

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

*Workplace Relations Act 1996*

Section 503 Referral to the Full Bench

**Health Services Union**

and

**Austin Health and others**

(BP2007/4059 and others)

**WITNESS STATEMENT OF MICHELLE LOUISE KOTIS**

I, **MICHELLE LOUISE KOTIS**, of Peter James Centre (Eastern Health), Mahoneys Road, Burwood East, in the State of Victoria, say as follows:

1. I hold the positions of Central East Director of Allied Health and Director of Ambulatory Services of Peter James Centre and Wantirna Health, and have done so since April 2007.
2. I am responsible for strategic and operational management of all allied health disciplines based at Box Hill Hospital, Peter James Centre and Wantirna Health. I report to both the General Manager of Box Hill Hospital and the General Manager of Peter James and Wantirna Health (which form a single entity) on client activity, that is, response time to referrals, finance and human resources, quality and business plans and issues arising in relation to service provision. I also put forward business cases for the expansion of services or the development of new initiatives.
3. My other area of responsibility is ambulatory services at Peter James Centre and Wantirna Health (ambulatory meaning outpatients, whether seen at home or on location on a consulting basis). Ambulatory services include ~~subacute ambulatory care services~~ (which refers to services provided following an inpatient stay or referrals directly from the community), Eastern Health post acute care (refers to the services received after

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discharge from acute facilities), HARP Aged Care (Hospital Admission Risk Programme, which is aimed at prevention and keeping people independent and at home) and ACAS (Aged Care Assessment Services where people are assessed as to whether they need high or low level residential care, that is, in nursing homes).

4. My portfolio of allied health extends beyond health professionals to groups such as dieticians and psychologists / neuropsychologists. It does not, however, encompass all groups of health professionals. Rather, my responsibilities are limited to physiotherapists, occupational therapists, social workers, speech pathologists, music therapists and podiatrists. I am not qualified to speak about other groups of health professionals such as community development workers, health information managers and medical imaging technicians and my comments in this statement do not necessarily apply to these groups.
5. I am a qualified speech pathologist (1987) and have an MPhil in linguistics (1995) and a Masters of Public Health (2005).
6. Prior to my current position at Eastern Health, I worked on secondment from St. Vincent's in the Program Branch of the Department of Human Services for about 15 months where I was responsible for ambulatory policy for HARP, Sub-acute Ambulatory Services and Post Acute Care for the state.
7. Prior to that I worked at St Vincent's, as Program Manager for the HARP Restoring Health chronic disease programme.
8. I make this statement from my own knowledge except as otherwise indicated. Where I have made this statement on the basis of information provided to me by another person or by reading that information, I believe such information to be true.

### **Eastern Health Structure**

9. I refer to the witness statement of Natalie Sullivan, General Manager Angliss Hospital and Yarra Ranges Health and Chief Allied Health Officer. I have read that witness statement and agree with what is said in respect of the structure of Eastern Health at paragraphs 6 to 13.

### **Structure of the Central East region and staffing arrangements**

10. In 2005 Wantirna Health was commissioned by the State Government and in October 2007 Wantirna Health was opened.
11. In or around April 2007 Eastern Health commenced a review of the allied health and sub-acute ambulatory services staffing profile at the Peter James Centre in order to

determine what staffing profile would be required at Wantirna Health. One of the outcomes of this review was the development of a department profile for each allied health discipline and the sub-acute ambulatory care services profile that would be required at Wantirna Health. It was initially intended that each discipline specific Chief would have operational responsibility for the relevant allied health professionals at both the Peter James Centre and Wantirna Health. However, during the review/ restructure process the then Chief of Physiotherapy and the Chief of Occupational Therapy at Box Hill Hospital resigned.

12. The resignation of the Chief of Physiotherapy and the Chief of Occupational Therapy prompted the Executive of Eastern Health to consider a restructure of allied health operations across all Central Health sites which would best facilitate continuity of care across acute and sub acute facilities – the Peter James Centre and Wantirna Health provide sub-acute inpatient and ambulatory care services and palliative care services and the Box Hill Hospital provides acute inpatient services, outpatient clinics and some community health services.
13. In or around May 2007, it was decided that continuity of care across acute and sub acute facilities would best be facilitated through a structure that extended across all Central Health sites. It was therefore decided that a discipline specific Chief with operational responsibility for all relevant allied health professionals across all Central East sites, including the Peter James Centre, Wantirna Health and the Box Hill Hospital would be appointed in respect of each allied health discipline.
14. I am aware that the restructure processes triggered conciliation proceedings before the Australian Industrial Relations Commission (**Commission**), brought by the Health Services Union (**HSU**), which was represented by Fleur Harbridge.
15. I attended one of the conciliation conferences before Commission Cribb. I recall that Commission Cribb recommended that the new model could be implemented under the terms of the EBA and the Award, but recommend that a further consultative meeting be held with the allied health professionals employed at the Box Hill Hospital.
16. I am aware that representatives of Eastern Health met with the allied health professionals at the Box Hill Hospital in accordance with Commission Cribb's recommendation.
17. The new structure was successfully implemented in or around August 2007. The new structure was extended to the Speech Pathology and Dietetics departments in or around October 2007.

18. The new structure has significantly improved patient flow from acute to subacute through to the community. The re-structure was not implemented to save money, rather it was designed to create a management structure that was more efficient and which best supported the delivery of services. In fact, the money that was saved as a result of making some of the Chief positions redundant at the Peter James Centre was used to employ additional allied health professionals at the Peter James Centre, Wantirna Health and at the Box Hill Hospital, including a number of Senior Clinicians and a Grade 4 position.
19. Eastern Health considers that the new structure has had a positive impact on the delivery of services and on the day to day operation of Eastern Health. Personally, I have received a lot of positive feedback from staff about the new structure. I have had no complaints about management structure issues and have lost no managers under the new structure.

#### **Response to the claims of the Health Services Union**

20. I am aware that the HSU is pursuing a number of claims in these proceedings. I have seen the draft Workplace Determination filed by the HSU which outlines these claims. I outline the impact those claims, if ordered by the Commission, would have on Eastern Health below.

#### *Staffing profile*

21. At clause 18 and Schedule 2 of the Health Services Union (**HSU**) draft Workplace Determination, the HSU seeks that there be a skill mix of allied health professionals in each department of no less than 1/3 grade 1, 1/3 grade 2 and 1/3 senior clinician or higher classification.
22. The staffing profile of allied health professionals at the Peter James Centre, Wantirna Health and the Box Hill Hospital reflects the service delivery requirements of those sites as well as facilitating continuity of care across the sites.
23. While some departments/teams at the Peter James Centre, Wantirna Health and Box Hill Hospital have a staffing profile similar to the one proposed by the HSU, for example physiotherapy, other departments/teams have a distinctly different staffing profile, for example music therapy. The staffing profile of each department/team varies depending on the service delivery requirements of the department/team, including the complexity of the conditions that are being treated, and patient needs. For example, the skill and expertise of allied health professionals at the Grade 3 level is required in the neurology stream because the complexity of the conditions being treated. On the other hand, allied health professionals at the Grades 1, 2 and 3 levels are employed in other

teams/departments because the complexity of the case load varies, enabling Grade 1 and Grade 2 professionals to receive clinical support and mentoring from more senior specialist staff to treat more complex cases. In many departments/teams, there is simply not enough demand of service to require the skill mix sought by the HSU, or to justify the employment of additional allied health professionals at various levels. Music therapy would be an example of this – currently there is a senior clinician and a grade 2 working within this department providing services at Wantirna Health.

24. The proposed staffing profile is not suitable for Eastern Health because it is inflexible and in no way takes into account the service delivery requirements of different departments/teams, the complexity of the conditions that are treated, the needs of the patients and their families / carers, or the level of skill and experience of the allied health professionals required to effectively treat and manage patients.
25. Further, if Eastern Health was required to implement the proposed staffing profile it would suffer significant funding strain. Eastern Health would be forced to employ a significant number of additional allied health professionals in those departments/teams and/or would have to promote a significant number of allied health professionals to levels they are unlikely to be properly skilled or experienced to perform at.
26. Despite the funding implications the proposed Staffing Profile would not improve the quality of treatment or care, or provide an improved career structure for allied health professionals. As noted above, Eastern Health has developed a structure for Central East which, in addition to providing an effective approach to service delivery by ensuring staff have adequate support structures, along with consistency in the management structure, also provides an exciting career structure for allied health professionals. Before the restructure of allied health at the Peter James Centre and Box Hill Hospital Eastern Health mostly employed allied health professionals at the Grade 1, 2 and Chief level only. As a result of the restructure, Eastern Health now has a much more developed career structure for allied health professionals who are passionate about clinical work rather than management. Eastern Health has moved from a very flat structure to a very deep career structure and professional development pathway.
27. The staffing profile should not be a mandated, inflexible, one size fits all approach. Eastern Health requires the flexibility to determine, based on service delivery requirements, and quality of treatment and care, how many allied health professionals it employs at any particular classification.

*Senior Clinician – Grade 4*

28. At clause 21.11 of the draft Workplace Determination, the HSU proposes that a full time Senior Clinician, Grade 4, be appointed on each site and in each section of each department.
29. This proposal would be impractical for Eastern Health which simply does not have the volume of staff, or the service demand to necessitate the employment of Senior Clinicians Grade 4 for every stream on every site and in each section of each department. The skill and expertise of a Senior Clinician simply could not be utilised in some sections of some departments to support the ongoing professional development of this role.
30. Further, the requirement to appoint a Senior Clinician Grade 4 on every site, in every section of every department would have significant cost implications for Eastern Health. The cost of implementing this proposal would come without any practical benefit to service delivery.
31. In addition, Box Hill Hospital did not have a chief of podiatry or speech pathology prior to the restructure. The manager of speech pathology was a senior clinician grade 3 and podiatry was managed by physiotherapy as there were only grade 2 clinicians in this department. Both these departments have now, through the restructure, been given an actual chief/management structure which has provided an improved career pathway for staff and provides effective professional leadership for these disciplines. This could not have been achieved without service consolidation across sites. In creating the new structure, extensive consultation took place in accordance with the Eastern Health organisational change processes.

*Chief structure*

32. At clause 21.10.7 of the HSU draft Workplace Determination, the HSU seeks that:
- a hospital department, howsoever called, that operates on more than one campus, appoint a Senior Chief and a Chief, who will be remunerated according to the total numbers of staff in the department and the numbers of health professionals that the Chief is operationally and/or professional responsible for;
  - a hospital department, howsoever called, that operates on one campus appoint a Chief and a Deputy Chief of the department, who will be remunerated according to the total numbers of staff in the department and the

numbers of health professionals that the Chief is operationally and/or professional responsible for.

33. The proposed Chief structure is not suitable or workable for Eastern Health. It does not take into account the service delivery requirements of the health service and the demand for focused clinical practitioners. Rather it proposes additional, and unnecessary layers of management.
34. As outlined above, six, discipline specific Chiefs currently operate across the Peter James, Wantirna Health and Box Hill Hospital sites.
35. Allied health Chiefs deal with staffing professional issues, recruitment and replacement, budget issues, clinical targets in a particular area and quality improvement initiatives. If there were an incident (which is very rare) involving, for example, occupational health and safety, then that would go through the Chief, as would any human resource, or industrial matters. Chiefs do not carry a specific clinical caseload (with the exception of assisting in times of sickness for example). This means that they are predominantly able to remain focused on management and leadership. Conversely, allied health clinicians are not involved in recruitment or budgetary issues (unless this is an expressed wish as part of their annual performance development plan for clinicians looking to move into management positions), and therefore have no managerial responsibilities outside of their day to day clinical and team responsibilities, (which include for example, reallocating case load if someone is absent from work). This structure ensures that allied health professionals are focused on providing clinical services and that management across all sites is consistent.
36. In order to fulfil these duties, the Chiefs sit on campus committees where information is shared as to what is going on at each campus. Further, Eastern Health has discipline specific professional leadership groups (comprised of Senior Clinicians and above) which meets monthly across allied health to share information to ensure consistency in clinical practice. This leadership group reports to the Allied Health Council (which comprises all the discipline specific Senior Advisors and Allied Health Directors), which in turn reports to the Executive across the health service.
37. In addition, Chiefs have professional (but not operational) leadership for employees of their allied health discipline who work in multidisciplinary teams.
38. Multidisciplinary teams exist in ambulatory areas. SACS rehabilitation for the Peter James Centre and Wantirna Health, for example, has a Chief grade 5 speech pathologist that leads a multidisciplinary team ~~comprised of nursing and allied health disciplines~~. For the speech discipline this manager could provide professional support,

while all the other professionals will get professional support through their department/discipline.

#### *Organisational Change Process*

39. At clause 18 and clause 8 of the draft Workplace Determination, the HSU proposes a process to be followed wherever a health service seeks to change the staffing profile of a department/team.
40. The proposed process is unworkable and unjustifiably prescriptive and would prevent Eastern Health from responding to the need to recruit additional staff as demand for services increased. Further, the proposed process does not contemplate that Eastern Health cannot always recruit at the desired level. For example, if Eastern Health advertises a position at the Grade 2 level but receives no applicants, it may be appropriate depending on the nature of the work, re-advertise at the Grade 1 level. If Eastern Health had to go through the proposed process every time it needed to change the staffing profile, it could not replace staff in a timely manner, which is critical, especially where there is a need to recruit staff in acute care. The union's proposal would cause unnecessary delays in recruitment which would put greater stress on clinicians and could result in us losing the applicant in a very tight market.
41. As seen in the commissioning of Wantirna Health, my managers and I are well placed to decide, based on our experience and research, the staffing that is needed for good patient care and efficient service delivery for new services. The proposed committee referred to in clause 18.3 of the HSU's draft workplace determination could not give us any better advice than what we do currently, which is using best practice benchmarks from other like facilities/ international standards and our own experience in the field.

#### *Classifications*

42. At clause 21.1.3 of the draft Workplace Determination, the HSU proposes that allied health professionals who have completed post-graduate degrees be classified at higher levels than allied health professionals who have only completed undergraduate studies.
43. This proposal fails to acknowledge that all new graduates have a qualification as a base level, and regardless of whether the graduate has completed an undergraduate degree, masters or doctorate, they have not yet acquired sufficient practical experience to warrant being classified at any level except the entry level.

*Sole employee*

44. At clause 21.10.3 of the draft Workplace Determination, the HSU proposes that an employee who is the only person in a particular discipline, or who is working independently, shall not be classified at less than the Grade 2 level.
45. This proposal is unsuitable for Eastern Health because it could apply to allied health professionals who work independently, or who may be the only allied health professional of a particular discipline in a team, but are still part of a team, and have the support and supervision of the team leader.
46. If an employee is the only person employed in a particular discipline in an organisation (and certain of the classifications now included in the list do not designate disciplines), it is reasonable that they should be employed at a grade 2 yr 1 minimum.
47. Eastern Health now operates a number of programs to ensure that patients with particular conditions receive focused care, including the chronic disease management program. It is possible that an allied health professional of a particular discipline will be the only allied health professional of that discipline within that program. However, the allied health professional is still part of a team and there are structures in place to ensure this clinician has access to professional support from their respective discipline.

*Study and professional development leave*

48. At clause 44 and clause 46 of the draft Workplace Determination, the HSU proposes an increase to the entitlement to study leave and professional development leave.
49. Eastern Health encourages attendance at courses and always contributes to conference registration and always pays for the period of leave. The HSU's claim is excessive and would have significant cost implications for Eastern Health and would increase the burden of finding staff to backfill.

*Backfill*

50. At clause 49.1 of the draft Workplace Determination, the HSU proposes that Eastern Health be required to backfill 100% of absences of five days or more.
51. Eastern Health currently backfills absences of ten or more days. Backfilling has significant cost implications for Eastern Health because it doubles the expense of labour for the duration of the absence. Further, Eastern Health often experiences great difficulty finding allied health professionals to do backfilling, particularly over a short

period of time, for example anything less than ten days (it is much easier to find an allied health professional to backfill for a more substantial period).

52. The HSU proposal that absences of five days or more be backfilled does not take account of the increased cost Eastern Health would experience, or of the difficulties Eastern Health currently experiences finding allied health professionals to backfill absences. It would be even more difficult to backfill an absence of five days than it would an absence of ten days.

**Response to the witness statement of Michelle O'Rourke**

53. I have read the witness statement of Michelle O'Rourke, Speech Pathologist, Southern Health.
54. I refer to paragraph 7 of Ms O'Rourke's statement where she claims that speech pathologists have unique skills and knowledge that encompass all aspects of communication and swallow function. While it is true that Speech Pathologists treat conditions which affect communication and swallow function, it is misleading to say that they have unique skills and knowledge that encompass all aspects of communication and swallow function, as not all conditions relating to communication and swallow function are treated solely by speech pathologists. For example, neuropsychologists may also be involved in the management of patients with communication impairments. The skills and knowledge that Speech Pathologists have is particular to communication and swallow function, however this is not mutually exclusive to this discipline.
55. I refer to paragraph 10 of Ms O'Rourke's statement where she outlines some of the causes of communication and swallowing difficulties. The causes listed are some of the areas which Speech Pathologists study while at university. I note that training in respect of all of these conditions has not changed, at least not in the last 18 years since I attended university and studied Speech Pathology. I note that while I have not clinically practised as a Speech Pathologist for the last 18 months, it is plausible that I could go back to practising tomorrow and only need to develop an understanding in respect of recently released technologies and receive a refresher on current clinical practice. My other skills would however, not need to be further developed before returning to practice.
56. I refer to paragraph 11 of Ms O'Rourke's statement where she claims that there has been an increase in the responsibility and expectations of Speech Pathologists which has required a rapid increase in the range of skills and knowledge demanded of both new graduate and experienced Speech Pathologists. There has not been an increase in the responsibility and expectations of Speech Pathologists. The expectation of Speech Pathologists in the medical community has always been that they deliver best evidence

based treatment. There has been a natural progression in the profession as with other professions in the use of different technologies. Different technologies are used for the purposes of diagnosing and we therefore have access to instruments that enable us to assess patients differently, however this is a natural progression which has occurred over the last ten or so years and has not resulted in an increased level of responsibility or expectation of speech pathologists. Speech pathologists use the same skills they have always used except that there is new equipment and/or resources which requires ongoing professional development. This is consistent for all professionals working in health.

57. I refer to paragraph 12 of Ms O'Rourke's witness statement where she notes that there has been a significant increase in the number of referrals to speech pathologists in recent years. It is true that there has been an increase in the number of referrals to Speech Pathologists working in hospitals. As the profession has gained recognition from other health professionals including medicine, the number of referrals have increased. However there has also been a great deal of investment in the ambulatory and community health sectors in recent years which means that the impact of the increase in referrals in the acute sector can be diverted where appropriate and safe to do so to these expanding services.
58. I refer to paragraph 13 of Ms O'Rourke's statement where she says that an additional 40% of the workload for speech pathologists is now from people with orthopaedic or multiple co-morbidities who occupy the non neurological beds in the ward. Ms O'Rourke claims that speech pathologists are not staffed to cover these beds. She claims this has had the effect of significantly increasing the need for acute style service in what is a sub-acute or rehabilitation section. It is unclear what Ms O'Rourke is claiming here. If a patient's condition is acute then they are classified as acute and if they are sub-acute they're classified as sub-acute. Further, there is no difference in treating a patient with a sub-acute condition to an acute condition to the extent that a Speech Pathologists would use the same skills and be treating similar conditions. The differences lie in length of stay during an inpatient admission and ongoing management either within sub-acute or a care plan that extends to ambulatory services.
59. I refer to paragraph 16 of Ms O'Rourke's witness statement where she says that the paediatric swallowing and feeding disorder is one of the most rapidly evolving patient care areas for health care professionals, particularly speech pathologists. I do not agree that this area of practice is rapidly evolving only that there have been changes in technology to the extent that babies born prematurely have access to improved technologies to maintain life. Once again however, as for other professionals, this would

be a natural progression of the profession in accordance with evolving clinical methods and technologies.

60. I refer to paragraph 17 of Ms O'Rourke's statement where she says due to the heavy demands on staff, Speech Pathologists in Southern Health have had to institute a division of time guideline for each grade level and a prioritisation document to prioritise patient care. While I am not able to comment on the practice at Southern Health, I note that Speech Pathologists, like all allied health professionals and health professionals generally, have always been required to prioritise patient care based on urgency and need.
61. I refer to paragraph 14 of Ms O'Rourke's witness statement where she refers to the Allied Health Guidelines, which she notes recommend that the ratio for Speech Pathologist to beds should be approximately 10:1. I have read the Allied Health Guidelines and am aware that there is debate within the allied health professions as to whether the proposed ratios should be a minimum requirement, or whether it is considered a "best practice" recommendation only. These guidelines are also more focussed on sub-acute inpatient ratios which vary from the acute sector.
62. I refer to paragraph 15 of Ms O'Rourke's statement and say that speech pathologists, like all allied health professionals are, to some extent, now required to work differently than they would have ten years ago. This is partially due to increased demand, changes in technology which have largely improved the way in which Speech Pathologists work, as a result of a higher occurrence of more complex conditions. As for all professionals working in the acute health care sector changes to demand and an ageing population have required all disciplines to adapt to these evolving work demands. Technologies have been introduced to streamline the assessment and management processes in order to meet the changes in demand, with the development of prioritisation tools based on acuity identified as another tool to facilitate workload management. However this has resulted in changes to policy and funding, with ambulatory services receiving more focus.
63. I refer to paragraph 20 of Ms O'Rourke's witness statement where she claims that there is an increased focus on achieving through-put targets. The focus of achieving through put targets is not new, it has been part of the responsibility of all health professionals for at least ten years. The skills that are required of Speech Pathologists and other allied health professionals in achieving through put targets is the skill of prioritising patient care. Speech Pathologists and allied health professionals have always been required to prioritise patient care. I further note that the push to reduce a patient's length of stay in hospital is not just about freeing up beds. There's been considerable funding provided to community based services over the last five to ten years so that patients may be

referred while in hospital to these services when safe and appropriate to do so. This is in the best interest of the patients and carers as hospitals are not the ideal place to stay long term due to the impact on health and function.

64. I refer to paragraph 29 of Ms O'Rourke's witness statement where she claims that Speech Pathologists are now required to have increased knowledge of and ability to use a range of clinical assessment and instrumental evaluation tools including fiberoptic endoscopic evaluation of swallowing (**FEES**) pulse oximetry cervical auscultation and electrical stimulation. The FEES instrument has been used for many years by the medical profession and is increasingly being used by Speech Pathologists with or without medical supervision. The use of these tools does not change the clinical interpretation that the Speech Pathologists uses, but has seen an evolution of equipment made available to them to enhance clinical practice.
65. At paragraph 29, Ms O'Rourke also claims that speech pathologists now have to have a more comprehensive understanding of anatomy and physiology. Speech Pathologists have always been required to have an extensive knowledge of anatomy and physiology and with changes in the course structure at some universities they will resume first year study of anatomy and physiology with medical students. This was the case when I studied first year.
66. I refer to paragraph 33 of Ms O'Rourke's statement and say that COPD has been around for many years and involvement of speech pathologists in providing services for patients with COPD has evolved over the last ten years. COPD presentations have increased with improvements in diagnostic procedures and people with a long standing history of smoking accessing the hospital system.
67. I refer to paragraph 46 of Ms O'Rourke's statement where she claims that the increased focus on ensuring competency and evidence based standards of practice requires time and access to literature and that staff undertake additional reading and researching out of hours to ensure best practice patient care. While there is no requirement at Eastern Health for allied health professionals to undertake reading and researching out of hours, it is the responsibility of all health professionals to keep abreast of developments in their field of expertise, read new research and update their skills as and when required.
68. I further note that Eastern Health has recently developed a research programme for allied health staff to undertake post graduate study or perform research. Under the training scheme, staff are released from normal duties to participate in formal education of six to seven training sessions and are allocated a supervisor (existing clinicians with masters or other post graduate qualifications) for them to conduct literary reviews to give them an opportunity to pursue related activities outside normal clinical practice. Because

the supervisors hold senior positions, part of their role is to provide leadership in research and implementation of evidence based practice and their clinical caseload is commensurate with these additional training requirements / duties.

**Response to the witness statement of Terrence Kelly**

69. I have read the witness statement of Terrence Kelly, Social Worker, Peter James Centre, Eastern Health.
70. I refer paragraph 5 of Mr Kelly's witness statement and confirm that as part of the restructure of allied health at the Peter James Centre and Box Hill Hospital, the positions of Chief of Physiotherapy, Chief Occupational Therapy, Chief of Social Work and Chief of Speech Pathology at the Peter James Centre were made redundant and new Chief positions were created in respect of all allied health disciplines which have responsibility across all three sites. I note that the Chief of Physiotherapy and the Chief of Occupational Therapy at the Box Hill Hospital resigned from their respective positions before the decision to restructure the three sites was made. The Chief of Social Work at the Box Hill Hospital was given the option of applying for the newly created Chief position, being re-deployed to another position, or being offered a redundancy package – she elected to be re-deployed.
71. I refer to paragraph 6 of Mr Kelly's witness statement and say that the re-structure of allied health at the Peter James Centre, and Box Hill Hospital was not designed to cut costs, nor did it cut costs. The money saved by making the duplicate Chief positions redundant was used to create new allied health profession positions at both sites, including for example, additional Grade 1 rotational positions in each discipline, new or additional site Senior Clinician (Grade 3) positions and a Grade 4 position in Physiotherapy at Box Hill Hospital.
72. I refer to paragraphs 10 and 11 of Mr Kelly's witness statement where he claims that the re-structure has negatively impacted on employee's accessibility to, and communication with discipline based management, and that overall discipline Chiefs are less able to deal responsively to everyday concerns. Mr Kelly also says that the overall Chief has less capacity to support staff, assist with and understand the everyday concerns of staff and advocate on behalf of individual team members. It has never been the role of a discipline specific Chief to deal with the 'everyday concerns' of the staff in their team unless this is impacting service delivery and performance. Eastern Health has a structured supervision system for all disciplines of which social work adheres too and all allied health professionals are expected to liaise with their clinical supervisor in respect of every day concerns unless these need to be escalated to the manager level in which case the manager would step in and provide the necessary support and guidance. This

methodology has not been averted by the new structure. In fact the support mechanisms in place provide allied health professionals with access to a broader base of clinical expertise and support within their respective disciplines.

73. I refer to paragraph 12 of Mr Kelly's statement where he claims that since the 2007 changes, decision making has become less collaborative and information sharing is more difficult as the Chief is the linchpin in these processes. While Eastern Health has appropriate consultative processes which it uses in respect of changes that may impact directly upon staff, it has never been the case that allied health professionals in junior clinical roles are involved in final decision making at a senior management level. It is simply not practical in a large organisation to involve all staff at all levels in final decision making. Adequate consultation is provided, comments on any proposed changes are sought and then an implementation plan based on where possible all the comments received is delivered in accordance with the Eastern Health and site specific organisational strategic direction. The management structure at Eastern Health ensures that allied health professionals working in clinical roles are able to maximise their clinical capabilities and deliver clinical services. This is important as the demand for clinical expertise has grown. The new structure makes clear the management role of Chiefs, the clinical leadership roles of Senior Clinicians and team leaders and the clinical role of allied health professionals.
74. At paragraph 12 of his witness statement Mr Kelly refers to the "Expression of Interest" document Social Workers are required to fill out to indicate their working preferences. Mr Kelly claims that formalised processes like this are being used rather than negotiating local working patterns collaboratively having regard to patient needs. I note that the "Expression of Interest" document was used by the Chief of Social Worker as part of the process of liaising with the Social Workers at the Peter James Centre to give each Social Worker the opportunity to work in the area and develop skills in the area that most interested them. As part of this process the Chief of Social Work met with each Social Worker individually to discuss their preferences. The process was, contrary to Mr Kelly's claim, a collaborative process which was designed to give Social Workers the opportunity to develop skills in the area they were most interested in, and to avoid having to direct any Social Workers to work in areas that were outside their interest.
75. I refer to paragraph 13 of Mr Kelly's statement where he claims that it is now more difficult for smaller sites to have their needs considered under the overall Chief arrangement, and that larger sites will absorb the attention of overall managers. Contrary to Mr Kelly's claim, each of Chiefs spends an equal amount of time at each site, regardless of the size of the site and the larger site, being Box Hill Hospital (based on inpatient beds), does not absorb any more or less attention of any of any of the

Chiefs as this is within the scope of their leadership and management capacity and abilities.

- 76. I refer to paragraph 15 of Mr Kelly's statement where he claims that all staff in Physiotherapy, Occupational Therapy and Social Work routinely work overtime for which they are not paid. This is not the case. No allied health professionals work overtime unless they are directed, and there is rarely the need to direct allied health professionals to work overtime. Where overtime is directed, it is paid in accordance with the EBA. Approval must be sought by the Director of Allied Health for all overtime.
  
- 77. I refer to paragraph 20 of Mr Kelly's statement where he claims that there are no Clinical Educator position at Eastern Health. Contrary to Mr Kelly's claim there is a Physiotherapy Clinical Educator conjointly employed by Eastern Health and Latrobe University to work across all Eastern Health sites and a Grade 4 Physiotherapist at Box Hill Hospital with clinical specialisation in orthopaedics who works across the Central East sites but provides professional support across Eastern Health in respect to her professional expertise.
  
- 78. I refer to paragraph 22 of Mr Kelly's statement where he claims that an on-site management structure is important to ensure the quality of patient focused practice as well as offering an enhanced career structure for allied health professionals. I disagree with Mr Kelly. The aim of the 2007 allied health restructure was to reduce the layers of management and invest in clinical positions to ensure timely and quality care and improved outcomes for patients. There is no doubt that the needs of patients are best addressed through investment in clinical positions, and not in unnecessary layers of management. The restructure has invested in these additional clinical positions. Further, the new structure developed has provided more opportunities for career development than ever before. Previously at the Peter James Centre and Box Hill Hospital there were only a limited number of positions at the Grade 3 level and these were not in every discipline – now we have positions at the Grade 3 level in every discipline on every site. We have also established a new Grade 4 position at Box Hill Hospital. In addition to this Box Hill Hospital has for the first time a Director of Allied Health who is an allied health professional, who is part of the senior management team and is able to directly inform the General Manager at Box Hill Hospital (and the General Manager of the Peter James Centre / Wantirna Health) of allied health needs and expanding service requirements.

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**MICHELLE LOUISE KOTIS**