

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 MARYANNE EGAN

I, **MARYANNE EGAN**, of St Vincent's Hospital (Melbourne) Limited (**SVHM**), 41 Victoria Parade, Fitzroy in the State of Victoria, Manager, say as follows:

- 1 I am the Group Manager of Allied Health and Community Programs at SVHM. I have held this role since April 2008.
- 2 I am authorised to make this statement on behalf of SVHM. 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.

Professional and academic background

- 3 Prior to taking up my current position, I was the Director of Social Work, Interpreters and Aboriginal Health at Austin Health. I held this role for a period of 7 years.
- 4 I completed a bachelors degree in arts in 1990 and a bachelors degree in social work in 1993.

SVHM facilities and sites

- 5 SVHM operates as one entity over a number of different health facilities including St Vincent's Hospital in Fitzroy (hereafter referred to as St Vincent's Hospital), St George's in Kew , Caritas Christi Hospice and Prague House.

- 6 St Vincent's Hospital is a major teaching, research and tertiary referral centre, providing adult medical, surgical and mental health services, as well as a range of community and outreach services.
- 7 St George's in Kew is a comprehensive aged care service providing in-patient aged care, evaluation and management, residential aged care, rehabilitation, acute aged psychiatry and a range of community-based assessment and treatment service.
- 8 Caritas Christi Hospice provides palliative care and aged care services. These services are provided at the Kew campus (where there are 26 beds, as well as a day hospice and a community day care centre) and the Fitzroy campus (where there are 8 beds that are co-located with the acute services of St Vincent's hospital).
- 9 Prague House is a 45 bed residential aged care facility in Kew, providing residential services for older men and woman who have special needs, such as drug and alcohol dependency, and have experienced homelessness.
- 10 SVHM also operates a number of services from numerous other sites around Melbourne including residential care facilities, ambulatory care centres and services at the Melbourne Remand Centre and Port Phillip Prison.
- 11 Allied health professionals work at St Vincent's Hospital, St George's Health Service, Caritas Christi and in some community programs, residential care facilities, and sub-acute ambulatory care facilities.

Organisation of Allied health across SVHM

- 12 Allied health professionals employed at SVHM are employed across different directorates and in different portfolios within those directorates.
- 13 The majority of allied health professionals employed by St Vincent's sit within the Allied Health & Community Programs portfolio, which is within the directorate of Aged Care and Allied Health.
- 14 Within the Community Programs part of the Allied Health & Community Programs portfolio, St Vincent's employs allied health professionals in Aged Care Assessment Services (**ACAS**), the Polio Service of Victoria, Sub-acute Ambulatory Care Services (**SACS**) and Transition Care. Approximately half of the employees in the ACAS and SACS department are allied health professionals. Other health professionals working in these programs include geriatricians, rehabilitationalists, nurses (including clinical nurse consultants), allied health assistants, administrative staff and allied health professionals not covered by the *Health Services Union of Australia Health Professionals Victorian Public Sector Multiple Business Agreement 2004 – 2007* (for example, nutritionists).

- 15 Within the discipline specific departments of Allied Health in my portfolio, St Vincent's employs allied health professionals in hand therapy, occupational therapy, physiotherapy, podiatry, prosthetics and orthotics, social work and speech pathology departments.
- 16 Some allied health professionals at SVHM are employed in the area of Health Service Demand and Mental Health. Programs within this area receive specific funding allocations, and as the additional program funding is received, SVHM recruits to those positions.
- 17 SVHM also employs allied health professionals in medical imaging services situated within the Clinical Support directorate.
- 18 There are also allied health professionals such as medical librarians, health information managers and welfare workers who are employed across SVHM.

Organisational models in allied health departments at SVHM

- 19 Allied health departments at SVHM deliver services across multiple sites, and are not segmented into site-based departments. Some allied health clinicians and all Chiefs of Departments spend their time delivering services at both St Vincent's Hospital and at St George's. For instance, SVHM has a Chief Occupational Therapist and clinical occupational therapists who are perform duties at both St Vincent's Hospital and at St George's. They are not employed to provide services solely at one site or the other.
- 20 The background of this structure is as follows. A review of allied health was undertaken several years ago, and included a consultative process with key stakeholders including senior managers at SVHM and other health services and interviews and discussions with key unions (HSUA 3 & 4).
- 21 One outcome of this review was for one department (Speech Pathology) to move to a one chief model immediately.
- 22 Other departments followed this model when there was natural attrition and after appropriate consultation and review. For example, in late 2005, the sub-acute occupational therapy manager left the health service. As a result, the Group Manager of Allied Health set up a reference group and consulted with key stakeholders which included members of the occupational therapy department, Executive of the Directorate, human resources and the HSU. The focus of the reference group was to explore the advantages or benefits of various models and then decide upon the appropriate model. The clinicians' views were engaged with the emphasis on patient care and staff professional support. The outcome was to move to a "one chief" model across campuses for occupational therapy.
- 23 A similar consultative process was undertaken with the social work department and the outcome was to initiate a "one chief" model there also.

- 24 In my view, the “one chief” model that is in operation operates well. There is greater opportunity for all staff to move through a range of areas and gain greater clinical experience. It is in line with patient continuum of care and offers increased opportunities for breadth of collegiate support and learning and a greater range of professional development for staff.
- 25 One of the benefits of having departments and employees operate across multiple sites is that it opens up greater career pathways for employees. Limiting an employee’s career opportunities to a particular site may mean that that employee may not be able to progress in their chosen area of specialty – especially as some of our services run across sites for example, sub acute rehabilitation and aged care.
- 26 At this stage, physiotherapy is divided into acute and subacute streams with substantive Chief of Acute Physiotherapy and Chief of Sub-acute Physiotherapy positions. Until approximately one year ago, the Chief of Acute Physiotherapy was based at St Vincent’s Hospital and the Chief of Sub-Acute Physiotherapy was based at St George’s. However, at that time, the Chief of Sub-Acute Physiotherapy resigned and it was decided that the Physiotherapy Department would move to a “one chief” model in line with other SVHM allied health departments.
- 27 Since November 2007, physiotherapy has piloted different options of redistributing the funding from the Chief of Sub-Acute Physiotherapy position that best meet the needs of the department and the move to a “one chief” model. The department is now ready to proceed to adopting this model formally, even though they have been observing it at a practical level for almost a year.
- 28 This is consistent with current practice in other allied health department at SVHM.
- 29 A similar restructure took place in the Social Work department in early 2008. SVHM considers that this restructure has created efficiencies, improved career pathways for social workers, and will assist in recruitment and retention of staff.
- 30 However, the final reorganisation of the Physiotherapy Department has been suspended pending the outcome of these workplace determination proceedings. As an interim measure, the current Chief of Acute Physiotherapy is also the Acting Chief of Sub-acute Physiotherapy.
- 31 If the restructure proceeds, the Chief of Acute Physiotherapy would progress from being a Chief Grade 4 to being a Chief Grade 5. The position which previously existed at the Chief Grade 3 level would not be filled. SVHM has consulted with clinicians in the Physiotherapy Department to determine how the surplus funds that would be freed up could be applied. The clinicians have proposed that the additional funds be applied to employing an extra Grade 1 clinician for backfill leave cover, upgrading some Grade 3 clinicians to Grade 4, and creating of a new project position, which could (for example) assist with research. This proposal would enhance the career structure for physiotherapists (by improving training and research

opportunities and creating more Senior Grade 4 positions) and assist with work/life balance (by providing some backfill to cover authorised leave). The restructure would better support staff and address some caseload issues that were identified as being important to staff. This structure was designed based on the outcomes of piloting of several options and was decided on by physiotherapy clinicians.

Funding

- 32 SVHM provides public health services in accordance with the Health Service Agreement with the Department of Human Services (**DHS**). SVHM is predominately funded by DHS, however, the organisational structure differs from that of many other health services in Victoria. Unlike other health services, SVHM is a company and the Sisters of Charity are exposed to fund the costs of any shortfalls. Unlike other health services, there is no transitional funding from DHS if we do make loses from trading as a public hospital. If budget is not met, the Sisters of Charity bear the costs of shortfalls.
- 33 SVHM operates well financially as a health services provider however it is projecting to record a deficit for the 2008-09 financial year. This means exploring other non-Health Service Agreement commercial activities to ensure the company does not trade at a loss and erode its reserves. It also puts at risk the SVHM Mission based activities.

The Health services Union's draft workplace determination

- 34 I am aware that the Health Services Union (**HSU**) has filed a draft workplace determination in these proceedings claiming a number of changes to the terms and conditions of employment for allied health professionals. Many of these will have a significant impact on SVHM, which I deal with generally below.

Wage increases

- 35 As SVHM is largely funded by DHS, wage increases will need to be matched by increased government funding. If such funding is not forthcoming, there will be a shortfall which will have a significant impact upon SVHM as it would with any other company. This would in all likelihood require SVHM to examine areas in which there can be cost efficiencies. If the wage increase is any more than the funding allocation, a shortfall is expected and this would add further to our forecast operational deficit.

Organisational change

- 36 SVHM has had organisational change agreements with nurses and HSU 1 and 4 employees. SVHM continues to apply the principles in these agreements in managing organisational change. SVHM uses change impact statements to assess and discuss proposed change, and is transparent in its processes.

- 37 The HSU's proposed organisational change procedure would stop management from being able to make legitimate decisions around managing staff and conducting minor reorganisations of services. It would also have a dramatic impact on the provision of services to patients. For instance, SVHM may receive an allocation of money to fund a particular service over a short timeframe such as opening extra beds to respond to increased demand in winter. Responding to these short-term funding allocations in a timely manner requires flexibility, something which would be encumbered by a bureaucratic organisational change procedure.
- 38 Currently, if a proposed change is significant and materially affects the way people work, SVHM will complete a change impact statement, meet with affected employees and inform the relevant union. However, the ultimate decision as to implementing change rests with management. Health services are always looking for efficiencies and better way of delivering health services.

Fixed-term employees

- 39 SVHM has a number of fixed-term or temporary employees, particularly in the context of specific allocations of funding for particular projects or programs. Some of this fixed-term funding around grants or short-term projects will exceed 12 months (eg, we may receive Australian Research Council grants for between one to three years). At other times we get additional funding allocations that extend projects beyond 12 months. Our ability to be responsive to these funding allocations would be impeded by the proposed prohibition on employing fixed-term employees for longer than 12 months as the term of the project may exceed 12 months.

Chief structure

- 40 In determining the management structures of a health service, the needs of the community it serves must be the primary consideration. The structure currently in place at SVHM is one that has been developed over several years. It has been designed to take into account the operational needs of our health service, and how we can best serve our client base.
- 41 Generally Chiefs of departments do not have a clinical caseload. However, due to the small sizes of the departments, the Chief of the Podiatry Department and the Chief of the Prosthetics and Orthotics Department at SVHM do perform clinical work.
- 42 At SVHM there are multiple campuses that are not clearly defined by clinical area as may be the case at other health services. For instance, sub-acute inpatient and ambulatory care services are delivered at both the Fitzroy and Kew campuses. Caritas Christi is a separate geographic entity that provides palliative care services, which are also delivered at the Fitzroy campus. Splitting off clinical areas under each campus would not achieve optimal patient care

outcomes. It is more appropriate to have one chief over our campuses for each clinical discipline.

- 43 One of the reasons for such a model is that the level of services provided at each campus can differ considerably depending on the size of the campus. For example a site such as Caritas Christi has only 0.5 equivalent full-time (**EFT**) physiotherapist services and 0.6 EFT occupational therapist services, compared to St Georges which has approximately 7 EFT physiotherapy and 5 EFT occupational therapy and St Vincent's which has approximately 32 EFT physiotherapy and 14 EFT occupational therapy. Accordingly, there would be issues of parity if there were chiefs at each site.
- 44 In my opinion, having multiple Chiefs in a single discipline can also make it more difficult to ensure consistent policies and services and having a Senior Chief for each department, and a Chief at every site, would make the health service unnecessarily top-heavy. It would be untenable in Mental Health as there are multiple sites, its structure is programmatic within a discipline matrix.
- 45 The structure proposed by the HSU also seems to fail to recognise the varying sizes of departments. For example, there are only three staff members in podiatry across SVHM. Again, such a model would cause issues of parity.

Allied health staffing profile

- 46 The following comments relate to the HSU's claim for a staffing profile and a mix as set out in Schedule 2 of their draft workplace determination, ie of one-third Grade 1 clinicians, one-third Grade 2 clinicians and one-third Grade 3 clinicians or above.
- 47 The "one size fits all" approach of the HSU's proposed allied health staffing profile is inappropriate not only between different health services, but also within the one health service. At SVHM, there are huge differences in service needs between sites and departments. The application of such an inflexible staffing profile would be simply untenable, as it would impede us responding to service needs, and would not provide any tangible improvements in the quality of patient care.
- 48 Not only does the proposed allied health staffing profile undermine flexibility in service provision, but it may also indirectly impede the enhancement of an individual's clinical expertise. For example, SVHM offers rotations for Grade 1s through various sites and areas of clinical interest. Imposing a rigid staffing profile would stifle opportunity to offer individual clinicians the ability to try different areas of practice on a temporary or short term basis.

- 49 Further, as previously stated, a site such as Caritas Christi has only 0.5 EFT physiotherapist services and 0.6 EFT occupational therapist services. It is unrealistic and inappropriate to impose proportions of staff in each of the classification grades.

Backfill

- 50 Any mandated requirement to provide backfill would impose significant financial burdens on SVHM. Aside from cost, SVHM would face real issues around recruiting appropriately qualified staff to backfill for short periods of time, particularly at the more senior levels. These difficulties would only be compounded by many of the HSU's other claims, for example, claims requiring the employment of Grade 4 Senior Clinicians and Clinical Educators.
- 51 Further, backfill is often provided by existing staff working additional hours, and other claims made by the HSU (eg such as for part-time employees working additional hours) would mean that the costs of using these employees to backfill positions would escalate exponentially.

Automatic progression

- 52 Employers need to retain the requirement that employees be appointed to the grade, rather than progressing automatically from one grade to the next, particularly given the lack of clarity in the existing descriptions of each classification. Many duties are performed across grades. Automatic progression between grades as proposed by the HSU would make it extremely difficult for an employer to effectively manage their workforce, and do so in a way that retains the appropriate mix of clinical skills, stays within budget, and observes the staffing profile proposed by the HSU. Appointment to a grade ensures the breadth of experience and appropriate skill level is accounted for.

Other issues: Additional classifications

- 53 The additional classifications proposed by the HSU are inconsistent with the current approach of modernisation and simplification of industrial instruments.

Other issues: Entry at fourth year of experience

- 54 There is little if any justification for starting allied health professionals who have bachelors degrees at a pay rate that is equivalent to the fourth year of experience. It is inappropriate to assume that years of study equate to years of practical experience on the ground.

Other issues: Sole work allowance "working independently"

- 55 It is difficult to assess the impact of this proposal, as it is not clear what is meant by "working independently". Most, if not all, allied health positions require some independent work. Exercising independent judgments and performing work with more or less supervision is

inherent in the nature of allied health work. To automatically remunerate these employees at the Grade 2 rate does not adequately reflect the employees' experience.

- 56 SVHM has employees who attend residential care facilities by themselves, and a number of staff (for example, all ACAS staff) would go on home visits by themselves. However, they work very much as part of team and are supported by a team of allied health professionals. It is unclear as to whether they ought be considered to be "working independently" for the purposes of this claim.
- 57 SVHM would have clinicians who would be the only people in a particular classification on a particular site at a particular time (for example, ACAS workers on home visits, fractional workers on wards at Caritas Christi Hospice). If the HSU's claim was granted, it would be financially catastrophic for SVHM. These employees remain supported and are constantly in communication with (and supported by) doctors, nurses, and other health professionals. Imposing such allowances would run the risk of SVHM no longer providing some services as they could not be financially sustained.

Other issues: Community health and psychiatric services

- 58 In relation to the matters claimed at clause 21.10.5 of the HSU's draft workplace determination, although SVHM has no community health centres, SVHM does have community health and community mental health programmes. If the HSU's claim were accepted, this would be restrictive and inflexible.

Other issues: Grade 4 Senior Clinicians and Clinical Educators

- 59 To have a Grade 4 Senior Clinician on each site and in each section of a department would also make it unviable to maintain the 1/3, 1/3, 1/3 allied health staffing profile proposed by the HSU, particularly in smaller departments. Once again, having a centrally-mandated staffing profile inhibits a health service provider's flexibility and ability to organise itself in the way that best meets community needs. It does not recognise the unique structure of SVHM, specifically the split of specialties and services across sites.
- 60 SVHM supports clinical education and attempts to incorporate it in the role of every level of clinician. We have already adopted some of our own measures, such as employing a consultant from the University of Melbourne to come and provide us with academic and professional support for research. SVHM also has a Grade 4 clinical educator in the Social Work Department and a Grade 4 research position in Physio Department. These positions operate across sites. However a centrally-mandated approach as proposed by the HSU would be inappropriate and prohibitively expensive.

Other issues: Meal breaks

- 61 It is important from an occupational health and safety perspective that staff take a break during the day. Rests are essential to ensuring efficiency at work throughout the shift and are important for self care and rejuvenation. This should remain an unpaid break so staff are encouraged to take this break rather than work through it.
- 62 Further, the HSU's claim is open to abuse and in many cases whether an employees was "unable" to take their leave could not be monitored.

Other issues: Study leave

- 63 If the HSU's claim were accepted, I would be concerned with the lack of discretion for employers as to the terms on which they would be required to grant study leave. There is no requirement that the course of study be relevant to the employee's area of practice. The claim also has cost implications and would raise staffing issues where an employee is absent from work due to study leave.

Witness statement of Amanda Kennedy

- 64 I am aware that Ms Amanda Kennedy has prepared a witness statement in these proceedings. I comment upon the issues raised in her statement as follows.
- 65 Whilst I do not refute Ms Kennedy's claim at paragraph 13 that there is increased pressure to discharge or not admit patients, ultimately these decisions are made by the patients' treating medical practitioner, not an allied health professional. Allied health professionals play a supporting role in executing these decisions.
- 66 In regard to Ms Kennedy's comments in paragraph 14, it is usual practice to prioritise referrals and work allocation. The category system referred to of physiotherapy is not the same as the hospitals categorisation of patients.
- 67 In regard to Ms Kennedy's comments in paragraph 16, I make the following clarification. ALERT (Assessment, Liaison & Early Referral Team) in the Emergency Department received funding and EFT increases during the period to which Ms Kennedy refers. In fact in the 06/07 financial year there was an increase of 1.4 EFT care-coordination of allied health and nursing to support the Emergency Medical Unit. The last 3 years has seen growth in EFT for ALERT.
- 68 Whilst I do not refute Ms Kennedy's claims at paragraph 19 regarding increased patient complexity and acuity, I consider that the field of health care is dynamic and shifting, and that it is part of the role of allied health professionals to change and shift with their professional field. I consider this an exciting and fulfilling part of being a health care professional.

- 69 Regarding paragraph 21, Ms Kennedy's comments cannot refer to SVHM as the SVHM physiotherapy department does not provide evening shifts nor do night spinal treatments.
- 70 In paragraph 28, Ms Kennedy refers to our Intensive Care Unit. Developments in medicine have made it possible for these patients to be treated and managed better. This treatment and management is primarily done by medical and nursing staff around the clock, supported by a number of allied health professionals.
- 71 In paragraph 34, Ms Kennedy refers the development of physiotherapy services in new areas. While I agree that physiotherapy services have been extended into the areas claimed by Ms Kennedy, it is also true that SVHM has increased the EFT of allied health staff, including physiotherapy staff to meet the demands of the new services. I make the following specific comments regarding SVHM's contribution to the services referred to by Ms Kennedy. With regard to Ms Kennedy's reference to complex disability clinic, it is correct that St Vincent's does deliver specialist care for young adults with chronic disabilities. This area has been acknowledged as a growth area and we have increased our allied health services in this area particularly occupational therapy and hand therapy. With regard to Ms Kennedy's reference to the new services in the Emergency Department, SVHM has begun a DHS funded pilot project for Primary Contact Physiotherapy position – the position in which Ms Kennedy has just commenced. With regard to Ms Kennedy's reference to the Orthopaedic Waiting List Clinics, SVHM has provided physiotherapy services, funded increase from the surgical directorate.
- 72 In regards to the statements around senior clinicians now being responsible for some day to day operational and/or administrative processes this is true of all clinicians in health. The general understanding is that administration is a part of any clinical role and adds to the ongoing review of patient care and improvements in our service delivery.
- 73 In terms of the final statements regarding the movement of physiotherapists, I believe that we provide great opportunities and training for allied health professionals across a breadth of skill areas. This provides allied health professionals with more experience and therefore greater choice in the 'market place'. It is also widely accepted that the professions are in demand globally and Australian trained allied health professionals are well regarded internationally. This, combined with younger people wanting to travel, means there will be great movement in the professions and in recruitment to health.

DATED: 9 September 2008

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MARYANNE EGAN