

Organisational Change

- 60 The HSU's claim (clause 8) imposes an organisational change policy process requiring consultation when employees are affected by "any change" that is "likely to have a significant impact on an employee". This includes but is not limited to matters such as work practices or location, job security, remuneration or training.
- 61 Northern Health has followed the Western Health Care Network Organisational Change Agreement 1996 since it was certified by the Commission. The current arrangement meets the needs of Northern Health.
- 62 The HSU claim is very broad in scope and would extend to "any change". Changes occur in our departments every day that impact on an individual employee. If we were required to go through a detailed and prescriptive organisational change process on each occasion a roster had to be changed or each occasion a new piece of equipment or technology were introduced it would limit the ability of Northern Health to make and implement decisions necessary to provide its health services. That is, it would limit Northern Health's ability to make changes in a timely manner, to respond to service needs and it would increase administrative costs.

Other observations

- 63 The HSU claim (clause 25.5), if approved, would entitle staff to a registration allowance. Individuals should be responsible for their own professional registration. Northern Health does not have any capacity in its financial budget to cover the cost of this allowance. We do not cover registration costs for doctors or nurses and this claim, if granted, could lead to demands for similar payment from other health professionals.
- 64 The HSU claim (clause 27.1.4), if approved, would impose a minimum engagement period of four hours. This claim is problematic for Northern Health because some staff may work 2.5 days per week. The half day (based on a 7.6 hour day) would require payment of slightly more than the hours that the employee actually works. Northern Health needs to have the flexibility to staff departments according to service needs. Similarly, it may suit a staff member with family or other commitments to work 3 hours but not 4 hours. The clause removes the flexibility of the health service to respond to service needs.
- 65 The HSU claim (clause 28.3), if approved, would entitle an employee to receive additional remuneration if they are unable to take a meal break on more than three occasions in any fortnight. Northern Health structures workloads to ensure that staff are able to take meal breaks. If meal breaks are not taken then it is most likely because the employee, for whatever reason, chooses not to do so. Whilst staff may not always be

able to take a break at the same time every day during their fortnight shift, they should be able to take their meal break at some stage. If they are unable to, then the appropriate response is to discuss workload issues with a supervisor rather than missing these breaks. This claim would also have a cost impact because the payment is calculated at time and a half after the first five hours of the shift when the employee was unable to take a break. We have no capacity to absorb the cost of this claim. The clause would also give employees a financial incentive to miss meal breaks.

- 66 The HSU claim (clause 30.1), if approved, would require Northern Health to develop and maintain a supplementary roster to record staff who are willing to work additional or changed shifts. Our practice is that if work times become vacant we issue an expression of interest to all staff. Those interested will volunteer. We only have a small percentage of allied health staff who work weekends. Creating a supplementary roster imposes a time consuming and administrative burden and a complexity to rostering that cannot be justified given the size and nature of our service. The time and administrative resources required to comply with this clause would need to be diverted from elsewhere (i.e. away from clinical services). The current arrangements work well. A supplementary roster is unnecessary and would not improve the efficiency or productivity of the health service.
- 67 The HSU claim (clause 31.3.5), if approved, would require part time employees who work more than their rostered hours be paid overtime. It is rare that service delivery needs would require a part-time employee to work overtime. It may arise in the event of a last-minute absence due to sick leave. If the clause were granted, Northern Health would not be able to afford to pay overtime to the part-time staff member covering the shift as well as paying sick leave to the absent staff member. The claim would increase costs which would have to be offset elsewhere in the budget. Alternatively, it would mean that part-time employees would not be offered overtime work.
- 68 The HSU claim (clause 35), if approved, would entitled Sunday shift worker to an allowance. At present, Northern Health does not employ any shift workers. If we had to engage shift workers in the future, the allowance would represent an additional cost burden which is likely to operate as a disincentive to introducing shift work. While some staff want the flexibility of shift work, the HSU's proposal would have the effect of Northern Health not being able to afford to give them such an option.
- 69 The HSU claim (clause 38.5), if approved, would entitle an employee to flexible annual leave arrangements. Northern Health already accommodates flexible annual leave arrangements but these are subject to the needs of the service. It is important that Northern Health retain its discretion to determine where and when the service can cope with absences. These arrangements need to be assessed on an individual basis. The

proposed clause would increase the formality, time and administrative burden of dealing with such requests. That is, the need to consider requests, respond within a certain time frame and follow the process prescribed in the clause. Moreover, the clause places the onus on the health service not to unreasonably refuse. Our current approach works well and the proposed clause is unnecessary.

- 70 The HSU claim (clause 38.8), if approved, would entitle staff who worked weekends or were rostered on-call or who performed overtime on weekends to receive an additional five days' annual leave each year. Currently employees are required to work 10 weekends before they are entitled to additional leave. This approach should remain. It provides an incentive to staff to cover weekend shifts which would not exist under the HSU clause. It is also excess for people to receive additional leave merely because they have worked one weekend. In addition, this proposal would be too expensive for Northern Health to manage. We would experience problems covering the extra leave, particularly if the HSU's claim for 100% backfill is granted. It is also possible that all disciplines would struggle to fill weekend rosters because people would no longer have the incentive of receiving the extra leave if they work 10 weekends.
- 71 The HSU claim (clause 44), if approved, would entitle staff to four hours per week of study leave. Northern Health already has a study leave system in place which provides for study leave backfill of 104 hours per placement (i.e. four hours per week for 26 weeks). Beyond this arrangement, leave must be mutually agreed on a case by case basis. As Northern Health Northern cannot afford to carry the cost of this claim for all staff, it is important that it retain the discretion to balance employee development needs against the needs of the service.
- 72 The HSU claim (clause 46), if approved, would entitle staff to two weeks paid professional development leave per year on full pay and reimbursement of approved costs up to \$20,000.00 each financial year. If these leave entitlements were to apply to every allied health staff member, it would become impossible to maintain our services due to the cost. It would also be difficult to provide necessary qualified staff to maintain continuity of care in particular areas. Existing study leave entitlements can be difficult to manage, particularly in light of other staff absences (i.e. annual leave and sick leave). This claim would only compound existing difficulties. Furthermore, in order to manage the provision of health services effectively and efficiently, professional development leave should only be permitted where mutually agreed and based on service and operational requirements.

HSU Evidence – Witness Statement of Simone Cariss

- 73 I have reviewed the witness statement of Simone Cariss dated 11 August 2008. I make the following comments with respect to that statement.
- 74 In paragraph 12, Ms Cariss refers to home visits and states "*many services no longer allow their staff into people's homes without prior assessment and recommendation ... This has lead to Occupational Therapists facing increased demand for home visits, liaison and report writing.*" Ms Cariss' specialisation is hand therapy and she is unlikely to conduct home visits as part of her role. In addition, the home visit safety checklist, which must be completed by staff, is not necessarily completed by the occupational therapists. The purpose of the checklist is to ensure that certain safety benchmarks have been considered and measured before staff undertake home visits. Ensuring staff safety has been Northern Health's standard approach since the inception of Northern Health in 2000. The introduction of the home visit safety checklist approximately five years ago simply reflects the formalisation of that approach
- 75 In paragraph 13, Ms Cariss states that time pressures mean that occupational therapists face "*higher demands for rapid response rates and acute intervention*" and refers to the Emergency Department as an example. She also states that occupational therapists have had to "*devise strategies to deal with this increased demand.*" I am not aware of any extra demands in terms of rapid response rates that have been placed on occupational therapists at Northern Health in recent years. This is particularly so in the Emergency Department because it has very low activity at present for OT services. Furthermore, in the acute area some backfill is available to assist workloads and service delivery. For instance 50% of annual leave and rostered days off are covered and backfill is also provided where people attend conferences. This backfill helps to keep workload demands reasonable.
- 76 Demands and expectations on professionals change all the time. It is inherent in the role and remuneration of a professional that they be expected to be able to research, keep up with developments in their field and implement them in their clinical practice. This is true of all professions not just in allied health. In health services fluctuations in demand are common and Northern Health responds to such changes as appropriate with increases in EFT, increased training and support for staff.
- 77 One of the strategies used by Northern Health to assess workload demands is through benchmarks. For occupational therapists, for example, we set a benchmark for a Grade 2 staff member that they should spend 75% of their time on clinical work and 25% of their time on administration and supervision. Grade 1 staff have a higher clinical work benchmark (i.e. 85%) because they do not have the increased supervision and training

responsibilities that accompany the Grade 2 level. If staff exceed those benchmarks (ie a Grade 2 is doing more than 85% clinical work) then we would know that there were problems in workload allocation and we would put strategies in place to ensure that work is managed appropriately. For instance, work would be prioritised and other staff may be asked to assist. This approach is inherent in the job and not just limited to occupational therapy.

- 78 If there were insufficient staff numbers to deal with throughput, Northern Health would submit a business case seeking additional funding for additional staff. However, growth is less than in previous years because of diversion programs such as HARP, referral to the Craigieburn Health Service (which has a minor injury and illness clinic) and the after hours GP service which is adjacent to the Emergency Department at Northern Hospital.
- 79 Analysis of current benchmarking shows that occupational therapists at Northern Health are not exceeding their expected clinical load. This means that Northern Health is achieving a structure and staffing profile that is appropriate to current service demands.
- 80 In paragraph 17, Ms Cariss talks about the "*de-institutionalisation of mental health care*" and an "*increased incidence of mental health disorders ...*" which has "*lead to an increase of community specific Occupational Therapy intervention.*" Northern Health does not provide occupational therapy services in mental health. These are provided by Melbourne Health.
- 81 In paragraph 21, Ms Cariss states that discharge planning for the allied health team, including occupational therapists, has increased as a result of "*complex intertwined issues*". I have not seen any evidence of such "complexity". All occupational therapy service discharge has some level of complexity. If discharge planning were simple then we would not need professional staff to carry out these services.
- 82 In paragraph 22, Ms Cariss states that occupational therapists "*are forced to become more creative with finding funding sources, often completing multiple forms to various agencies to try to pull the funding together. Significant time is spent justifying the need to the various stakeholders.*" It is common for staff to have to complete forms for AEP (Aids and Equipment Program), post acute programs or for the Department of Veteran Affairs. This administrative element has always existed as part of the job.
- 83 In paragraph 24, Ms Cariss refers to linking patients with appropriate community supports and asserts that occupational therapists are "*required to keep up to date with new programs, community services and private providers in order to assess patients and make recommendations in a short period of time.*" All professional staff have a responsibility to keep updating themselves professionally, particularly in relation to specialised areas so as to keep up to date for their clinical load. The benchmarks

discussed above include a non-clinical component for staff to undertake quality of care initiatives and education. Northern Health also meets award requirements for allowing people to attend professional development sessions as well as in-service sessions. We always try to accommodate staff needs and very rarely need to decline requests. Where requests are declined, this is due to service delivery demands.

84 In paragraph 25, Ms Cariss refers to an increase in weekend services and states that these services *"can often put increased strain on clinicians who often do the weekend shift in addition to their 40 hours per week. Junior clinicians are also often working weekends without peer support from more senior colleagues."* Northern Health has six occupational therapy staff who work weekend work. We also have a number of internal staff who are willing to work weekends. Every year we issue an expression of interest to determine which staff are interested in working weekends. This is purely voluntary. Consequently occupational therapy staff are not working a full week and then the weekend. In the event that they are, it is voluntary and is not a result of any "direction" from Northern Health. Those that do undertake such work receive an additional week of annual leave as required by the Award.

85 Ms Cariss' comments in paragraph 25 about peer support are inaccurate and misleading. Occupational therapy staff who are rostered to work weekends are at a certain grade and capable of working relatively autonomously. These staff have access to an on-call senior staff member who can assist when required. They also work along side other skilled staff (such as care coordinators and a nurse unit manager) who can act as a liaison if necessary. The nature of occupational therapy work generally does not lend itself to requiring immediate or emergency like responses. If a patient's condition is particularly serious, then it is unlikely that they would be discharged. I am not aware of any statistics that indicate re-admission issues have been caused by patients not seeing occupational therapists in a timely fashion.

86 In paragraph 26, Ms Cariss asserts that *"doctors, nurses and other allied health staff are becoming increasingly aware of Occupational Therapists' role as an alternative to admission or lengthy hospital stays"* and this is leading to *"higher demand for occupational therapy services"*. I am not aware of any evidence that there has been any change to the role of an Occupational Therapist. Occupational therapy practice is the same; it is no different to what it always has been. Inpatient occupational therapists only have to see those who are in the hospital; hand therapy is a niche area. I am also unclear about how this statement relates to the work that Ms Cariss performs.

87 In recent times we have experienced increase of demand for public hand therapy, WorkCover and TAC hand related injuries. As a result of this increased demand a business case was developed and submitted to the Executive. As a result of that

business case we have generally increased our complement of staff to respond to this work.

88 In paragraph 28, Ms Cariss states that "*many occupational therapists ... are demonstrating abilities and fulfilling roles above the usual range of expertise.*" I have no evidence that this is the case.

89 In paragraph 31, Ms Cariss states that hand therapists "*need to be well educated in wound management*" and are involved in "*removal of sutures, dressing changes and patient education.*" She also claims that "units" refer directly to occupational therapy and "*often little or incorrect diagnoses are given on referral forms*" ... "*The Hand Therapists are often correctly diagnosing and setting up management plans for patient injuries.*" The removal of sutures and other duties referred to in this statement are part of a hand therapist's normal role. I performed all of these tasks in the early 1990's whilst working as a hand therapist. This is not a new development. As to the assertion about incorrect diagnoses, I have seen no such evidence to support this allegation. Finally, hand therapists are expected to put together care plans for patients; this is part of their normal role.

90 In paragraph 33, Ms Cariss refers to performing in-service programs. All clinical staff educate each other. This is not a new development.

91 In paragraph 34, Ms Cariss asserts that new technology has "*impacted on the amount of work for Hand Therapists.*" Notwithstanding improved technology, a hand therapist's workload would not change. Therapists are capable of seeing only a certain number of patients per day. Moreover, as discussed above Northern Health has effective methods for monitoring the workload of all staff. If there is an emerging issue then a business case will be put to me about the need for additional EFT numbers potentially required.

92 In the past two financial years we have increased EFT in hand therapy through completing business cases. In addition, the opening of Northern Health's Craigieburn Health Service campus has reduced demand for the acute program. The Craigieburn service has also been manned with extra EFT in hand therapy. This effectively means that there has been a three pronged attack on Northern Health's occupational therapy (hand therapy) services which has increased staffing substantially.

93 In paragraph 35 Ms Cariss again refers to occupational therapists working under greater pressure. I refer to my comments above regarding benchmarks and Northern Health's effective monitoring of staff workloads.

94 In paragraph 39, Ms Cariss asserts that therapists need to be more "*accountable*" and able to "*provide patients with research based information on the intended treatment in*

order to gain their consent. Occupational therapists have always needed to involve their patients in the care pathway (development of a treatment plan), and occupational therapists have always used evidenced based practice. If they did not do so I would be extremely concerned. It would be very poor practice if therapists were not doing either of these things.

- 95 In paragraph 43, Ms Cariss asserts "*There are few official extended scope of practice occupational therapy roles across the state.*" I have no information from across the State to confirm whether this is an accurate statement.
- 96 In paragraph 46, Ms Cariss refers to professional development and research responsibilities. She asserts that "*with full clinical caseloads, involvement in research programs is performed in the Occupational Therapist's own time after work hours.*" This statement is misleading because all research programs are voluntary and where possible staff are provided with grants which enable them to be backfilled to conduct research.
- 97 In paragraph 49, Ms Cariss refers to the supervision of undergraduates and states that those staff who take on supervision roles are "*expected*" to develop additional competence in supervision, and develop skills in differing course models and approaches to problem based learning. Grade 1, 2 and 3 staff have always had supervision as an inherent part of their role. Northern Health's allied health directorate provides courses for staff to attend to assist them with their skill development in supervision competence. Northern Health regards supervision as part of a contemporary role which is career enhancing and benefits the therapist and their own competency level.
- 98 In paragraph 53, Ms Cariss states "*research ... grows more complex*" and a "*higher level of understanding of research techniques ... is expected from Occupational Therapists.*" I disagree with this comment. Research is either qualitative or quantitative; the same statistical methods have always been required. In some areas, research has been made easier as a result of new technology, for example Survey Monkey which is an online research tool. We also have specific staff employed by Northern Health to assist clinical staff to get started in research programs. We educate staff about initial research questions, how to conduct literature reviews and prepare submissions. As stated above, we also backfill staff where possible during periods where they are undertaking research programs and little or no clinical duties. Northern Health has also implemented a small grants program which means that each year staff can submit a submission to undertake a research program of their interest.

- 99 In paragraph 59, Ms Cariss refers to Northern Health's restructure in 2007 which resulted in "*existing site based chief positions [being] eliminated from the Northern Hospital, the Bundoora Extended Care Centre and the Broadmeadows Health Service sites.*" As discussed above, Northern Health moved from site-based managed approach to a program-based structure. As a result the need for site based chiefs was redundant. We created clinical lead roles which introduced a number of Grade 4 staff into our new structure. We also increased the number of Grade 3 staff into the occupational therapy discipline. Northern Health considered that this new structure would enhance the career structure for clinical staff.
- 100 Northern Health also considered the restructure appropriate based on feedback, particularly from the occupational therapy site managers. Anecdotal evidence suggests that this new structure has resulted in better patient care and the identification of clinical risk issues that had not been identified within the old structure. We also considered that it was important to focus on clinical duties which is what therapists are trained to do. Technology also allows each discipline manager to take on the management role effectively. They can still be in contact with staff without needing to have a site based chief supporting them on each campus.
- 101 In paragraph 61, Ms Cariss asserts that "*compaction of the Award based career structure has resulted in supervision of staff and managerial tasks being the mainstay of career advancement rather than allowing a clinician to advance through recognition of their clinical expertise.*" We now have extra Grade 4s and 3s as a result of the new structure which has increased succession planning opportunities and career progression opportunities for Grade 1s and Grade 2s.
- 102 In paragraph 63 Ms Cariss states "*the negative effects of there not being a chief on site are various.*" She asserts that there are "*sluggish responses to emails, a lack of on-site support, a lack of awareness about how streams are functioning on a day-to-day basis.*" Again, I have no evidence to suggest that any of these assertions have any foundation at Northern Health. Again, and particularly in the occupational therapy discipline, our manager has created a number of processes to assist staff, such as approval for leave and rosters that all staff can access. There is no evidence that there has been a slow response to emails etc. In any event, Ms Cariss spends a substantial amount of time working at Craigieburn Health Service where there have never been any site managers. Accordingly, these statements are unlikely to be based on her own experiences.
- 103 In paragraph 66, Ms Cariss states that the introduction of Advanced Allied Health Assistants has contributed to "*the bottom heavy structure of departments*" at Northern Health. Northern Health's structure is designed to meet service needs. Staff have always had to supervise other junior staff whether advanced or otherwise. We consider

that the introduction of these Assistants has taken the load off therapists substantially because, in the occupational therapy area for instance, Assistants organise the provision of equipment allowing therapist to focus on setting up treatment regimes. Assistants would then follow through on those treatment regimes. Assistants also assist the running of patient information groups, for example to help people with back education. The introduction of Assistants is complementary to the services provided at Northern Health.

- 104 In paragraph 67, Ms Cariss asserts that it is difficult to recruit staff with the required expertise. I disagree with this comment. Presently the hand therapy stream is fully staffed. We have also been able to secure locums.
- 105 In paragraph 68, Ms Cariss asserts that staff are limited in their ability to progress from a Grade 2 role to a Grade 3 role. A Grade 3 role is a senior clinician role. Grade 3s do not need to be employed unless there is a clinical need or department need. Northern Health doesn't have that many senior clinician roles simply because we are not a tertiary based hospital. However, as a result of Northern Health starting to create more specialities in the occupational therapy discipline (which warrant the need for more senior staff), we have increased our complement of Grade 4 and Grade 3 staff in our recent restructure to meet the patient care and departmental needs.
- 106 In paragraph 70, Ms Cariss refers to competition from overseas companies and private providers resulting in people leaving for better remunerated jobs. I am not aware of any good data that states that this is the case. Anecdotally, people talk about such competition but there is actually no hard data to support that. Further, the introduction of Allied Health Assistants is an example of how Northern Health is trying to help occupational therapists to continue to do the things that they are trained to do and that helps to keep them in the workforce.

DATED: 9 September 2008

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JENNIFER KAYE GRATTON VAUGHAN

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

Workplace Relations Act 1996

Section 503 referral to Full Bench to make a workplace determination

Health Services Union

and

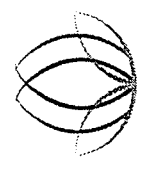
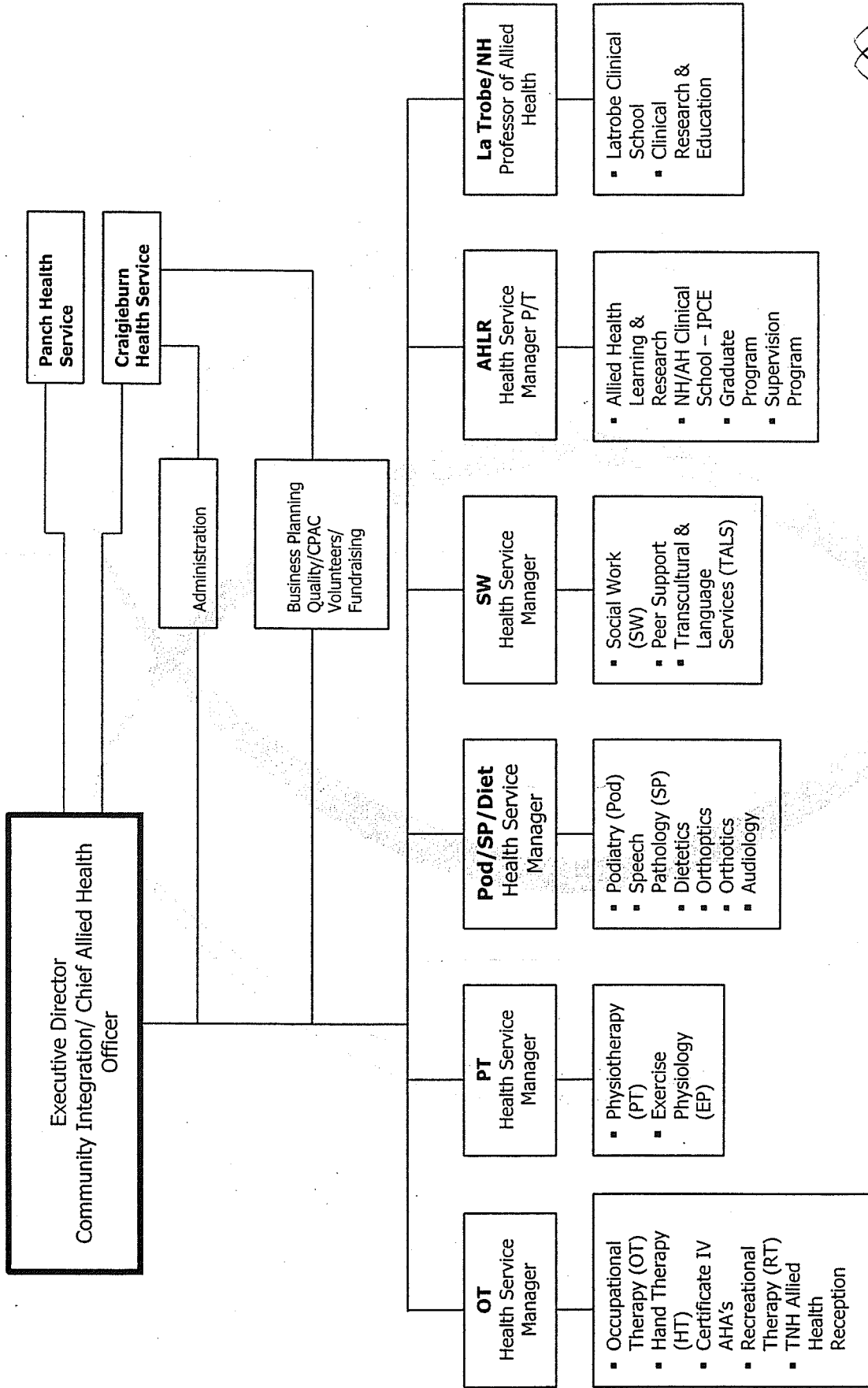
Austin Health and others

(BP2007/4059 and others)

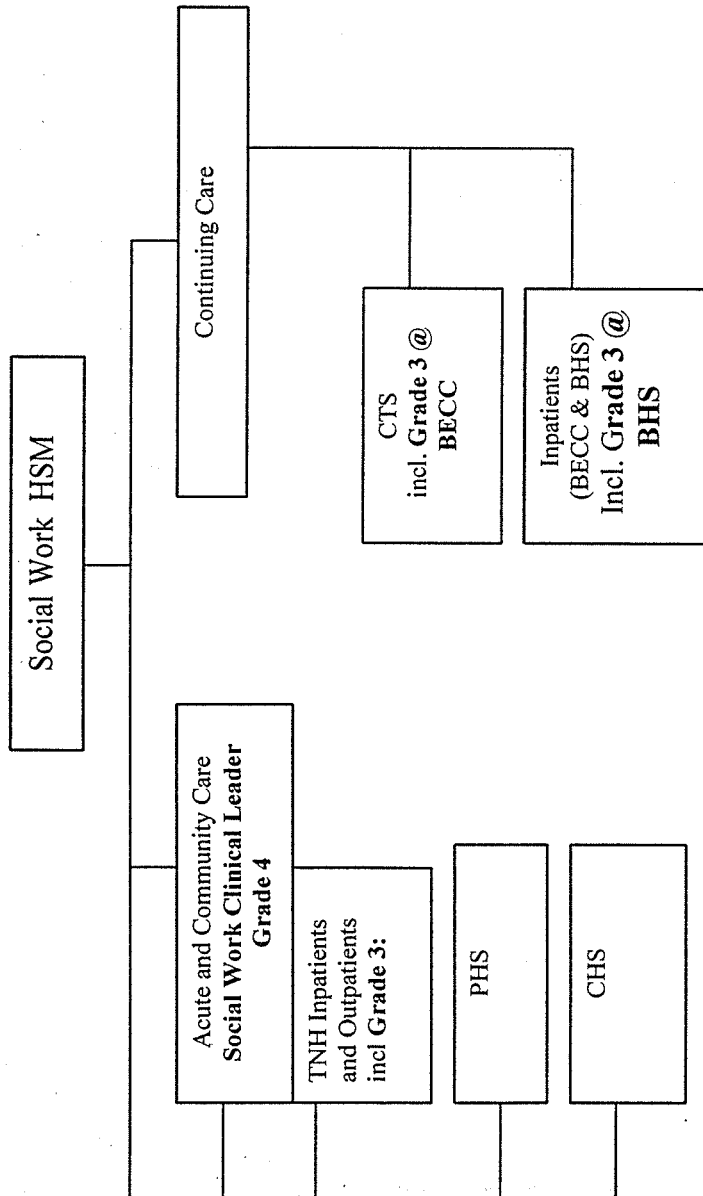
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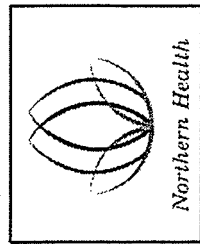
This is the Exhibit referred to in the witness statement of Jennifer Kaye Gratton Vaughan dated 9 September 2008 and marked **JGV-1**.

Allied Health Structure

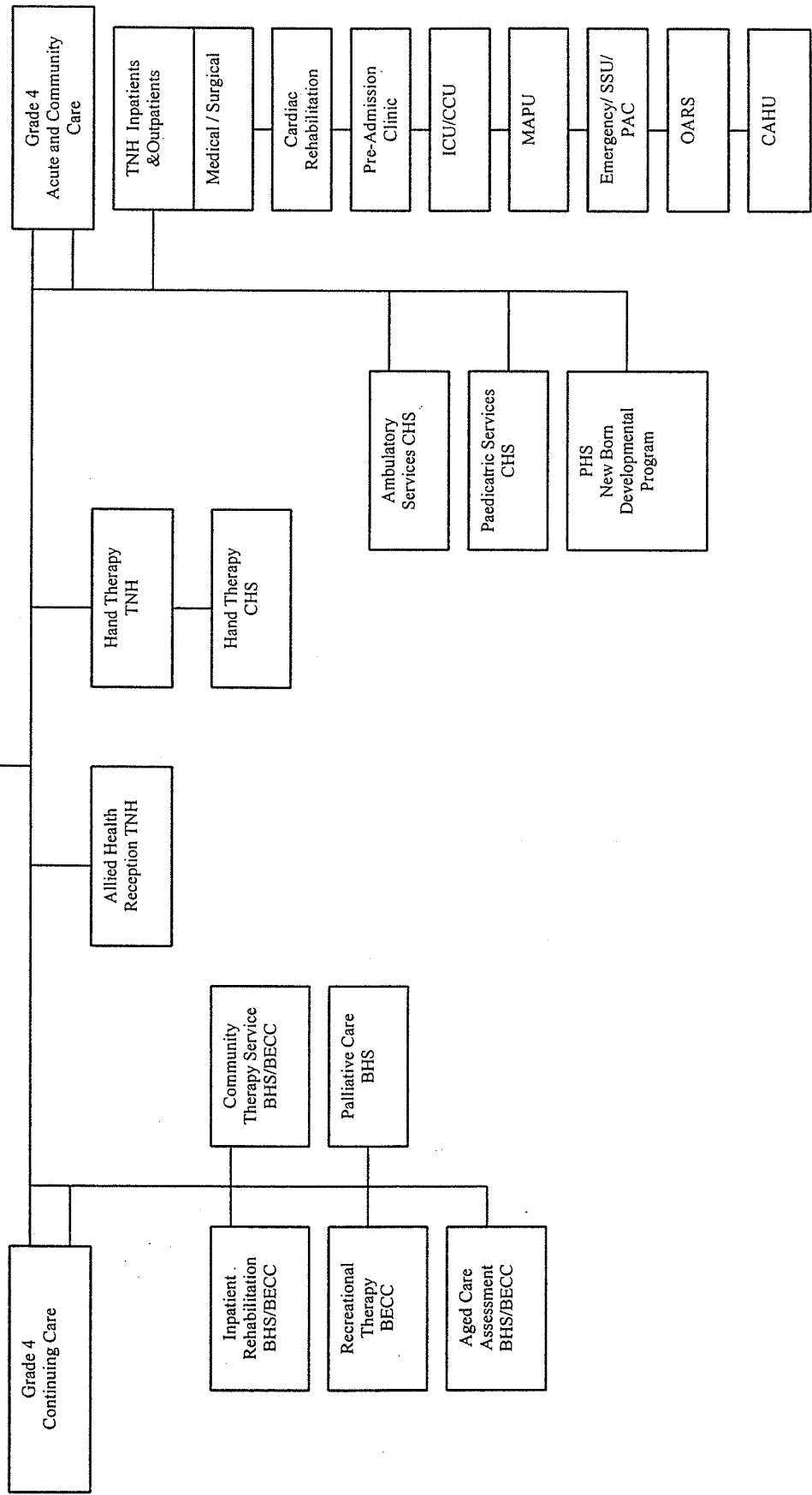


Northern Health
Social Work
Organisational Structure 2008

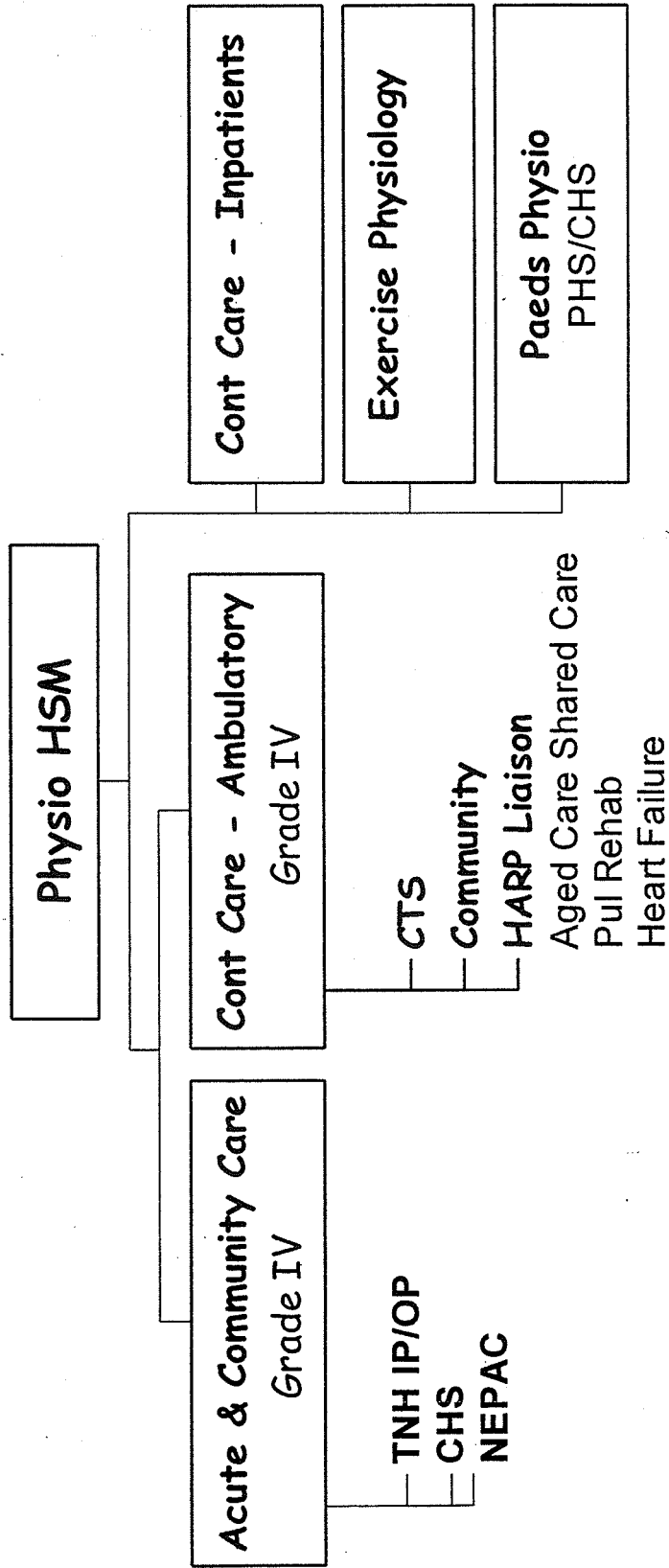




NORTHERN HEALTH SERVICE
 OCCUPATIONAL THERAPY DEPARTMENT
 ORGANISATION STRUCTURE

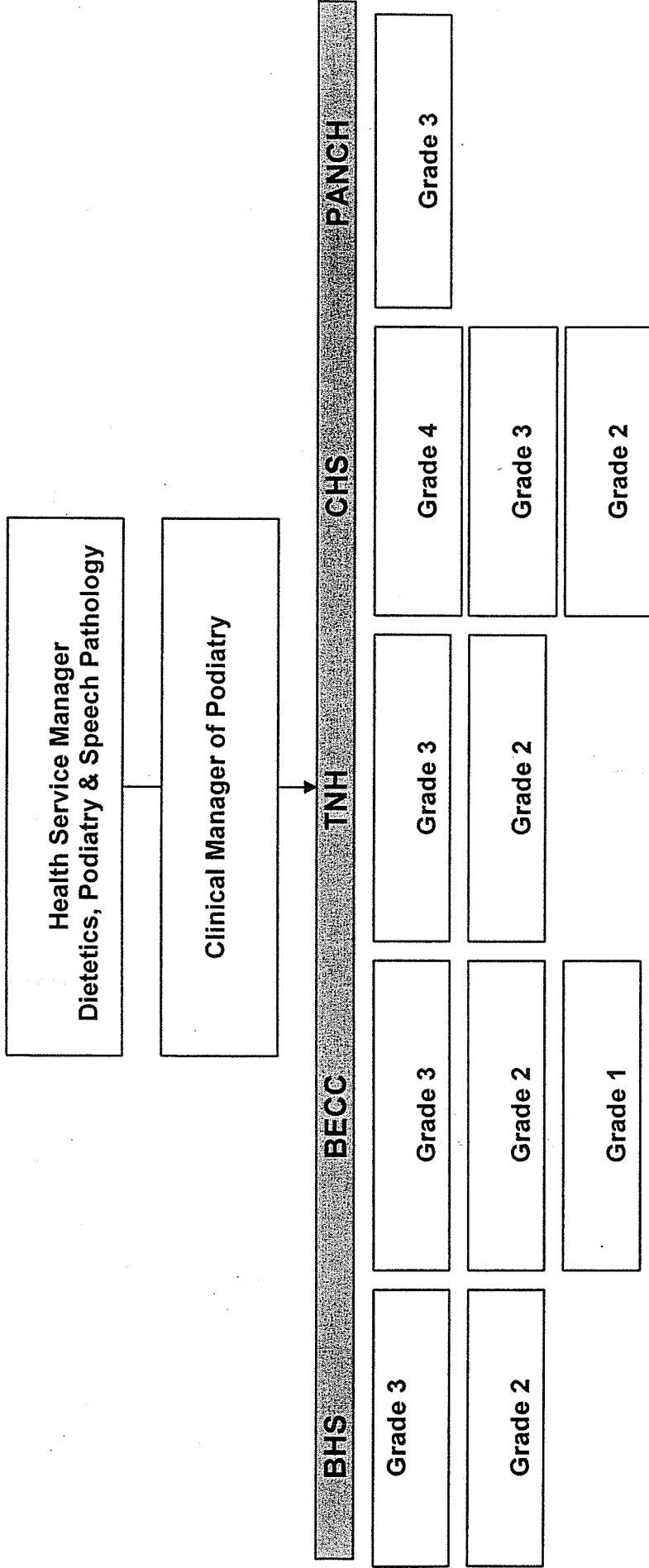


Northern Health
Physiotherapy
Organisational Structure August 2007



Northern Health Podiatry Department Structure

June 2008



Northern Health Speech Pathology Department Structure
 June 2008

